

Plan Provisions ¹		
Dependent Child Coverage	Less than 26 years of age	
Annual Deductible ²	\$200 per person; \$600 per family	
Annual Maximum Out-of-Pocket	\$2,200 per person; \$6,600 per family	
Lifetime Maximum ³	Unlimited	
Medical Services	You Pay	
	Participating Provider	Non-participating Provider
PREVENTIVE CARE SERVICES⁴		
Physical Exam (office visit) once per calendar year	No co-payment	
Preventive Screening Services		
Well Child Care Visit		
Childhood Immunizations		
Adult Immunizations		
Screening Laboratory Services - Outpatient		
MATERNITY SERVICES		
**Maternity Care	No co-payment	
Birthing Room [†]		
Newborn Nursery [†]		
DISEASE MANAGEMENT PROGRAMS[†]		
Smoking Cessation Program	No co-payment	
Asthma Education Program		
Diabetes Self-Management Training & Education Program		
Nutritional Counseling Programs		
PHYSICIAN SERVICES[†]		
Physician Office Visit	\$12 co-payment	
HOSPITAL SERVICES		
Room & Board (semi-private room)	20% of EC [*] ; deductible applies	
Hospital Ancillary Services		
Laboratory & Pathology - Inpatient		
EMERGENCY SERVICES		
Emergency Room Services	20% of EC [*] ; deductible applies	
Ambulance (ground or inter-island air)		
COMPLEMENTARY ALTERNATIVE MEDICINE[†]		
Chiropractic/Acupuncture Services Benefits limited to treatment of conditions of the neuromusculoskeletal system by a licensed provider	\$10 co-payment per visit First set of x-rays at 50% of EC [*] ; full charge for add'l sets; \$500 combined maximum per calendar year	Plan pays up to \$20 per visit X-rays not covered \$500 combined maximum per calendar year

¹ The information above is intended to provide a condensed explanation of UHA medical plan benefits. Please refer to the appropriate Medical Benefits Guide (MBG) for complete information on benefits and provisions. In case of a discrepancy between this comparison and the language contained in the MBG, the MBG will take precedence.

² Annual deductible does not apply to all services. Refer to your Medical Benefits Guide to verify which services apply.

³ No annual or lifetime maximum.

⁴ All U.S. Preventive Services Task Force (USPSTF) A and B recommended screening services are covered at 100% as required under the provisions of the Patient Protection and Affordable Care Act (ACA).

[†] UHA 3000 annual deductible does not apply.

^{*} EC (Eligible Charge) Refer to your Medical Benefits Guide for detailed definition.

^{**} Covered, including prenatal, false labor, delivery, and postnatal services provided by your physician or midwife. Maternity care does not include related services such as nursery care, labor room, hospital room and board, diagnostic testing, and other lab work and radiology. Please refer to the specific benefits for more information on those services.

Annual maximum out-of-pocket \$4,850 per person; \$7,200 per family (Excludes mandatory generic substitution or other dispense as written [DAW] penalties)

PRESCRIPTION DRUG BENEFITS	YOUR CO-PAYMENT/COINSURANCE		
	PARTICIPATING PHARMACY 30 DAY RETAIL	PARTICIPATING PHARMACY MAIL ORDER/EXTENDED FILL	NON - PARTICIPATING PHARMACIES 30-DAY RETAIL ONLY
Generic	\$10	90 day - \$15	30% of EC
Preferred Brand	\$30	90 day - \$60	30% of EC
Non-Preferred Brand	\$65	90 day - \$160	30% of EC
All Prescriptions over \$250 ^[1] (per 30-day supply)	20% of ingredient cost	20% of ingredient cost	30% of EC
Diabetic Supplies^{[2][3]}			
Preferred Brand	\$7	90 day - \$11	30% of EC
Non-Preferred Brand	\$30	90 day - \$65	30% of EC
Diabetic Drugs^[3]			
Generic	\$10	90 day - \$15	30% of EC
Preferred Brand	\$30	90 day - \$60	30% of EC
Non-Preferred Brand	\$65	90 day - \$160	30% of EC
Insulin^[3]			
Preferred Brand	\$30	90 day - \$60	30% of EC
Non-Preferred Brand	\$65	90 day - \$160	30% of EC
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs ^[4]	None	90 day - None	30% of EC
Oral chemotherapy drugs	None	30 day - None	30% of EC
Oral Contraceptives & Other Contraceptive Methods (i.e. diaphragms, cervical caps)			
Generic	None	90 day - None	30% of EC
Preferred Brand (Single Source)	None	90 day - None	30% of EC
Preferred Brand (Multi Source, if any)	\$30 ^[5]	90 day - \$60 ^[5]	30% of EC
Non-Preferred Brand	\$65 ^[5]	90 day - \$160 ^[5]	30% of EC
Smoking Cessation: patches, gum, Chantix, Zyban ^[6]	None	90 day - None	30% of EC
Spacers & Peak Flow Meters for Asthma	Please refer to the applicable generic, preferred & non-preferred co-payments or 20% coinsurance above		30% of EC

