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?	**Medical**: $2,500 person / $7,500 family. **Prescription Drug**: $5,400 person / $8,300 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 towards 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	$12 copay	$12 copay	None
	Specialist visit	$12 copay	$12 copay	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 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	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% 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	$10 copay retail (30 days) $15 copay mail order (90 days)	30% coinsurance retail only	[1] 20% of eligible charge for all prescriptions over $250 (per 30-day supply) except diabetes supplies, drugs & insulin
	Preferred brand drugs	$30 copay retail (30 days) $60 copay mail order (90 days)	30% coinsurance retail only	[1] 20% of eligible charge for all prescriptions over $250 (per 30-day supply) except diabetes supplies, drugs & insulin [2] diabetic supplies: $7 copay retail (30 days) & $11 copay mail order (90 days)
	Non-preferred brand drugs	$65 copay retail (30 days) $160 copay mail order (90 days)	30% coinsurance retail only	[1] 20% of eligible charge for all prescriptions over $250 (per 30-day supply) except diabetes supplies, drugs & insulin. You are responsible for the greater of 20% of eligible charge or $65 (30 days), $130 (31-60 days), or $195 (61-90 days) [2] diabetic supplies: $30 copay retail (30 days) & $65 copay mail order (90 days)
	Specialty drugs	20% coinsurance	20% coinsurance	Prior Authorization required for certain injectables, refer to uhahealth.com.

* 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)	
				Benefits may be denied if Prior Authorization is not obtained.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% 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	$12/visit & 20% coinsurance (for the office visit & surgery)	$12/visit & 20% coinsurance (for the office visit & surgery)	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Air transportation limited to the nearest adequate hospital within the State of Hawaii
	Urgent care	$12 copay/visit	$12 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	All hospital stays require notification
	Physician/surgeon fees	$12/visit & 20% coinsurance (for the office visit & surgery)	$12/visit & 20% coinsurance (for the office visit & surgery)	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$12 copay/visit	$12 copay/visit	Prior Authorization required for outpatient psychological testing; benefits may be denied if Prior Authorization is not obtained.
	Inpatient services	$12 professional, 20% facility	$12 professional, 20% facility	All inpatient services require notification
If you are pregnant	Office visits	No charge	No charge	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance 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 other special health	Home health care	20% coinsurance	20% coinsurance	Up to 150 visits per calendar year; home total parenteral nutrition (TPN) for adults requires Prior Authorization; benefits may

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)	
needs				be denied if Prior Authorization is not obtained.
	Rehabilitation services	$12 copay/visit	$12 copay/visit	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	$12 copay/visit	$12 copay/visit	Same as Rehabilitation services
	Skilled nursing care	20% coinsurance	20% coinsurance	Up to 120 days per calendar year
	Durable medical equipment	20% coinsurance	20% 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	Hospice / Concurrent Care Services require Prior Authorization after initial 14 days; benefits may be denied if Prior Authorization is not obtained.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limitation of one eye exam per calendar year.
	Children's glasses	Plan pays up to $175 per calendar year, you pay balance	Plan 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 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)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
• Long-term care

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)	• 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. 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 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
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, 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.

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.

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 copayment	**$12**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$300
What isn't covered	
Limits or exclusions	$80
The total Peg would pay is	**$400**

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 copayment	**$12**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$20
What isn't covered	
Limits or exclusions	$10
The total Joe would pay is	**$830**

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

The plan's overall deductible	**$0**
Specialist copayment	**$12**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$80
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$480**

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