`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, contact Trust Fund Office at (800) 251-5014. 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.dol.gov/ebsa/healthreform or call (800) 251-5014 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100** individual / **$300** family	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. Certain preventive care, In-Network online visits, outpatient prescription drugs will be 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: **$2,500** individual / **$7,500** family. Prescription Drug Coverage: **$4,350** individual / **$6,200** 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?	Medical Limit: Premiums, balance-billing charges, penalties for failure to obtain preauthorization, outpatient prescription drug expenses, and health care this plan doesn't cover. Prescription Drug Limit: Premiums, balance-billing charges, penalties for failure to obtain preauthorization, medical expenses, and prescription drugs 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 http://www.hmsa.com/search/providers or call the Trust Fund Office at (800) 251-5014 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.

Important Questions	Answers	Why This Matters:
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	Online visit: No charge, deductible does not apply. Office visit: 10% coinsurance	Online visit: Not covered. Office visit: 30% coinsurance	First office visit with a network provider is covered at no charge after deductible.
	Specialist visit	10% coinsurance	30% coinsurance	First office visit with a network provider is covered at no charge after deductible.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Well child immunizations: No charge, deductible does not apply. Non-prescription drug contraceptives for women: 50% coinsurance. All other: 30% coinsurance. Deductible does not apply to well-child physician visits, contraceptives for women, screening mammography.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Inpatient: 10% coinsurance Outpatient: 20% coinsurance	30% coinsurance	Preauthorization for certain services is required.
	Imaging (CT/PET scans, MRIs)	Inpatient: 10% coinsurance Outpatient: 20% coinsurance	30% coinsurance	Preauthorization for certain services is required.

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 www.hmsa.com	Generic drugs (Tier 1)	Retail: $7 copayment/script. Mail order: $11 copayment/script.	You pay 100% of the cost of the drug at purchase and send a claim to HMSA. You will be responsible for 20% of the eligible charge after a $7 copayment /script is deducted. Mail order: Not covered.	• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit). • One retail copayment for 1-30 day supply, two retail copayments for 31-60 day supply, and three retail copayments for 61-90 day supply. • One mail order copayment for 84-90 day supply at a 90-day at retail network or contracted mail order provider. • No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). • If preauthorized, you may qualify for Tier 3 drugs at a Tier 2 copayment if you have a chronic condition (at least 3 months) and have tried and failed other alternatives, or all other drugs are contraindicated based on your diagnosis.
	Preferred brand drugs (Tier 2)	Retail: $30 copayment/script. Mail order: $65 copayment/script.	You pay 100% of the cost of the drug at purchase and send a claim to HMSA. You will be responsible for 20% of the eligible charge after a $30 copayment /script is deducted. Mail order: Not covered.	
	Non-preferred brand drugs (Tier 3)	Retail: $75 copayment/script. Mail order: $200 copayment/script.	You pay 100% of the cost of the drug at purchase and send a claim to HMSA. You will be responsible for 20% of the eligible charge after a $75 copayment /script is deducted. Mail order: Not covered.	
	Specialty drugs	Retail: $100 copayment/script. Mail order: Not covered	Not covered	• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit). • Up to 30-day supply.

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)	20% coinsurance	30% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	You pay 10% coinsurance for a covered In-Network physician office visit.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None.
	Emergency medical transportation	20% coinsurance	30% coinsurance	• Ground transportation covered to the nearest adequate hospital to treat your illness or injury. • 20% coinsurance for covered air ambulance with In-Network or Out of Network provider. Balance billing will not apply to covered air ambulance services. Air transportation limited to the nearest adequate hospital within the State of Hawaii. • Professional/physician charges may be billed separately.
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization required for transplant services and for elective inpatient admission.
	Physician surgeon fees	10% coinsurance	30% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Online visit: No charge, deductible does not apply. Office visit: No charge. Other outpatient services: 20% coinsurance	Online visit: Not covered. Office visit: 30% coinsurance	None.
	Inpatient services	Professional services: No charge. Facility: 10% coinsurance	30% coinsurance	Preauthorization required for inpatient services with a Non-Contract facility (including residential treatment admission) outside the State of Hawaii.
If you are pregnant	Office visits	No charge	30% coinsurance	• Cost sharing does not apply to certain preventive services. • Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	None.
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None.

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 help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Limited to 150 visits per calendar year.
	Rehabilitation services	Outpatient: 20% coinsurance Inpatient: 10% coinsurance	30% coinsurance	Physical and occupational rehabilitation services require preauthorization.
	Habilitation services	Not covered.	Not covered.	You must pay 100% of this service, even In-Network.
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 120 days per calendar year.
	Durable medical equipment	20% coinsurance	30% coinsurance	Preauthorization is required.
	Hospice services	No charge.	Not covered.	None.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	If you elect vision coverage, it will be through a separate vision plan with Vision Service Plan (VSP).
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	If you elect dental coverage, it will be through a separate dental plan with Hawaii Dental Services (HDS).

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult and Child – payable under a separate dental plan if elected)
- Habilitation services
- Long-term care
- Routine eye care (Adult and Child – payable under a separate vision plan if elected)
- Routine foot care
- Weight loss programs (except as required by the health reform law)

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

- Bariatric surgery (requires preauthorization)
- Chiropractic care
- Hearing aids (limited to one hearing aid per ear every 60 months)
- Infertility treatment (requires preauthorization and limited to a one time only benefit for one outpatient procedure per lifetime)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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 the Trust Fund Office at 1-800-251-5014. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 (800) 251-5014.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 251-5014.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 251-5014.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 251-5014.

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** **$100**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **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	$100
Copayments	$10
Coinsurance	$1,210
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,380**

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

- **The plan's overall deductible** **$100**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **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	$100
Copayments	$730
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$920**

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

- **The plan's overall deductible** **$100**
- **Specialist coinsurance** **10%**
- **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	$100
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$610**

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