Mandatory Generic Substitution Policy

If a brand name Covered Drug is obtained when a generic equivalent is available, you are responsible for (i) the difference in Eligible Charge between the brand name Covered Drug and the generic equivalent, and (ii) the generic co-payment. By requesting generic drugs you can reduce your costs. Speak with your physician about the drug that is appropriate for your medical condition.

[1] For mail order/extended fill, ingredient cost increasing to \$500 (31-60 day supply) and \$750 (61-90 day supply). For a non-preferred brand drug, you will be responsible for the greater of 20% of the ingredient cost or \$65 for a 30 day supply, \$130 (31-60 day supply), or \$195 (61-90 day supply).

[2] Any brand not designated as preferred or non-preferred is excluded from coverage from this drug plan; you will be responsible for the entire cost of the supply.

[3] Diabetic supplies, drugs and insulin are exempt from the 20% coinsurance tier.

[4] USPSTF A & B recommended drugs are covered if your physician orders them as part of your treatment and writes a prescription for the items to be purchased at a pharmacy.

[5] For a 30-day supply, if ingredient cost is greater than \$250, coinsurance is 20% of ingredient cost. For mail order/extended fill, ingredient cost increasing to \$500 (31-60 day supply) and \$750 (61-90 day supply). The mandatory generic penalty applies.

[6] This benefit is limited to coverage for 180 days in a 360 day period.

Notes: Co-payments for a 60-day supply of mail order/extended fill: \$15 (generic), \$60 (preferred brand), and \$130 (non-preferred brand).

If you go to a non-participating mail order pharmacy, no coverage is provided. If you go to a participating retail pharmacy who is not in the extended fill network, you will be limited to a 30-day supply of your medication. If you go to a non-participating retail pharmacy, you must pay the full cost of your drug at the pharmacy and submit a claim to UHA. UHA will reimburse you based on the eligible charge minus the 30% coinsurance. You will be responsible for any remaining balance over the eligible charge up to the full drug cost.

See back page for more information, or call UHA Customer Services at 532-4000, or 1-800-458-4600 from the neighbor islands

About this Plan

- UHA Drug Plan T features a tiered co-payment structure. Your co-payment is based on the type of drug that is used to fill your prescription.
- Refills will be covered for up to twelve (12) months from the date the original prescription was written.
- Drugs must be federally approved, medically necessary and obtained with a prescription from a licensed provider with prescriptive authority. Medically Necessary means the definition established in Hawaii Revised Statutes (sect. 432E-1.4).
- For a list of drugs that require Prior Authorization, please refer to UHA's list of Drugs That Require Prior Authorization on our website at uhahealth.com/webForms/drugsearch.
- Drugs in certain ongoing drug therapy categories could be subject to Step Therapy, which is a program designed to reduce your costs by requiring you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. Step Therapy manages drug costs by ensuring that patients try first-line (first step), clinically effective, lower-cost medications before they "step up" to a second-line/higher cost medication. You will need authorization from UHA before filling prescriptions for second-line drugs. Please refer to our website at uhahealth.com/uploads/forms/list-of-step-therapy-drugs.pdf to find out if this program applies to any of your drugs.

Mail Order and Extended Fill Program

You may obtain an extended supply of your maintenance medications through mail order or at pharmacies in the National Plus 90 Day Network. These services allow you to purchase a 90-day supply under the listed co-payment for their prescription maintenance medication. Please visit uhahealth.com/page/benefit-tips for more information about these services, and to locate the most current list of participating pharmacies (under "Choose Specialty", select "PHARMACY EXTENDED-FILL").

