



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.hmaa.com](http://www.hmaa.com) or call 1-888-941-4622. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.hmaa.com](http://www.hmaa.com) or call 1-888-941-4622 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$100/Individual or \$300/family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , primary care services, contraceptives, emergency services, prescription drug and supplies and well-child care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$2,500/Individual or \$7,500/family (applies to medical coverage). \$5,000/Individual or \$7,500/family (applies to drug coverage).	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> and <a href="#">coinsurance</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they do not count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.hmaa.com">www.hmaa.com</a> or call 1-888-941-4622 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a>	Age and frequency limitations may apply. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.hmaa.com">www.hmaa.com</a>	Generic drugs	\$5 <a href="#">copay</a> / Prescription (retail) \$10 <a href="#">copay</a> / Prescription (mail order)	Wholesale price minus \$5 <a href="#">copay</a> / Prescription (retail) \$10 <a href="#">copay</a> / Prescription (mail order)	<a href="#">Copayments</a> are charged per prescription. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). This is a mandatory generic <a href="#">plan</a> , which means if there is a generic equivalent available and a brand name drug is dispensed, then the member is responsible for the respective brand name <a href="#">copay</a> PLUS the cost difference between the generic and the brand name drug. If you go to an <a href="#">out-of-network provider</a> , member pays the total amount up front and is reimbursed based upon the wholesale price minus the applicable <a href="#">copayments</a> . The member will be responsible for any remaining balance over the eligible charge up to the full billed amount. In addition to the applicable <a href="#">copayment</a> , patient pays 20% of the cost for prescriptions > \$250 (retail) or > \$750 (mail order).
	Preferred brand drugs	\$20 <a href="#">copay</a> / Prescription (retail) \$45 co-pay/ Prescription (mail order)	Wholesale price minus \$20 <a href="#">copay</a> / Prescription (retail) \$45 <a href="#">copay</a> / Prescription (mail order)	
	Non-preferred brand drugs	\$35 <a href="#">copay</a> / Prescription (retail) \$75 <a href="#">copay</a> / Prescription (mail order)	Wholesale price minus \$35 <a href="#">copay</a> / Prescription (retail) \$75 <a href="#">copay</a> / Prescription (mail order)	
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	

\*For more information about limitations and exceptions, see the plan or policy document at [hmaa.com](http://hmaa.com)



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need		What You Will Pay		Limitations, Exceptions, & Other Important Information
			Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)		10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	Physician/surgeon fees		10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>		10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	None
	<a href="#">Emergency medical transportation</a>	<a href="#">Air</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Coverage for air transportation is limited to the United States.
		<a href="#">Ground</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<a href="#">Urgent care</a>		\$25 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	\$50 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	None	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)		10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced.
	Physician/surgeon fees		10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services		10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	Inpatient services		10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced.
<b>If you are pregnant</b>	Office visits		10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	Childbirth/delivery professional services		10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services		10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>		No charge	30% <a href="#">coinsurance</a>	Coverage limited to 150 days per calendar year. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced.

\*For more information about limitations and exceptions, see the plan or policy document at hmaa.com



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Rehabilitation services</a>	Inpatient: 10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply Outpatient: 20% <a href="#">coinsurance</a>	Inpatient: 30% <a href="#">coinsurance</a> Outpatient: 30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for inpatient services. If you don't get <a href="#">preauthorization</a> , benefits could be reduced.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	Inpatient: 10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	Coverage limited to 120 days in any calendar year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced.
	<a href="#">Hospice services</a>	No Charge	Not covered	None
	<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered
Children's glasses		Not covered	Not covered	None
Children's dental check-up		Not covered	Not covered	None

### Excluded Services & Other Covered Services:

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: HMAA at (888) 941-4622 or [CustomerService@hmaa.com](mailto:CustomerService@hmaa.com), or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

\*For more information about limitations and exceptions, see the plan or policy document at [hmaa.com](http://hmaa.com)

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: HMAA at (888) 941-4622 or CustomerService@hmaa.com, or the Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, HI 96813 at (808) 586-2804 or the Department of Labor Employment Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-941-4622.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-941-4622.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-941-4622.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-941-4622.

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

**PRA Disclosure Statement**

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Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact your plan sponsor.

\*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

\*For more information about limitations and exceptions, see the plan or policy document at hmaa.com

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,470</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$400
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$820</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$10
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$510</b>