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, please contact UHA Customer Services Department at 1-808-532-4000 or 1-800-458-4600. 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 uhahealth.com or call 1-800-458-4600 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	You don't have to meet deductibles for specific services.
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 person / $7,500 family.	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-billed charges, copayment for certain services and 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.
Will you pay less if you use a network provider?	Yes. See uhahealth.com or call 1-800-458-4600 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.

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	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge	No Charge	Age and frequency limitations may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Other practitioner office visit	10% coinsurance* $10 copay for chiropractor and acupuncturist	30% coinsurance* Plan pays up to $20 per visit; you pay balance	* APRN/Physician Assistant Coverage is limited to $500 annual max for combined chiropractic and acupuncture services; does not apply to out-of-pocket limit.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance (inpatient) 20% coinsurance (outpatient)	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance (inpatient) 20% coinsurance (outpatient)	30% coinsurance	Prior Authorization required for outpatient PET scans and CTCA; benefits may be denied if Prior Authorization is not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at uhahealth.com	Generic drugs	Not Covered	Not Covered	Covered under separate drug plan.
	Preferred brand drugs	Not Covered	Not Covered	Covered under separate drug plan.
	Non-preferred brand drugs	Not Covered	Not Covered	Covered under separate drug plan.
	Specialty drugs	20% coinsurance	30% coinsurance	Prior Authorization required for certain injectables; benefits may be denied if Prior Authorization is not obtained. Oral chemotherapy drugs: no copay (retail & mail order) when using a participating provider; there is no coverage when using a non-participating provider. Limited to a 30-day supply.

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

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Prior Authorization required for certain outpatient surgeries, refer to uhahealth.com; benefits may be denied if Prior Authorization is not obtained.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	20% coinsurance	30% coinsurance	Air transportation limited to the nearest adequate hospital within the State of Hawaii.
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	All hospital stays require notification
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Prior Authorization required for outpatient psychological testing; benefits may be denied if Prior Authorization is not obtained.
	Inpatient services	10% coinsurance	30% coinsurance	All inpatient services require notification.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	No Charge (hospital room & board)	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	Up to 150 visits per calendar year; home total parenteral nutrition (TPN) for adults requires Prior Authorization; benefits may be denied if Prior Authorization is not obtained.
	Rehabilitation services	20% coinsurance	30% coinsurance	Prior Authorization required following 32 units of physical and occupational therapy per calendar year; benefits may be denied if Prior Authorization is not obtained.
	Habilitation services	20% coinsurance	30% coinsurance	Same as Rehabilitation services
	Skilled nursing care	10% coinsurance	30% coinsurance	Up to 120 days per calendar year

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)	
	Durable medical equipment	20% coinsurance	30% coinsurance	Prior Authorization required when purchase is greater than $500 or rental is greater than $100/month; benefits may be denied if Prior Authorization is not obtained.
	Hospice services	No Charge	No Charge	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Coverage for these services is only available with applicable vision and dental riders. More information about vision and dental coverage is available at uhahealth.com or call 1-800-458-4600.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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 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 (if for treatment of conditions of the neuromusculoskeletal system)
- Bariatric Surgery
- Chiropractic Care (if for treatment of conditions of the neuromusculoskeletal system)
- Hearing aids
- Infertility treatment (Covered to the extent required by Hawaii Law; limited to a one-time only benefit for one outpatient in-vitro fertilization procedure while you are a UHA member)
- Routine eye care (services provided by ophthalmologists are only covered for treatment of medical condition)

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: 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. 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:
Customer Services Department, 700 Bishop Street, Suite 300, Honolulu, HI 96813-4100 at 1-800-458-4600

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

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, HI 96813 at 1-808-586-2804

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 1-800-458-4600.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-458-4600.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-458-4600.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-458-4600.

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

* For more information about limitations and exceptions, see the plan or policy document at uhahealth.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	$0
Specialist coinsurance	10%
Hospital (facility) coinsurance	0%
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$500**

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

The plan's overall deductible	$0
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$4,500
The total Joe would pay is	**$4,600**

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

The plan's overall deductible	$0
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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