



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:
What is the overall <u>deductible</u>?	\$6,850 person/ \$13,700 family Doesn't apply to well-child care and the following services from a participating provider: preventive care and generic prescription drugs and supplies.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,850 person/ \$13,700 family.	The <u>out-of-pocket limit</u> 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.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, payments for services subject to a maximum once you reach the maximum, any amounts you owe in addition to your copayment for covered services, physical exam, adult vision, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>network of providers</u>?	Yes. See http://www.hmsa.com/search/providers or call 1-800-776-4672 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> 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 7. See your policy or plan document for additional information about <u>excluded services</u> .

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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 provider's office or clinic	Primary care visit to treat an injury or illness	No charge	No charge	---none---
	Specialist visit	No charge	No charge	---none---
	Other practitioner office visit: Physical and Occupational Therapist	No charge	No charge	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Psychologist	No charge	No charge	---none---
	Nurse Practitioner	No charge	No charge	---none---
	Preventive care (Well Child Physician Visit)	No charge	No charge	Age and frequency limitations may apply.
	Screening (Grade A & B recommendations of the U.S. Preventive Services Task Force)	No charge	No charge	---none---
	Immunization (Standard)	No charge	No charge	---none---
If you have a test	Diagnostic test Inpatient	No charge	No charge	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Outpatient	No charge	No charge	Services may require precertification. Benefits may be denied if precertification is not obtained.
	X-ray Inpatient	No charge	No charge	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Outpatient	No charge	No charge	Services may require precertification. Benefits may be denied if precertification is not obtained.

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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 have a test	Blood Work Inpatient Outpatient	No charge No charge	No charge No charge	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Imaging (CT/PET scans, MRIs) Inpatient Outpatient	No charge No charge	No charge No charge	Services may require precertification. Benefits may be denied if precertification is not obtained.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.hmsa.com .	Tier 1 – mostly Generic drugs (retail)	\$10 copay/prescription (before deductible) No Charge (after deductible)	No charge	Benefits from a nonparticipating provider are available after the plan deductible is met
	Tier 1 – mostly Generic drugs (mail order)	\$20 copay/prescription (before deductible) No Charge (after deductible)	Not covered	Retail benefits limited to 30-day supply Mail order benefits limited to a 90-day supply
	Tier 2 – mostly Preferred drugs (retail)	No charge	No charge	Benefits are available after the plan deductible is met
	Tier 2 – mostly Preferred drugs (mail order)	No charge	Not covered	Retail benefits limited to 30-day supply Mail order benefits limited to a 90-day supply
	Tier 3 – mostly Other Brand Name drugs (retail)	No charge	No charge	Benefits are available after the plan deductible is met
	Tier 3 – mostly Other Brand Name drugs (mail order)	No charge	Not covered	Retail benefits limited to 30-day supply Mail order benefits limited to a 90-day supply
	Tier 4 – mostly Preferred Specialty Drugs (retail) Tier 5 – mostly Other Brand Name Specialty Drugs (retail) Tier 4 & 5 (mail order)	No charge No charge Not covered	Not covered Not covered Not covered	Benefits are available after the plan deductible is met Retail benefits limited to 30-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
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	---none---
	Physician Visit	No charge	No charge	---none---
	Surgeon fees	No charge (cutting) No charge (non-cutting)	No charge (cutting) No charge (non-cutting)	---none---
If you need immediate medical attention	Emergency room services			
	Physician Visit	No charge	No charge	---none---
	Emergency Room	No charge	No charge	---none---
	Emergency medical transportation (air)	No charge	No charge	Limited to air transport to the nearest adequate hospital within the State of Hawaii.
	Emergency medical transportation (ground)	No charge	No charge	Ground transportation to the nearest, adequate hospital to treat your illness or injury.
Urgent care	No charge	No charge	---none---	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	---none---
	Physician Visit	No charge	No charge	---none---
	Surgeon fee	No charge (cutting) No charge (non-cutting)	No charge (cutting) No charge (non-cutting)	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	Physician services	No charge	No charge	---none---
	Hospital and facility services	No charge	No charge	---none---
	Mental/Behavioral health inpatient services			
	Physician services	No charge	No charge	---none---
	Hospital and facility services	No charge	No charge	---none---
Substance use disorder outpatient services				
Physician services	No charge	No charge	---none---	
Hospital and facility services	No charge	No charge	---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
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder inpatient services			
	Physician services	No charge	No charge	---none---
	Hospital and facility services	No charge	No charge	---none---
If you are pregnant	Prenatal and postnatal care	No charge	No charge	---none---
	Delivery (surgery)	No charge	No charge	---none---
	Inpatient services (hospital room and board)	No charge	No charge	---none---
If you need help recovering or have other special health needs	Home health care	No charge	No charge	150 Services/Visits per Calendar Year
	Rehabilitation services	No charge	No charge	Services may require precertification. Benefits may be denied if precertification is not obtained. Excludes cardiac rehabilitation.
	Habilitation services	No charge (DME)	No charge (DME)	Services may require precertification. Benefits may be denied if precertification is not obtained.
		No charge (PT/OT outpatient)	No charge (PT/OT outpatient)	Services may require precertification. Benefits may be denied if precertification is not obtained.
		No charge (Speech Therapy outpatient)	No charge (Speech Therapy outpatient)	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Skilled nursing care	No charge	No charge	120 Days per Calendar Year
	Durable medical equipment	No charge	No charge	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Hospice service	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
If your child needs dental or eye care	Eye exam	\$10 copay/exam	50% co-insurance	Limited to one routine vision exam per calendar year. Benefits available through age 18.
	Glasses (single vision lenses and frames selected within designated group)	\$25 copay/glasses	50% co-insurance	Limited to one pair of glasses per calendar year. Benefits available through age 18.
	Dental check-up	Not covered	Not covered	Excluded service

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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
- Dental care (Adult)
- Dental care (Child)
- Long-term care
- Private-duty nursing
- 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)
- 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)
- Non-emergency care when traveling outside the U.S. For more information, see <http://www.hmsa.com>
- Routine eye care (Adult)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-776-4672. You may also contact your state insurance department at Insurance Division, P.O. Box 3614, Honolulu, HI 96811.

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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 individual health coverage, 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, you may 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.

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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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: \$540**
- **Patient pays: \$7,000**

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	\$6,850
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$150

Total \$7,000

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

- **Amount owed to providers: \$5,400**
- **Plan pays: \$2,900**
- **Patient pays: \$2,500**

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	\$2,420
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$2,500

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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