How To File A Prescription Drug Claim

When drugs are purchased from a non-participating pharmacy, or you are asked to pay for the full cost of your drugs at a participating pharmacy, you will need to complete a Prescription Drug Claim form. Contact UHA Customer Services to obtain a Prescription Drug Claim form, or download this form from our website at uhahealth.com/uploads/forms/form_prescrip_drug_claim.pdf. Claims must be filed within ninety (90) days from the date the drug is purchased.

30 Day Restriction On Coverage

All Covered Drugs are limited to a thirty (30) day supply, with the following exceptions:

- A single standard size package may be dispensed even though a smaller quantity is prescribed for the following: fluoride, tabs and drops; children's vitamins with fluoride (unbreakable package); nitroglycerine products (unbreakable package); miscellaneous: prenatal vitamins (requiring prescription), creams and ointments (standard package size), liquids (standard package size); diabetic supplies (unbreakable package): syringes, needles, test strips, lancets
- Up to a ninety (90) day supply may be dispensed for medications obtained by mail order service or Extended Fill Program

Drugs Not Covered

The following are expressly not covered by this drug plan:

- Injectable drugs except Lovenox, Glucagon, Imitrex, Depo Provera, Insulin and anaphylaxis (Epinephrine) kits
- Fertility agents
- Drugs used for cosmetic purposes
- Supplies, appliances and other non-drug items, except Diabetic Supplies
- Drugs furnished to hospital or skilled nursing facility inpatients
- Drugs prescribed for treatment plans that are not Medically Necessary
- Anti-obesity drugs
- Sexual function drugs
- Any drug that may be purchased without a prescription over-the-counter (OTC), except as specified below
- OxyContin (or its generic equivalents) and all other extended-release and long-acting narcotics, unless prescribed in compliance with UHA's Prior Authorization conditions and payment policies
- Drugs for which Prior Authorization is required but has not been obtained
- For drugs in a therapeutic class in which a former prescription drug in that class converts to an OTC drug, UHA reserves the right to provide coverage only for the former prescription drug that has converted to an OTC drug and to exclude from coverage all other drugs in that class
- Drugs and/or Diabetic Supplies obtained by mail order or extended fill from a Non-Participating Pharmacy
- Non-essential, low value and no value drugs; some of which are non-FDA approved, some are approved but hold no identifiable advantage over other more well-tested agents and some are considered to be of lower value by pharmacologists, professional organizations, other authorities, or all three. This list is to be updated annually
- Products that are chemically-similar drugs and share the same mechanism of action to an existing, approved chemical entity and offer no significant clinical benefit
- Drugs that are determined by the Pharmacy Benefits Manager due to availability of equally effective and safe alternatives. The current list of excluded drugs is available on our website at uhahealth.com/uploads/forms/list_prefdrug_condensed.pdf

This information is intended to provide a condensed explanation of UHA drug plan benefits. Please refer to the appropriate drug plan rider with your employer for complete information on benefits and provisions. In case of a discrepancy between this summary and the language contained in the rider, the rider will take precedence.

UHA - HDS \$1,500
HDS Group Number 2345
Summary of Dental Benefits
Effective January 1, 2019

