



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:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Medical:</b> \$2,500 person / \$7,500 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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 or clinic</a>	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<a href="#">Specialist</a> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<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 <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <u>coinsurance</u> (inpatient) 20% <u>coinsurance</u> (outpatient)	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> (inpatient) 20% <u>coinsurance</u> (outpatient)	30% <u>coinsurance</u>	<u>Prior Authorization</u> required for outpatient PET scans and CTCA; benefits may be denied if <u>Prior Authorization</u> 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 uhahealth.com	Generic drugs	\$10 <u>copay</u> retail (30 days) \$15 <u>copay</u> mail order (90 days)	30% <u>coinsurance</u> retail only	[1] 20% of eligible charge for all prescriptions over \$250 (per 30-day supply) except diabetes supplies, drugs & insulin [2] lesser of <u>copay</u> or eligible charge
	Preferred brand drugs	\$30 <u>copay</u> retail (30 days) \$60 <u>copay</u> mail order (90 days)	30% <u>coinsurance</u> 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 <u>copay</u> retail (30 days) & \$11 <u>copay</u> mail order (90 days) [3] lesser of <u>copay</u> or eligible charge
	Non-preferred brand drugs	\$65 <u>copay</u> retail (30 days) \$160 <u>copay</u> mail order (90 days)	30% <u>coinsurance</u> 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 <u>copay</u> retail (30

\* 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)	
				days) & \$65 <u>copay</u> mail order (90 days) [3] lesser of <u>copay</u> or eligible charge
	<a href="#">Specialty drugs</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain injectables, refer to uhahealth.com. Benefits may be denied if <u>Prior Authorization</u> is not obtained.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <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	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<a href="#">Emergency medical transportation</a>	20% coinsurance (air)	20% coinsurance (air)	Air transport limited to the nearest adequate hospital within the State of Hawaii, except in certain situations when transportation to the continental US is necessary for critical care in accord with UHA's medical payment policy. Certain exclusions apply; requires <u>Prior Authorization</u> .
		30% <u>coinsurance</u> (ground)	30% <u>coinsurance</u> (ground)	Ground transportation to the nearest adequate hospital to treat your illness or injury.
<a href="#">Urgent care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	All hospital stays require notification.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior Authorization</u> required for outpatient psychological testing; benefits may be denied if <u>Prior Authorization</u> is not obtained.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	All inpatient services require notification.
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain

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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)	
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	No Charge (hospital room & board)	20% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Charge	30% <u>coinsurance</u>	Up to 150 visits per calendar year; home total parenteral nutrition (TPN) for adults requires <u>Prior Authorization</u> ; benefits may be denied if <u>Prior Authorization</u> is not obtained.
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<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.
	<a href="#">Habilitation services</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Same as <u>Rehabilitation services</u> .
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Up to 120 days per calendar year.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	30% <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.
<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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at uhahealth.com.

## 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    | • 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 [plan](#) document.)

- |   |   |   |
|---|---|---|
| • Acupuncture (if for treatment of conditions of the neuromusculoskeletal system) | • Chiropractic care (if for treatment of 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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [uhahealth.com](http://uhahealth.com).

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>	\$0
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<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>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$80
<b>The total Peg would pay is</b>	<b>\$790</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>	\$0
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<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>	\$700
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Joe would pay is</b>	<b>\$810</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>	\$0
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<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>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$510</b>

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