



This is only a summary. Please read the FEHB Plan brochure (RI 73-010) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at www.hmsa.com/federalplan/ or by calling 1-800-776-4672.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$ 0/Self only \$ 0/ Self plus one \$ 0/Self and Family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$3,000 Self only \$6,000 Self Plus One (\$3,000 per covered individual) \$9,000 Self and Family (\$3,000 per covered individual)	The out-of-pocket limit , or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses. The "per covered individual" amount is the most that any one member would have to pay, regardless of whether the individual is enrolled in Self Plus One, or Self and Family.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	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.
Does this plan use a network of providers?	Yes. For a list of Plan providers, see www.hmsa.com/federalplan/ or call 1-800-776-4672.	If you use an in-network doctor or other health care provider , 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 provider for some services. We use the term Plan provider for providers in our network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See this plan's FEHB brochure for additional information about excluded services .

Questions: Call 1-800-776-4672 or visit us at www.hmsa.com/federalplan/.
 If you aren't clear about any of the underlined terms used in this form, see the Glossary.
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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 Plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non- Plan Provider (plus you may be balance billed)	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	30% coinsurance	---none---
	Specialist visit	\$15 copay/visit	30% coinsurance	---none---
	Other practitioner office visit	\$15 copay/visit	30% coinsurance	---none---
	Preventive care/screening / immunization	No charge	30% coinsurance	Physical exams/ Mammography (screening) / Immunizations
If you have a test	Diagnostic test (x-ray, blood work)	x-ray - 20% coinsurance blood work - No charge	30% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Services may require prior approval.

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HMSA Plan: High Option
Summary of Benefits and Coverage

Coverage Period: 01/01/2017-12/31/2017

Coverage for: Self Only, Self Plus One or Self and Family | Plan Type: HMO with POS

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non- Plan Provider (plus you may be balance billed)	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.hmsa.com/porta1/fedplan87/.</p>	Generic drugs	\$7 copay/ prescription (retail) \$0 copay/ prescription (mail order)	\$7 copay plus 20% coinsurance/ prescription (retail)	Retail benefits limited to a 30-day Mail Order benefits limited to a 90-day supply
	Preferred brand drugs	\$35 copay/ prescription (retail) \$75 copay/ prescription (mail order)	\$35 copay plus 20% coinsurance/ prescription (retail)	Retail benefits limited to a 30-day Mail Order benefits limited to a 90-day supply
	Non-preferred brand drugs	\$70 copay/ prescription (retail) \$185 copay/ prescription (mail order)	\$70 copay plus 20% coinsurance/ prescription (retail)	Retail benefits limited to a 30-day Mail Order benefits limited to a 90-day supply
	Specialty drugs	Preferred Specialty Drug \$80 copay/ prescription (specialty pharmacy) Non-Preferred Specialty Drug \$200 copay/prescription (specialty pharmacy)	Not covered	Covers up to a 30-day supply at a participating specialty pharmacy
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	---none---
	Physician/surgeon fees	Physician \$15 copay/visit Surgeon fees No charge	30% coinsurance	---none---

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If you need immediate medical attention	Emergency room services	Emergency Room Facility 20% coinsurance Physician 20% coinsurance/ visit	Emergency Room Facility 20% coinsurance Physician 20% coinsurance/ visit	---none---
	Emergency medical transportation	No charge (ground ambulance)	No charge (ground ambulance)	---none---
	Urgent care	\$15 copay/visit	30% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 per admission	30% coinsurance	The allowed amount is based on semi-private room rate
	Physician/surgeon fee	Physician \$15 copay/visit Surgeon fees No charge	30% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 copay/visit	30% coinsurance	---none---
	Mental/Behavioral health inpatient services	\$200 per admission	30% coinsurance	The allowed amount is based on semi-private room rate
	Substance use disorder outpatient services	\$15 copay/visit	30% coinsurance	---none---
	Substance use disorder inpatient services	\$200 per admission	30% coinsurance	The allowed amount is based on semi-private room rate
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	---none---
	Delivery and all inpatient services	Delivery No charge Inpatient services \$200 per admission	30% coinsurance	Inpatient Services – The allowed amount is based on semi-private room rate