ADULTS – AGE 19 & OLDER	CHILDREN – AGE 18 & UNDER	
<ul style="list-style-type: none"> • PLAN MAXIMUM \$1,500 per person per calendar year. The most HDS will pay for each person for all covered dental services performed during the calendar year. 	<ul style="list-style-type: none"> • MAXIMUM OUT OF POCKET (MOOP) \$350 per child or \$700 for 2 or more children, per calendar year. The most you will pay before your dental plan begins to pay 100% of your benefit. Out-of-pocket payments made for non-covered services, alternate benefits and non-medically necessary orthodontics will not count toward the MOOP. 	
DIAGNOSTIC & PREVENTIVE CARE (Time limitations based on calendar year)	HDS PLAN PAYS	
	CHILD	ADULT (& CHILD ages 19-25)
• Examinations – 2 per year	100%	100%
• Bitewing X-rays – 2 per year through age 18; 1 per year thereafter	70%	100%
• Other X-rays – full mouth X-rays limited to 1 every 5 years	70%	70%
• Cleanings – 2 per year	100%	100%
Expectant mothers – 3 per year; combination of cleanings or gum treatments	100%	100%
Diabetic patients – 4 per year; combination of cleanings or gum treatments	70%	70%
• Fluoride – 2 per year through age 18	100%	N/A
• Fluoride (high risk for cavities) – 1 per year	100%	100%
• Space Maintainers – through age 18	100%	N/A
• Sealants – through age 18	100%	N/A
BASIC CARE		
• Fillings – silver fillings; white-colored fillings limited to front teeth		
• Root Canals		
• Gum/Bone Surgeries & Maintenance	70%	70%
• Oral Surgeries		
MAJOR CARE		
• Crowns & Gold Restorations – 1 every 7 years	50%	
• Fixed Bridges & Dentures – 1 every 7 years	50%	50%
• Implants	N/A	
OTHER SERVICES		
• Emergency Treatment of Dental Pain	70%	70%
ORTHODONTICS		
• \$1,500 lifetime maximum per child for dependent children through age 25. Services are not covered if started prior to the date the patient is eligible under this individual plan.		50%
• Medically necessary coverage for dependent children through age 18. Limited to those cases involving repair of the cleft lip and/or cleft palate, severe facial birth defects, or an incurred injury that affects the function of speech, swallowing, and/or chewing.	50%	Non-medically necessary coverage for dependent children through age 25 only

Note: This summary includes a brief description of your HDS dental benefits. All benefits are governed by the provisions of University Health Alliance’s agreement with Hawaii Dental Service and HDS’s Procedure Code Guidelines. All dental claims must be filed within 12 months of the date of service to be eligible for HDS claims payment. As an HDS member, you may visit any licensed dentist, but your out-of-pocket costs may be lower when visiting an HDS participating dentist. Please consult your dentist or contact HDS Customer Service if you have any questions prior to enrolling.

For more information on your benefits, log on to your online account at www.HawaiiDentalService.com.

Access to HDS Information 24/7

Visit HDS Online at HawaiiDentalService.com to:

Access your online account today!

- Visit the HDS website at HawaiiDentalService.com
- Follow the directions on-screen to create a new account
- Complete the “Member Registration” form
- Select “yes” to “Request electronic Explanation of Benefits”
- A confirmation email will be sent to you with a link. Click the link to activate your account.

SEARCH

- For an HDS participating dentist in Hawaii, Guam or Saipan by specialty, location, handicap accessibility, weekend hours, and more
- For a Delta Dental Premier participating dentist on the Mainland or Puerto Rico by specialty, location, weekend hours and more

DOWNLOAD & PRINT

- A summary of your benefits for tax purposes
- Blank claim forms
- Your HDS membership card
- Your EOB statements
- HDS Notice of Privacy Practices

CHECK

- Whether you and/or your dependents are eligible for HDS benefits
- What dental services are covered by your plan
- What the limits are of each type of covered service and how much you have used

VIEW

- Your Explanation of Benefits (EOB) statements
- A list of frequently asked questions
- HDS contact information

REQUEST

- To receive emails when your claims are processed
- To receive EOB statements via email
- An HDS membership card to be mailed to you

How to Contact HDS

Customer Service Representatives

From Oahu: 529-9248
Toll-free: 1-844-379-4325

Customer Service Call Center Hours:

Monday – Friday: 7:30 AM – 4:30 PM HST
Excluding State observed holidays and the day after Thanksgiving

Walk-in Office Hours:

Monday – Friday: 8:00 AM – 4:30 PM HST

Send Written Correspondence to:

Hawaii Dental Service
Attn: Customer Service
700 Bishop Street, Suite 700
Honolulu, HI 96813-4196

E-mail: CS@HawaiiDentalService.com

FAX:

From Oahu: 529-9366
Toll-free fax: 1-866-590-7988

UHA Vision Plan 100

BETTER HEALTH • BETTER LIFE



UHA Vision 100

Vision Examination

- Plan pays 100% of the eligible charge for one routine vision examination and refraction per member, per calendar year

Appliances

- Up to \$130 every calendar year towards the purchase of eyeglasses, contact lenses, frames, lenses, or any combination thereof
- The member is responsible for paying the provider the difference between UHA's payment and the total actual charge

Vision Care Providers

Members have the choice of going to a participating or non-participating UHA vision provider who must be a licensed Ophthalmologist (M.D.) or Optometrist (O.D.).

