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, visit www.hma-hi.com/Times-Supermarkets or by calling 1-866-331-5913. 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 www.hma-hi.com/Times-Supermarkets or call 1-866-331-5913 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?	Yes. Preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $100 per person / $300 per family for in-network Other Services $100 per person / $300 per family for out-of-network services	You must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
What is the out-of-pocket limit for this plan?	Medical: $2,500 per person / $7,500 per family and Pharmacy: $4,850 per person / $7,200 per 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-billing 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.
Will you pay less if you use a network provider?	Yes. Please visit www.hma-hi.com/Times-Supermarkets or call 1-866-331-5913 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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$10 copayment	30% co-insurance	Deductible applies for out-of-network.
	Specialist visit	$10 copayment	30% co-insurance	
	Preventive care/screening/ immunization	No charge	30% co-insurance	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. For selected services deductible applies for out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance (inpatient) 20% coinsurance (outpatient)	30% coinsurance for inpatient and outpatient	Deductible applies for all out-of-network services except for preventive care.
	Imaging (CT/PET scans, MRIs)	10% coinsurance (inpatient) 20% coinsurance (outpatient)	30% coinsurance for inpatient and outpatient	Deductible applies for all out-of-network. Pre-authorization required for PET Scans, MRAs, and MRIs. If not obtained, benefit payments will be reduced by 10%.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pdmi.com.	Generic drugs*	$7 copayment	$60 copayment	Times Mail Order will be a 90 day supply for $10/generic, $25/brand name and $60/non-preferred brand medications. There will be a no reimbursements for members who go to a pharmacy other than Times for mail orders. *If the cost of the drug exceeds $5,000, the copayment is 20%, based on approved prior authorization. All Other Non-Preferred Pharmacies in the Synergy MedSolutions Network will be a 30 day supply ONLY for $60/generic, $90/brand name and $125/non-preferred brand medications.
	Preferred brand drugs*	$20 copayment	$90 copayment	
	Non-preferred brand drugs*	$50 copayment	$125 copayment	
	Specialty drugs** **If the cost of the covered Specialty drug exceeds $10,000, the coinsurance is 20%, based on approved prior authorization. Specialty drugs must be dispensed through Pharmacare. Step Therapy program applies. There will be a once per lifetime limitation on Hepatitis C treatment.	$100 copayment for 30 day supply	100% of charge	

* For more information about limitations and exceptions, see the plan or policy document at www.times-hma.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)	$50 copayment	30% coinsurance	Deductible applies for out-of-network.
	Physician/surgeon fees	10% coinsurance for cutting 20% coinsurance for non-cutting	30% coinsurance	Deductible applies for out-of-network. In some circumstances, services provided by an out-of-network provider at an in-network facility may be payable at 10% coinsurance for cutting and 20% coinsurance for non-cutting for surgeon fees.
If you need immediate medical attention	Emergency room care	20% coinsurance (facility) 10% coinsurance (physician services)		Covered only for true emergencies.
	Emergency medical transportation	20% coinsurance for ground or air ambulance	30% coinsurance for ground or air ambulance	Deductible applies for in-network and out-of-network. Emergency air limited to the State of Hawaii. In some circumstances, services provided by an out-of-network provider at an in-network facility may be payable at 20% coinsurance for air ambulance.
	Urgent care	10% coinsurance	30% coinsurance	Deductible applies for out-of-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Deductible applies for out-of-network. Pre-authorization is required. If not obtained, benefit payments will be reduced or denied.
	Physician visits Surgeon fees	10% coinsurance (visit) 10% coinsurance for cutting 20% coinsurance for non-cutting	30% coinsurance	Deductible applies for out-of-network physician hospital visits. In some circumstances, services provided by an out-of-network provider at an in-network facility may be payable at 10% coinsurance for physician visits and 10% coinsurance for cutting 20% coinsurance for non-cutting for surgeon fees.

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 need mental health, behavioral health, or substance abuse services	Mental/Behavioral Health Outpatient services	10% coinsurance	30% coinsurance	Deductible applies for out-of-network. Pre-authorization required. If not obtained, benefit payments will be reduced by 10%. In some circumstances, services provided by an out-of-network provider at an in-network facility may be payable at 10% coinsurance for physician and professional fees.
	Mental/Behavioral Health Inpatient services	10% coinsurance	30% coinsurance	
	Substance Abuse Disorder Outpatient service	10% coinsurance	30% coinsurance	
	Substance Abuse Disorder Inpatient service	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	$10 copayment	30% coinsurance	Deductible applies for out-of-network.
	Childbirth/delivery professional services	$10 copayment	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Deductible applies for out-of-network. Notification of maternity admission within 48 hours or by the next working day is required. If not provided, benefit payments will be reduced by 10%. In some circumstances, services provided by an out-of-network provider at an in-network facility may be payable at 10% coinsurance.
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Deductible applies for out-of-network. Maximum 150 visits per calendar year. Pre-authorization required. If not obtained, benefit payments will be reduced by 10%.
	Rehabilitation services	10% coinsurance for inpatient	30% coinsurance	Deductible applies for out-of-network. Pre-authorization required for physical therapy and occupational therapy. If not obtained, benefit payments will be reduced by 10%.
		20% coinsurance for outpatient	30% coinsurance	Deductible applies for in-network and out-of-network. Pre-authorization required for physical therapy and occupational therapy. If not obtained, benefit payments will be reduced by 10%.
	Habilitation services	20% coinsurance	30% coinsurance	Deductible applies for in-network and out-of-network. Pre-authorization required. If not obtained, benefit payments will be reduced by

* For more information about limitations and exceptions, see the plan or policy document at www.times-hma.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)	
				10%.
	Skilled nursing care	10% coinsurance	30% coinsurance	Deductible applies for out-of-network. Maximum 120 days of confinement per calendar year. Pre-authorization required. If not obtained, benefit payments will be reduced by 10%.
	Durable medical equipment	20% coinsurance	30% coinsurance	Deductible applies in-network and out-of-network. Pre-authorization required. If not obtained, benefit payments will be reduced by 10%.
	Hospice services	No charge	Not covered	Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
If your child needs dental or eye care	Children's eye exam	$10 annual deductible	100% of charge*	Limited to one eye exam per calendar year.
	Children's glasses	$10 annual deductible for Single or Multifocal Lenses $25 annual deductible for Contact Lenses $15 annual deductible for Frames	100% of charge*	Lenses limited to one per calendar year and frames limited to one frame every other calendar year. *See plan document regarding reimbursement for out-of-network providers.
	Children's dental check-up	Not covered	Not covered	Covered under Dental Rider.

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.)

Medical Plan:

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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

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: Hawaii Insurance Department, the Department of Labor's, Employee Benefits Security Administration at 1-866-444-3272 or

* For more information about limitations and exceptions, see the plan or policy document at www.times-hma.com.

www.dol.gov/ebsa/healthreform , the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov, or for more information contact the plan at 1-877-384-2875. 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:

HMA Customer Services Department, 1440 Kapiolani Boulevard, Suite 1000, Honolulu, HI 96814 at 1-866-331-5913.

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
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.

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

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	10%
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	**$11,520**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,180**

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	**$4,780**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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	**$2,220**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$80
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$580**

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