




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](http://uhahealth.com) or call 1-800-458-4600 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$200/person or \$600/family. Doesn't apply to <a href="#">preventive care</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , office visits, outpatient <a href="#">diagnostic testing</a> and outpatient laboratory and pathology 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 preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>Medical:</b> \$2,200 person / \$6,600 family. <b>Prescription Drug:</b> \$5,400 person / \$8,300 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, <a href="#">copayment</a> for certain services and penalties for failure to obtain <a href="#">prior authorization</a> for services and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count towards the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://uhahealth.com">uhahealth.com</a> or call 1-800-458-4600 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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.
<b>Do you need a <a href="#">referral</a> to</b>	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

Important Questions	Answers	Why This Matters:
see a <a href="#">specialist</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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or <a href="#">clinic</a>	Primary care visit to treat an injury or illness	\$12 <a href="#">copay</a> /visit	\$12 <a href="#">copay</a> /visit	<a href="#">Deductible</a> does not apply.
	<a href="#">Specialist</a> visit	\$12 <a href="#">copay</a> /visit	\$12 <a href="#">copay</a> /visit	<a href="#">Deductible</a> does not apply.
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	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 <a href="#">preventive</a> . 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>	20% <a href="#">coinsurance</a>	No Charge: Outpatient - laboratory & pathology services. <a href="#">Deductible</a> does not apply to outpatient <a href="#">diagnostic testing</a> and outpatient laboratory & pathology services. <a href="#">Deductible</a> does apply to outpatient radiology.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Prior Authorization</a> required for outpatient PET scans and CTCA; benefits may be denied if <a href="#">Prior Authorization</a> is not obtained.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">uhahealth.com</a>	Generic drugs	10% <a href="#">coinsurance</a> retail (30 days) & mail order (90 days)	30% <a href="#">coinsurance</a> retail only	<a href="#">Deductible</a> does not apply
	Preferred brand drugs	10% <a href="#">coinsurance</a> retail (30 days) & mail order (90 days)	30% <a href="#">coinsurance</a> retail only	<a href="#">Deductible</a> does not apply
	Non-preferred brand drugs	30% <a href="#">coinsurance</a> retail (30 days) & mail order (90 days)	30% <a href="#">coinsurance</a> retail only	<a href="#">Deductible</a> does not apply
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Prior Authorization</a> required for certain injectables; benefits may be denied if <a href="#">Prior</a>

\* 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)	
				<u>Authorization</u> is not obtained.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain outpatient surgeries, refer to uhahealth.com. Benefits may be denied if <u>Prior Authorization</u> is not obtained.
	Physician/surgeon fees	\$12 <u>copay</u> /visit & 20% <u>coinsurance</u> (for the office visit & surgery)	\$12 <u>copay</u> /visit & 20% <u>coinsurance</u> (for the office visit & surgery)	<u>Deductible</u> does not apply to physician visits
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Air transportation limited to the nearest adequate hospital within the State of Hawaii.
	<a href="#">Urgent care</a>	\$12 <u>copay</u> /visit	\$12 <u>copay</u> /visit	<u>Deductible</u> does not apply to physician visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	All hospital stays require notification.
	Physician/surgeon fees	\$12 <u>copay</u> /visit & 20% <u>coinsurance</u> (for the office visit & surgery)	\$12 <u>copay</u> /visit & 20% <u>coinsurance</u> (for the office visit & surgery)	<u>Deductible</u> does not apply to physician visits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$12 <u>copay</u> /visit	\$12 <u>copay</u> /visit	<u>Prior Authorization</u> required for outpatient psychological testing; benefits may be denied if <u>Prior Authorization</u> is not obtained. <u>Deductible</u> does not apply to physician visits.
	Inpatient services	\$12 <u>copay</u> /visit professional, 20% <u>coinsurance</u> facility	\$12 <u>copay</u> /visit professional, 20% <u>coinsurance</u> facility	All inpatient services require notification.
If you are pregnant	Office visits	No charge	No charge	Cost sharing does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge	
	Childbirth/delivery facility services	No charge	No charge	
If you need help recovering or have	<a href="#">Home health care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Up to 150 visits per calendar year; home total parenteral nutrition (TPN) for adults

\* 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)	
<b>other special health needs</b>				requires <u>Prior Authorization</u> ; benefits may be denied if <u>Prior Authorization</u> is not obtained.
	<a href="#">Rehabilitation services</a>	\$12 <u>copay</u> /visit	\$12 <u>copay</u> /visit	<u>Prior Authorization</u> required following 32 units of physical and occupational therapy per calendar year; benefits may be denied if <u>Prior Authorization</u> is not obtained. <u>Deductible</u> does not apply.
	<a href="#">Habilitation services</a>	\$12 <u>copay</u> /visit	\$12 <u>copay</u> /visit	Same as <u>Rehabilitation services</u> .
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Up to 120 days per calendar year.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required when purchase is greater than \$500 or rental is greater than \$100/month; benefits may be denied if <u>Prior Authorization</u> is not obtained.
	<a href="#">Hospice services</a>	No charge	No charge	Hospice / Concurrent Care Services require <u>Prior Authorization</u> after initial 14 days; benefits may be denied if <u>Prior Authorization</u> is not obtained. <u>Deductible</u> does not apply.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	No charge	Limitation of one eye exam per calendar year.
	Children's glasses	<u>Plan</u> pays up to \$175 per calendar year, you pay balance	<u>Plan</u> pays up to \$175 per calendar year, you pay balance	Towards the purchase of eyeglasses, contact lenses, frames, lenses, or any combination thereof.
	Children's dental check-up	Not covered	Not covered	Coverage for these services is only available with applicable dental riders. More information about dental coverage is available at uhahealth.com or call 1-800-458-4600.

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Dental care (adult)	• Private-duty nursing	• Weight loss programs
• Long-term care		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
• Acupuncture (if for treatment of conditions of the neuromusculoskeletal system)	• Chiropractic care (if for treatment for conditions of the neuromusculoskeletal system)	• Infertility treatment (Covered to the extent required by Hawaii Law, but limited to one outpatient in vitro fertilization procedure under any UHA medical benefit plan)
• Bariatric surgery	• Hearing Aids	• Routine eye care (Adult)

**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 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.

**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 on how 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 at 1-800-458-4600

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)

Hawaii Insurance Division, ATT: 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

[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 1-800-458-4600.

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, kwijigo holne' 1-800-458-4600.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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>	\$200
■ <a href="#">Specialist</a> copayment	\$12
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	20%

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>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$80
<b>The total Peg would pay is</b>	<b>\$320</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>	\$200
■ <a href="#">Specialist</a> copayment	\$12
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

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>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Joe would pay is</b>	<b>\$480</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>	\$200
■ <a href="#">Specialist</a> copayment	\$12
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$670</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.