



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://www.hmsa.com> or by calling 1-800-776-4672.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<b>\$0</b>	See the chart starting on page 2 for your costs for services this plan covers.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes. <b>\$2,500</b> person/ <b>\$7,500</b> family.	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, prescription drug copayments, payments for services subject to a maximum once you reach the maximum, any amounts you owe in addition to your copayment for covered services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. See <a href="http://www.hmsa.com/search/providers">http://www.hmsa.com/search/providers</a> or call 1-800-776-4672 for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	Yes.	This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <b>excluded services</b> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	Not covered	---none---
	Specialist visit	\$15 copay/visit	Not covered	---none---
	<b>Other practitioner office visit:</b> Physical and Occupational Therapist	\$15 copay/visit	Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Psychologist	\$15 copay/visit	Not covered	---none---
	Nurse Practitioner	\$15 copay/visit	Not covered	---none---
	<b>Preventive care</b> (Well Child Physician Visit)	No charge	Not covered	Age and frequency limitations may apply.
	<b>Screening</b> Colonoscopy Screening	No charge	Not covered	---none---
	Mammography Screening	No charge	Not covered	For age 35 to 39, limited to one screening. For age 40 and over, limited to one screening per calendar year.
	Pap Smears Screening	No charge	Not covered	Limited to one per calendar year.
	Prostate Specific Antigen Test Screening	10% co-insurance	Not covered	---none---
Sigmoidoscopy Screening	No charge	Not covered	---none---	
<b>Immunization</b> (Standard)	No charge	Not covered	---none---	

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<b>If you have a test</b>	<b>Diagnostic test</b> Inpatient Outpatient	No charge 10% co-insurance	Not covered Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
	<b>X-ray</b> Inpatient Outpatient	No charge 10% co-insurance	Not covered Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
	<b>Blood Work</b> Inpatient Outpatient	No charge 10% co-insurance	Not covered Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
	<b>Imaging (CT/PET scans, MRIs)</b> Inpatient Outpatient	No charge 10% co-insurance	Not covered Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.hmsa.com">http://www.hmsa.com</a> .	Generic drugs (retail)	\$7 copay/prescription	\$7 copay and 20% co-insurance/prescription	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.
	Generic drugs (mail order)	\$11 copay/prescription	Not covered	One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider.
	Preferred brand drugs (retail)	\$30 copay/prescription	\$30 copay and 20% co-insurance/prescription	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.
	Preferred brand drugs (mail order)	\$65 copay/prescription	Not covered	One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider.
	Non-preferred brand drugs (retail)	\$30 copay/prescription	\$30 copay and 20% co-insurance/prescription	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.hmsa.com">http://www.hmsa.com</a> .	Non-preferred brand drugs (mail order)	\$65 copay/prescription	Not covered	One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider. Other Brand Cost Share of \$35 per each retail copay or \$105 at a 90 day at retail network or mail order provider.
	Specialty drugs (retail)	\$30 copay/prescription	\$30 copay and 20% co-insurance/prescription	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.
	Specialty drugs (mail order)	\$65 copay/prescription	Not covered	One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider. Other Brand Cost Share of \$35 per each retail copay or \$105 at a 90 day at retail network or mail order provider.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	---none---
	Physician Visit	\$15 copay/visit	Not covered	---none---
	Surgeon fees	\$15 copay (cutting) \$15 copay (non-cutting)	Not covered Not covered	---none--- ---none---
<b>If you need immediate medical attention</b>	<b>Emergency room services</b>			
	Physician Visit	No charge	No charge	---none---
	Emergency Room	\$75 copay/visit	\$75 copay/visit	---none---
	Emergency medical transportation (air)	20% co-insurance	Not covered	Limited to air transport to the nearest adequate hospital within the State of Hawaii.