Limitations And Exclusions

The following services are not covered:

- Contact lens fitting
- Repair or replacements of frame parts and accessories
- Sunglasses
- Prescription inserts for diving masks
- Nonprescription industrial safety goggles
- Tinting of glasses

How To File A Vision Claim For Services From A Non-Participating Provider

- Send your receipt or invoice and copy of your UHA medical card

Via Mail:
700 Bishop Street, Suite 300
Honolulu, HI 96813

Via Fax:
866-572-4393

- All claims must be filed within one year from the date of service; claims filed after one year will not be paid


If you have any questions about your vision plan benefits, please contact UHA Customer Services at 808-532-4000, or 1-800-458-4600 from the neighbor islands.



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 ?	\$200/person or \$600/family. Doesn't apply to preventive care .	Generally, 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 .
Are there services covered before you meet your deductible ?	Yes. Preventive care , office visits, outpatient diagnostic testing and outpatient laboratory and pathology services 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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: \$2,200 person / \$6,600 family. Prescription Drug: \$4,850 person / \$7,200 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 , copayments 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 .
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 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	\$12 copay /visit	\$12 copay /visit	Deductible does not apply
	Specialist visit	\$12 copay /visit	\$12 copay /visit	Deductible does not apply
	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.
	Other practitioner office visit	\$12 copay /visit* \$10 copay for chiropractor and acupuncturist	\$12 copay /visit* 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 ; deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	No Charge: Outpatient - laboratory & pathology services. Deductible does not apply to outpatient diagnostic testing and outpatient laboratory & pathology services. Deductible does apply to outpatient radiology.
	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.

* 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 need drugs to treat your illness or condition More information about prescription drug coverage 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% ingredient cost for all prescriptions over \$250 (per 30-day supply); except for diabetic supplies, drugs & insulin
	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% ingredient cost for all prescriptions over \$250 (per 30-day supply); except for diabetic supplies, drugs & insulin [2] diabetic supplies: \$7 <u>copay</u> retail (30 days) & \$11 <u>copay</u> mail order (90 days)
	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% ingredient cost for all prescriptions over \$250 (per 30-day supply); except for diabetic supplies, drugs & insulin. You are responsible for the greater of 20% of ingredient cost or \$65 (30 days), \$130 (31-60 days), or \$195 (61-90 days) [2] diabetic supplies: \$30 <u>copay</u> retail (30 days) & \$65 <u>copay</u> mail order (90 days)
	Specialty drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain injectables; benefits may be denied if <u>Prior 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>	\$12 <u>copay</u> /visit / 20% <u>coinsurance</u>	<u>Deductible</u> does not apply to physician visits
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Air transportation limited to the nearest adequate hospital within the State of Hawaii.
	Urgent care	\$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>	\$12 <u>copay</u> /visit / 20% <u>coinsurance</u>	<u>Deductible</u> does not apply to physician visits

* 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 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 copay/visit professional, 20% <u>coinsurance</u> facility	\$12 copay/visit professional, 20% <u>coinsurance</u> facility	All inpatient services require notification.
If you are pregnant	Office visits	No charge	No charge	<u>Cost sharing</u> 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 other special health needs	Home health care	20% <u>coinsurance</u>	20% <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.
	Rehabilitation services	\$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.
	Habilitation services	\$12 <u>copay</u> /visit	\$12 <u>copay</u> /visit	Same as <u>Rehabilitation services</u>
	Skilled nursing care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Up to 120 days per calendar year
	Durable medical equipment	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.
	Hospice services	No charge	No charge	<u>Deductible</u> does not apply
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limitation of one routine vision exam per calendar year
	Children's glasses	Plan pays up to \$130 per calendar year; you pay balance	Plan pays up to \$130 per calendar year; you pay balance	Towards the purchase of eyeglasses, contact lenses, frames, lenses, or any combination thereof

* 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)	
	Children's dental check-up	Not covered	Not covered	Coverage for these services is only available with applicable dental endorsements or riders. Please refer to your HDS plan information, uhahealth.com or call 1-800-458-4600 for more information about dental coverage.

