



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                                                                                                                                                                                        | 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="#">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<br>(You will pay the least)                                | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                   | 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.                                                                                                                                                                                                                                                                                                                                                    |
| If you have a test                                                                                                                                                                       | <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>                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.hmaa.com">www.hmaa.com</a> | Generic drugs                                          | No charge                                                                   | 20% <a href="#">coinsurance</a>                    | Coverage limited to diabetic drugs and diabetic supplies for all members. Contraceptives covered for women only.<br>Only preferred brand named diabetic supplies are covered at no charge.<br>Diabetic drugs and non-preferred brand named diabetic supplies have a 20% <a href="#">coinsurance</a> .<br>Non-preferred brand named diabetic drugs have a 30% <a href="#">coinsurance</a> .<br>Diaphragms, cervical caps and generic contraceptives for women are covered at no charge when using a <a href="#">network provider</a> .<br>Coverage for specialty drugs limited to oral chemotherapy only. |
|                                                                                                                                                                                          | Preferred brand drugs                                  | 20% <a href="#">coinsurance</a>                                             | 20% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                          | Non-preferred brand drugs                              | 20% <a href="#">coinsurance</a>                                             | 30% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                          | <a href="#">Specialty drugs</a>                        | No charge                                                                   | No charge                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| If you have outpatient surgery                                                                                                                                                           | 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

\*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<br>(You will pay the least)                                           | Out-of-Network Provider<br>(You will pay the most)                             |                                                                                                                                                                              |
|                                                                           | Physician/surgeon fees                           |                        | 10% <a href="#">coinsurance</a> ;<br><a href="#">deductible</a> does not apply         | 30% <a href="#">coinsurance</a>                                                |                                                                                                                                                                              |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              |                        | 10% <a href="#">coinsurance</a> ;<br><a href="#">deductible</a> does not apply         | 10% <a href="#">coinsurance</a> ;<br><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                                                                                                                                                                         |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               |                        | 10% <a href="#">coinsurance</a> ;<br><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> ;<br><a href="#">deductible</a> does not apply         | 30% <a href="#">coinsurance</a>                                                |                                                                                                                                                                              |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              |                        | 10% <a href="#">coinsurance</a> ;<br><a href="#">deductible</a> does not apply         | 30% <a href="#">coinsurance</a>                                                | None                                                                                                                                                                         |
|                                                                           | Inpatient services                               |                        | 10% <a href="#">coinsurance</a> ;<br><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.                                                 |
| If you are pregnant                                                       | Office visits                                    |                        | 10% <a href="#">coinsurance</a> ;<br><a href="#">deductible</a> does not apply         | 30% <a href="#">coinsurance</a>                                                | None                                                                                                                                                                         |
|                                                                           | Childbirth/delivery professional services        |                        | 10% <a href="#">coinsurance</a> ;<br><a href="#">deductible</a> does not apply         | 30% <a href="#">coinsurance</a>                                                |                                                                                                                                                                              |
|                                                                           | Childbirth/delivery facility services            |                        | 10% <a href="#">coinsurance</a> ;<br><a href="#">deductible</a> does not apply         | 30% <a href="#">coinsurance</a>                                                |                                                                                                                                                                              |
| If you need help recovering or have other special health needs            | <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. |
|                                                                           | <a href="#">Rehabilitation services</a>          |                        | Inpatient: 10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply | Inpatient: 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.                          |
|                                                                           |                                                  |                        | Outpatient: 20%                                                                        | Outpatient: 30%                                                                |                                                                                                                                                                              |

\*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<br>(You will pay the least)                                           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                              |
|                                        |                                           | <a href="#">coinsurance</a>                                                            | <a href="#">coinsurance</a>                        |                                                                                                                              |
|                                        | <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                                                                                                                         |
| If your child needs dental or eye care | Children's eye exam                       | Not covered                                                                            | Not covered                                        | None                                                                                                                         |
|                                        | 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**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$0            |
| Coinsurance                       | \$1,400        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,460</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> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$100          |
| Copayments                        | \$0            |
| Coinsurance                       | \$900          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,020</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> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$100        |
| Copayments                        | \$0          |
| Coinsurance                       | \$400        |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$500</b> |