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency medical transportation (ground)	20% co-insurance	Not covered	Ground transportation to the nearest, adequate hospital to treat your illness or injury.
	Urgent care	\$15 copay/visit	Not covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	\$75 copay/day	Not covered	1 Copay Per Day
	Physician Visit	No charge	Not covered	---none---
	Surgeon fee	No charge (cutting) No charge (non-cutting)	Not covered Not covered	---none--- ---none---
If you have mental health, behavioral health, or substance abuse needs	<b>Mental/Behavioral health outpatient services</b>			
	Physician services	\$15 copay/visit	Not covered	---none---
	Hospital and facility services	No charge	Not covered	---none---
	<b>Mental/Behavioral health inpatient services</b>			
	Physician services	No charge	Not covered	---none---
	Hospital and facility services	\$75 copay/day	Not covered	---none---
	<b>Substance use disorder outpatient services</b>			
	Physician services	\$15 copay/visit	Not covered	---none---
Hospital and facility services	No charge	Not covered	---none---	
If you are pregnant	<b>Substance use disorder inpatient services</b>			
	Physician services	No charge	Not covered	---none---
	Hospital and facility services	\$75 copay/day	Not covered	---none---
	Prenatal and postnatal care	No charge	Not covered	---none---
If you are pregnant	Delivery (surgery)	No charge	Not covered	---none---
	Inpatient services (hospital room and board)	\$75 copay/day	Not covered	1 Copay Per Day

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<b>If you need help recovering or have other special health needs</b>	Home health care	No charge	Not covered	365 Visits per illness/injury
	Rehabilitation services	\$15 copay/visit	Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained. Excludes cardiac rehabilitation.
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	No charge	Not covered	60 Days per Benefit Period
	Durable medical equipment	50% co-insurance	Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Hospice service	No charge	Not covered	---none---
<b>If your child needs dental or eye care</b>	Eye exam	\$15 copay/exam	Not covered	Limited to one routine vision exam per calendar year.
	Glasses (single vision lenses and frames selected within designated group)	\$25 copay/glasses	All charges less \$28 plan payment	The frequency in which you can obtain a pair of glasses may vary
	Dental check-up	No charge	No charge	2 Services/Visits per Calendar Year

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cardiac rehabilitation
- Chiropractic care (e.g. hot/cold application, laser therapy)
- Cosmetic surgery
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (requires precertification)
- Dental care (Adult) (limited to services covered under a rider)
- Hearing aids (limited to one hearing aid per ear every 60 months)
- Infertility treatment (requires precertification and limited to a one time only benefit for one outpatient procedure while you are an HMSA member)
- Private-duty nursing
- Routine eye care (Adult)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-776-4672. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <http://www.cciio.cms.gov>.

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## Your Grievance and Appeals Rights:

All benefits are subject to the definitions, limitations, and exclusions set forth in the Guide to Benefits (GTB). If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For group health coverage subject to ERISA, you must submit a written request for an appeal to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about appeals, you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>. You may also file a grievance with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.

For non-federal governmental group health plans and church plans that are group health plans, you must submit a written request for an appeal to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about appeals, you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also file a grievance with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.

If you disagree with our appeals decision and coverage is insured (i.e. fully insured) you must request review by an Independent Review Organization (IRO) selected by the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804. If coverage is self-funded, you must request review by an Independent Review Organization (IRO) selected by HMSA at random from a panel of three IROs. Send written requests to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii, 96805-1958.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-776-4672.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-776-4672.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-776-4672.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-776-4672.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

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Coverage Examples

Coverage for: All Coverage Tiers | Plan Type: HMO

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: **\$7,540**
- Plan pays: **\$7,230**
- Patient pays: **\$310**

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Co-pays	\$90
Co-insurance	\$70
Limits or exclusions	\$150
<b>Total</b>	<b>\$310</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: **\$5,400**
- Plan pays: **\$4,240**
- Patient pays: **\$1,160**

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Co-pays	\$430
Co-insurance	\$650
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,160</b>

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-776-4672.

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- \* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- \* **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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