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Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non- Plan Provider (plus you may be balance billed)	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Covers up to 150 visits per calendar year
	Rehabilitation services	20% coinsurance	30% coinsurance	Services may require prior approval
	Habilitation services	20% coinsurance	30% coinsurance	Services may require prior approval
	Skilled nursing care	No charge	30% coinsurance	Covers up to 100 days per calendar year
	Durable medical equipment	20% coinsurance	30% coinsurance	Services may require prior approval
	Hospice service	No charge	Not covered	---none---
If your child needs dental or eye care	Eye exam	20% coinsurance	30% coinsurance	Limited to one exam per year
	Glasses	Not covered	Not covered	
	Dental check-up	No charge	30% coinsurance	Limited to one exam per year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other excluded services.)

- Acupuncture
- Cardiac Rehabilitation (except as offered through an HMSA program)
- Chiropractic Care
- Cosmetic Surgery
- Glasses (except for certain medical conditions)
- Long-term Care
- Private Duty Nursing
- Weight loss programs not offered through HMSA

Other Covered Services (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

- Bariatric Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Non-emergency care when traveling outside the U. S.
- Routine Eye Care (Adult)
- Routine Foot Care

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will 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. An individual policy may also provide different benefits than you had 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, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-776-4672 or visit www.opm.gov/insure/health.

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Your Appeal Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For information about your **appeal** rights please see Section 3, “How you get care,” and Section 8 “The disputed claims process,” in your plan's FEHB brochure. If you need assistance, you can contact: HMSA, Member Advocacy and Appeals, P. O. Box 1958, Honolulu, Hawaii 96805-1958 or call us at 808-948-5090 or toll free at 1-800-462-2085.

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.” **Coverage under this plan qualifies as 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). **The health coverage of this plan does meet the minimum value standard for the benefits the plan 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, kwijigo 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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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 \$7,140
- Patient pays \$400

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
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$210
Coinsurance	\$40
Limits or exclusions	\$150
Total	\$400

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

- Amount owed to providers: \$5,400
- Plan pays \$4,640
- Patient pays \$760

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
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$430
Coinsurance	\$250
Limits or exclusions	\$80
Total	\$760

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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, copayments, and coinsurance 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 copayments, deductibles, and coinsurance. 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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Important Information About Your Health Plan

HMSA doesn't discriminate

We comply with applicable federal civil rights laws. We don't discriminate, exclude people, or treat people differently because of:

- Race.
- Color.
- National origin.
- Age.
- Disability.
- Sex.

Services that HMSA provides

To better communicate with people who have disabilities or whose primary language isn't English, HMSA provides free services such as:

- Language services and translations.
- Text Relay Services.
- Information written in other languages.
- Information in other formats, such as large print, audio, and accessible digital formats.

If you need these services, please call 1 (800) 776-4672 toll-free.

How to file a grievance or complaint

If you believe that we've failed to provide these services or discriminated in another way, you can file a grievance in any of the following ways:

- Phone: 1 (800) 776-4672 toll-free
- Email: Compliance_Ethics@hmsa.com
- Fax: (808) 948-6414 on Oahu
- Mail: 818 Keeaumoku St., Honolulu, HI 96814

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, in any of the following ways:

- Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1 (800) 368-1019 toll-free; TDD users, call 1 (800) 537-7697 toll-free
- Mail: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201

For complaint forms, please go to hhs.gov/ocr/office/file/index.html.



English: This notice has important information about your HMSA application or plan benefits. It may also include key dates. You may need to take action by certain dates to keep your health plan or to get help with costs.

If you or someone you're helping has questions about HMSA, you have the right to get this notice and other help in your language at no cost. To talk to an interpreter, please call 1 (800) 776-4672 toll-free.

Ilocano: Daytoy a pakaammo ket naglaon iti napateg nga impormasion maipanggep iti aplikasionyo iti HMSA wenno kadagiti benepisioyo iti plano. Mabalin nga adda pay nairaman a petsa. Mabalin a masapulyo ti mangaramid iti addang agpatingga kadagiti partikular a petsa tapno agtalinaed kayo iti plano wenno makaala kayo iti tulong kadagiti gastos.

