This is only a summary. If you want more detail about your medical coverage and costs, you can get the complete terms in the policy or plan document at www.hma-hi.com or by calling 1-866-331-5913. If you want more detail about your prescription drug coverage and costs, you can get the complete terms in the policy or plan document at www.catamaranrx.com or by calling 1-888-869-4600.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes. $2,800** per person / **$8,400** per family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, prescription drug copayments, penalties for failure to obtain prior authorization for services and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.hma-hi.com or call 951-4694 (Oahu) or 1-866-331-5913 (Neighbor Island). For a list of participating pharmacies, please visit www.catamaranrx.com.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% co-insurance	20% co-insurance	----- None -----
	Specialist visit	10% co-insurance	20% co-insurance	
	Other practitioner office visit	100% of charge for chiropractic services less reimbursement	100% of charge for chiropractic services less reimbursement	Limited to 12 visits per calendar year. Reimbursement of $5.50 for each first visit and $5.00 for each subsequent visit. Reimbursement of $50.00 per calendar year for X-ray films.
	Preventive care/screening/ immunization	10% co-insurance for immunizations and well baby care	20% co-insurance for immunizations and well baby care	Routine physical exam: Not Covered. You owe no co-insurance for TB test, Mammography, Routine Pap Smear & PSAs.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% co-insurance	----- None -----
	Imaging (CT/PET scans, MRIs)	No charge	20% co-insurance	Prior authorization required for PET scans, MRAs and MRIs. If not obtained, benefit payments will be reduced by 10%.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.catamaranrx.com	Generic drugs	15 Day Supply (Retail): $6 60 Day Supply (Retail): $9 60 Day Supply (Mail Order): $9	100% of actual charges and can be reimbursed 100% of E.C. (Eligible Charges) after $4 copay*	*Limited to a 15 day supply through Direct Member Reimbursement (DMR)
	Preferred brand drugs	15 Day Supply (Retail): $18 60 Day Supply (Retail): $28 60 Day Supply (Mail Order): $28	100% of actual charges and can be reimbursed 100% of E.C. after $10 copay*	*Limited to a 15 day supply through DMR
	Non-preferred brand drugs	15 Day Supply (Retail): $18 60 Day Supply (Retail): $28 60 Day Supply (Mail Order): $28	100% of actual charges and can be reimbursed 100% of E.C. after $10 copay*	*Limited to a 15 day supply through DMR
	Specialty drugs	Medical Plan: 20% co-insurance Drug Plan: Generic or Brand copay applies	Medical Plan: 20% co-insurance Drug Plan: Generic or Brand copay applies	Prior authorization required for certain injectables. If not obtained, benefit payments will be reduced by 10%. Oral Specialty medications covered under prescription drug benefit; prior authorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% co-insurance	Prior authorization required for certain outpatient surgeries. If not obtained, benefit payments will be reduced by 10%.
	Physician/surgeon fees	No charge	20% co-insurance	
If you need immediate medical attention	Emergency room services	No charge	20% co-insurance	Covered only for true emergencies.
	Emergency medical transportation	10% co-insurance for ground and 20% co-insurance for air ambulance	20% co-insurance for ground and air ambulance	Air ambulance limited to transport within the State of Hawaii; transport within U.S.A. is covered when facilities in Hawaii are not equipped to furnish treatment.
	Urgent care	10% co-insurance	20% co-insurance	----- None -----

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% co-insurance	Prior authorization required for non-emergency and non-maternity admissions. If not obtained, benefit payments will be reduced by 10%.
	Physician/surgeon fee	10% co-insurance (physician fee) No charge (surgeon fee)	20% co-insurance	----- None -----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% co-insurance	20% co-insurance	Treatment Plan required for inpatient and outpatient services. Prior authorization required for inpatient services. If not obtained, benefit payments will be reduced by 10%.
	Mental/Behavioral health inpatient services	No charge	20% co-insurance	
	Substance use disorder outpatient services	10% co-insurance	20% co-insurance	
	Substance use disorder inpatient services	No charge	20% co-insurance	
If you are pregnant	Prenatal and postnatal care	10% co-insurance (physician services)	20% co-insurance	Prior authorization required for more than 2 OB ultrasounds per pregnancy. If not obtained, benefit payments will be reduced by 10%.
	Delivery and all inpatient services	No charge (facility fee) 10% co-insurance (physician services)	20% co-insurance	Notification to HMA required within 48 hours or by the next business day. If notice is not provided, benefit payments will be reduced by 10%.
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance	Up to 150 visits per calendar year. Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Rehabilitation services	20% co-insurance	20% co-insurance	Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Habilitation services	Not covered	Not covered	Excluded service

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	10% co-insurance	20% co-insurance	Up to 120 days per calendar year. Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Durable medical equipment	20% co-insurance	20% co-insurance	Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Hospice service	No charge	Not covered	Up to 150 days for a terminal illness. Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
If your child needs dental or eye care	Eye exam	100% of charge less reimbursement	100% of charge less reimbursement	Limited to one eye exam every 12 months; reimbursement up to $45 when performed by an Optometrist (O.D.) and up to $50 when performed by an Ophthalmologist (M.D.).
	Glasses	100% of charge less reimbursement	100% of charge less reimbursement	Limited to (1) pair of lenses and (1) frame or (1) pair of contact lenses every 24 months; reimbursement up to $105/single vision lenses & frame, up to $125/multifocal lenses & frame, up to $130/contact lenses and up to $50/frame only. Refer to AFL vision listing for in-network providers.
	Dental check-up	Not covered	Not covered	Covered under separate Dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

Medical Plan:

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

Drug Plan:

- Cosmetic Medications (except those specified in the Plan Document)
- Outpatient Injectables
- Over The Counter (OTC) Medications (except those specified in the Plan Document)
- Sexual Dysfunction Medications

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

Medical Plan:

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State Laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-331-5913. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U. S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

HMA Customer Services Department, 1440 Kapiolani Boulevard, Suite 1020, Honolulu, HI 96814 at 1-866-331-5913.

Catamaran Customer Service, 1600 Kapiolani Boulevard, Suite 1322, Honolulu, HI 96814 at 1-888-869-4600 (prescription drug benefits only).

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This Plan does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefit it provides.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,140
- **Patient pays** $400

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$100
Co-insurance	$300
Limits or exclusions	$0
Total	**$400**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,110
- **Patient pays** $290

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$200
Co-insurance	$90
Limits or exclusions	$0
Total	**$290**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.