**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?** | 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. |



*(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019: DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022: HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)*

COMP E-31-2 010127 OP2 (Rx 12/24/48-CO_Max)

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; deductible does not apply (retail) $24 copay/ Prescription; deductible does not apply (mail order) | Wholesale price minus $12 copay/ Prescription; deductible does not apply (retail) $24 copay/ Prescription; deductible does not apply (mail order) | The annual deductible is $500.00. It is a fixed dollar amount you must pay each calendar year before benefits become available. You cannot pay the annual deductible amount to us in advance. You must meet the deductible on a claim by claim basis. 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 |
| | 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 | |

*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: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | | | | member will be responsible for any remaining balance over the eligible charge up to the full billed amount. In addition to the applicable copayment, 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 | Air | 20% coinsurance | 20% coinsurance | Coverage for air transportation is limited to the United States. |
| | | Ground | 20% coinsurance | 30% coinsurance | |
| | 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 | | No charge; deductible does not apply | 30% coinsurance | None |
| | Childbirth/delivery professional services | | No charge; deductible does not apply | 30% coinsurance | |
| | Childbirth/delivery facility services | | No charge; deductible does not apply | 30% coinsurance | |

*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) | |
| **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 | Inpatient: 10% coinsurance; deductible does not apply | Inpatient: 30% coinsurance | Preauthorization is required for inpatient services. If you don't get preauthorization, benefits could be reduced. |
| | | Outpatient: 20% coinsurance | Outpatient: 30% coinsurance | |
| | Habilitation services | Not covered | Not covered | None |
| | 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 | 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

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

**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.**
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, kwiijigo 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 plan's overall deductible | $100 |
| Specialist coinsurance | 0% |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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** | **$12,700** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$60** |

### 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** | **$5,600** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $400 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$820** |

### 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** | **$2,800** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $10 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$510** |

The plan would be responsible for the other costs of these EXAMPLE covered services.