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 .)			
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • 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.)			
<ul style="list-style-type: none"> • Acupuncture (if for treatment of conditions of the neuromusculoskeletal system) • Bariatric Surgery • Chiropractic Care (if for treatment of conditions of the neuromusculoskeletal system) 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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 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

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

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

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, 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.* —————

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](#) \$200
- [Specialist](#) [copayment](#) \$12
- [Hospital \(facility\) coinsurance](#) 20%
- [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	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$20
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Peg would pay is	\$1,220

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

- The [plan's](#) overall [deductible](#) \$200
- [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	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,100

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

- The [plan's](#) overall [deductible](#) \$200
- [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	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$500

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance policy](#). Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- [Underlined](#) text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

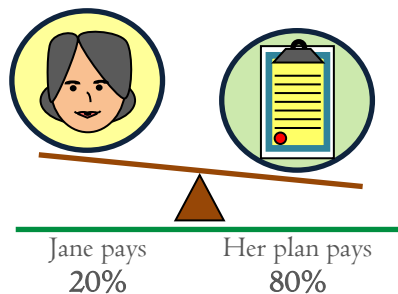
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your [deductible](#), your coinsurance payment of 20% would be \$20. The health insurance or [plan](#) pays the rest of the allowed amount.)



Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

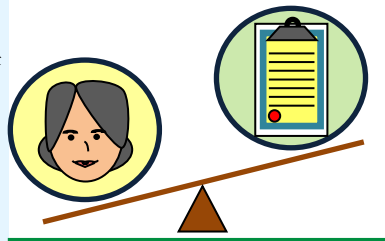
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% Her plan pays 0%
(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost sharing](#) amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement

Sometimes called the “individual mandate”, the duty you may have to be enrolled in health coverage that provides [minimum essential coverage](#). If you don’t have [minimum essential coverage](#), you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered healthcare services. Your share is usually lower for in-[network](#) covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange”. The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-[network](#) services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Health coverage that will meet the [individual responsibility requirement](#). 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.

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

Out-of-network Copayment

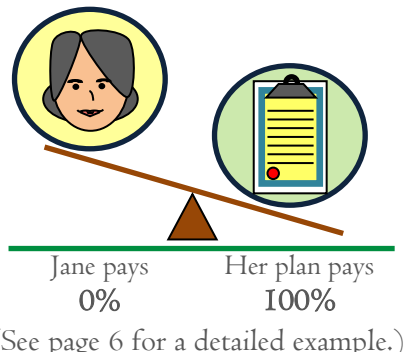
A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do *not* contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

Out-of-network Provider (Non-Preferred Provider)

A [provider](#) who doesn't have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you'll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.



Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "[health insurance](#)".

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called prior authorization, prior approval or precertification. Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each "tier" of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is *not* the same as “skilled care services”, which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

How You and Your Insurer Share Costs - Example

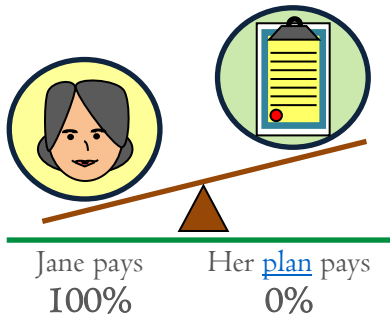
Jane's Plan Deductible: \$1,500

Coinsurance: 20%

Out-of-Pocket Limit: \$5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



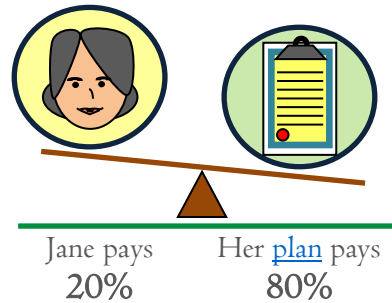
Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



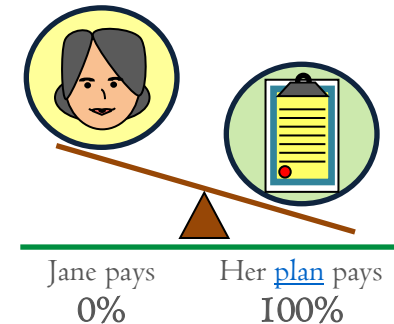
Jane reaches her \$1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: \$125

Jane pays: 20% of \$125 = \$25

Her plan pays: 80% of \$125 = \$100



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$125

Jane pays: \$0

Her plan pays: \$125