No addaan kayo wenno addaan ti maysa a tao a tultulonganyo iti salud-sod maipanggep iti HMSA, karbenganyo a maala daytoy a pakaammo ken dadduma pay a tulong iti bukodyo a pagsasao nga awan ti bayadna. Tapno makapatang ti maysa a mangipatarus ti pagsasao, tumawag kay koma iti 1 (800) 776-4672 toll-free.

Tagalog: Ang abiso na ito ay naglalaman ng mahalagang impormasyon tungkol sa inyong aplikasyon sa HMSA o mga benepisyo sa plano. Maaari ding kasama dito ang mga petsa. Maaaring kailangan ninyong gumawa ng hakbang bago sumapit ang mga partikular na petsa upang mapanatili ninyo ang inyong planong pangkalusugan o makakuha ng tulong sa mga gastos.

Kung kayo o isang taong tinutulungan ninyo ay may mga tanong tungkol sa HMSA, may karapatan kayong makuha ang abiso na ito at iba pang tulong sa inyong wika nang walang bayad. Upang makipag-usap sa isang tagapagsalin ng wika, mangyaring tumawag sa 1 (800) 776-4672 toll-free.

Japanese: 本通知書には、HMSAへの申請や医療給付に関する重要な情報や日付が記載されています。医療保険を利用したり、費用についてサポートを受けるには、本通知書に従って特定の日付に手続きしてください。

患者さん、または付き添いの方がHMSAについて質問がある場合は、母国語で無料で通知を受けとったり、他のサポートを受ける権利があります。通訳を希望する場合は、ダイヤルフリー電話 1 (800) 776-4672 をご利用ください。

Chinese: 本通告包含關於您的 HMSA 申請或計劃福利的重要資訊。也可能包含關鍵日期。您可能需要在某確定日期前採取行動，以維持您的健康計劃或者獲取費用幫助。

如果您或您正在幫助的某人對 HMSA 存在疑問，您有權免費獲得以您母語表述的本通告及其他幫助。如需與口譯員通話，請撥打免費電話 1 (800) 776-4672。

Korean: 이 통지서에는 HMSA 신청서 또는 보험 혜택에 대한 중요한 정보가 들어 있으며, 중요한 날짜가 포함되었을 수도 있습니다. 해당 건강보험을 그대로 유지하거나 보상비를 수령하려면 해당 기한 내에 조치를 취하셔야 합니다.

신청자 본인 또는 본인의 도움을 받는 누군가가 HMSA에 대해 궁금한 사항이 있으면 본 통지서를 받고 아무런 비용 부담 없이 모국어로 다른 도움을 받을 수 있습니다. 통역사를 이용하려면 수신자 부담 전화 1 (800) 776-4672번으로 연락해 주시기 바랍니다.

Spanish: Este aviso contiene información importante sobre su solicitud a HMSA o beneficios del plan. También puede incluir fechas clave. Pueda que tenga que tomar medidas antes de determinadas fechas a fin de mantener su plan de salud u obtener ayuda con los gastos.

Si usted o alguien a quien le preste ayuda tiene preguntas respecto a HMSA, usted tiene el derecho de recibir este aviso y otra ayuda en su idioma, sin ningún costo. Para hablar con un intérprete, llame al número gratuito 1 (800) 776-4672.

Vietnamese: Thông báo này có thông tin quan trọng về đơn đăng ký HMSA hoặc phúc lợi chương trình của quý vị. Thông báo cũng có thể bao gồm những ngày quan trọng. Quý vị có thể cần hành động trước một số ngày để duy trì chương trình bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí.

Nếu quý vị hoặc người quý vị đang giúp đỡ có thắc mắc về HMSA, quý vị có quyền nhận thông báo này và trợ giúp khác bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, vui lòng gọi số miễn cước 1 (800) 776-4672.

Samoaan - Fa'asamoa: O leni fa'aliga tāua e fa'ataua i lau tusi talosaga ma fa'amanuiaga 'e te ono agava'a ai, pe'a fa'amanuiaina 'oe i le polokalame o le HMSA. E aofia ai fo'i i lalo o leni fa'aliga ia aso tāua. E ono mana'omia 'oe e fa'atinoina ni galuega e fa'atonuina ai 'oe i totonu o le taimi fa'atulagaina, ina 'ia e agava'a ai pea mo fa'amanuiaga i le poloka-

