



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 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 or call 1-888-941-4622 to request a copy.

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



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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance ; deductible does not apply	30% coinsurance	None
	Specialist visit	10% coinsurance ; deductible does not apply	30% coinsurance	
	Preventive care/screening/immunization	No charge	30% coinsurance	Age and frequency limitations may apply. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance ; deductible does not apply	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance ; deductible does not apply	30% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hmaa.com	Generic drugs	\$12 copay / Prescription (retail) \$24 copay / Prescription (mail order)	Wholesale price minus \$12 copay / Prescription (retail) \$24 copay / Prescription (mail order)	Copayments 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 plan , 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 copay PLUS the cost difference between the generic and the brand name drug. If you go to an out-of-network provider , member pays the total amount up front and is reimbursed based upon the wholesale price minus the applicable copayments . The member will be responsible for any remaining balance over the eligible charge up to the full billed amount. In addition to the applicable copayment ,
	Preferred brand drugs	\$24 copay / Prescription (retail) \$48 co-pay/ Prescription (mail order)	Wholesale price minus \$24 copay / Prescription (retail) \$48 copay / Prescription (mail order)	
	Non-preferred brand drugs	\$48 copay / Prescription (retail) \$96 copay / Prescription (mail order)	Wholesale price minus \$48 copay / Prescription (retail) \$96 copay / Prescription (mail order)	
	Specialty drugs	20% coinsurance	20% coinsurance	



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)	
				patient pays 20% of the cost for prescriptions > \$250 (retail) or > \$750 (mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance ; deductible does not apply	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance ; deductible does not apply	30% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance ; deductible does not apply	10% coinsurance ; deductible does not apply	None
	Emergency medical transportation	20% coinsurance	30% coinsurance	Coverage for air transportation is limited to the United States.
	Urgent care	\$25 copay ; deductible does not apply	\$50 copay ; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance ; deductible does not apply	30% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced.
	Physician/surgeon fees	10% coinsurance ; deductible does not apply	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance ; deductible does not apply	30% coinsurance	None
	Inpatient services	10% coinsurance ; deductible does not apply	30% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced.
If you are pregnant	Office visits	10% coinsurance ; deductible does not apply	30% coinsurance	None



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)	
	Childbirth/delivery professional services	10% coinsurance ; deductible does not apply	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance ; deductible does not apply	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Coverage limited to 150 days per calendar year. Preauthorization is required. If you don't get preauthorization , benefits could be reduced.
	Rehabilitation services	20% coinsurance	30% coinsurance	Preauthorization is required for inpatient services. If you don't get preauthorization , benefits could be reduced.
	Habilitation services			
	Skilled nursing care	Inpatient: 10% coinsurance ; deductible does not apply	30% coinsurance	Coverage limited to 120 days in any calendar year.
	Durable medical equipment	20% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced.
	Hospice services	No Charge	Not covered	None.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Coverage limited to one exam per calendar year. Benefits available through age 18.
	Children's glasses	No Charge	Not covered	Single vision lenses and frames selected within designated group. Coverage limited to one pair of glasses per calendar year. Benefits available through age 18.
	Children's dental check-up	No Charge	20% coinsurance	Coverage limited to 2 exams per calendar year. Benefits available through age 18.

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, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 or call 1-800-318-2596.

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.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.*-----

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 [plan's](#) overall [deductible](#) \$100
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$48
Coinsurance	\$1,364
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,472

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$684
Coinsurance	\$479
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,318

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$296
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$396