



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](http://www.dol.gov/ebsa/healthreform) or call (800) 251-5014 to request a copy.

Important Questions	Answers	Why This Matters:
<b><u>What is the overall deductible?</u></b>	<b>\$100 individual / \$300 family</b>	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b><u>Are there services covered before you meet your deductible?</u></b>	Yes. Certain <u>preventive care</u> , <u>In-Network online visits</u> , <u>outpatient prescription drugs</u> will be covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b><u>Are there other deductibles for specific services?</u></b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b><u>What is the out-of-pocket limit for this plan?</u></b>	Medical: <b>\$2,500 individual / \$7,500 family</b> . <u>Prescription Drug Coverage: \$4,350 individual / \$6,200 family</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b><u>What is not included in the out-of-pocket limit?</u></b>	Medical Limit: <u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , <u>outpatient prescription drug expenses</u> , and health care this <u>plan</u> doesn't cover. <u>Prescription Drug Limit</u> : <u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , medical expenses, and prescription drugs this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b><u>Will you pay less if you use a network provider?</u></b>	Yes. See <a href="http://www.hmsa.com/search/providers">http://www.hmsa.com/search/providers</a> or call the Trust Fund Office at (800) 251-5014 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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, <u>deductible</u> does not apply. Office visit: 10% <u>coinsurance</u>	Online visit: Not covered. Office visit: 30% <u>coinsurance</u>	First office visit with a <u>network provider</u> is covered at no charge after <u>deductible</u> .
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	First office visit with a <u>network provider</u> is covered at no charge after <u>deductible</u> .
	<u>Preventive</u> care/screening/immunization	No charge. <u>Deductible</u> does not apply.	Well child immunizations: No charge, <u>deductible</u> does not apply. Non-prescription drug contraceptives for women: 50% <u>coinsurance</u> . All other: 30% <u>coinsurance</u> . <u>Deductible</u> does not apply to well-child physician visits, contraceptives for women, screening mammography.	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	<u>Diagnostic test</u> (x-ray, blood work)	Inpatient: 10% <u>coinsurance</u> Outpatient: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preadmission</u> for certain services is required.
	<u>Imaging</u> (CT/PET scans, MRIs)	Inpatient: 10% <u>coinsurance</u> Outpatient: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preadmission</u> 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)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.hmsa.com">www.hmsa.com</a></p>	Generic drugs (Tier 1)	<p>Retail: \$7 <u>copayment</u>/script. Mail order: \$11 <u>copayment</u>/script.</p>	<p>You pay 100% of the cost of the drug at purchase and send a <u>claim</u> to HMSA. You will be responsible for 20% of the eligible charge after a \$7 <u>copayment</u> /script is deducted.</p> <p>Mail order: Not covered.</p>	<ul style="list-style-type: none"> <li>• <u>Deductible</u> does not apply. <u>Cost sharing</u> counts toward the <u>out-of-pocket limit</u> for <u>prescription drugs</u> (not the medical limit).</li> <li>• One retail <u>copayment</u> for 1-30 day supply, two retail <u>copayments</u> for 31-60 day supply, and three retail <u>copayments</u> for 61-90 day supply.</li> <li>• One mail order <u>copayment</u> for 84-90 day supply at a 90-day at retail <u>network</u> or contracted mail order <u>provider</u>.</li> <li>• No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).</li> <li>• If preauthorized, you may qualify for Tier 3 drugs at a Tier 2 <u>copayment</u> 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.</li> <li>• Disposable Continuous Glucose Monitor (CGM) and insulin pumps are covered under the prescription drug plan.</li> </ul>
	Preferred brand drugs (Tier 2)	<p>Retail: \$30 <u>copayment</u>/script. Mail order: \$65 <u>copayment</u>/script.</p>	<p>You pay 100% of the cost of the drug at purchase and send a <u>claim</u> to HMSA. You will be responsible for 20% of the eligible charge after a \$30 <u>copayment</u> /script is deducted.</p> <p>Mail order: Not covered.</p>	
	Non-preferred brand drugs (Tier 3)	<p>Retail: \$75 <u>copayment</u>/script. Mail order: \$200 <u>copayment</u>/script.</p>	<p>You pay 100% of the cost of the drug at purchase and send a <u>claim</u> to HMSA. You will be responsible for 20% of the eligible charge after a \$75 <u>copayment</u> /script is deducted.</p> <p>Mail order: Not covered.</p>	
	Specialty drugs	<p>Retail: \$100 <u>copayment</u>/script. Mail order: Not covered</p>	Not covered	<ul style="list-style-type: none"> <li>• <u>Deductible</u> does not apply. <u>Cost sharing</u> counts toward the <u>out-of-pocket limit</u> for <u>prescription drugs</u> (not the medical limit).</li> <li>• Up to 30-day supply.</li> </ul>

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

	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None.
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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)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	Limited to 150 visits per calendar year.
	<u>Rehabilitation services</u>	Outpatient: 20% coinsurance Inpatient: 10% coinsurance	30% <u>coinsurance</u>	Physical and occupational <u>rehabilitation services</u> require preauthorization. Intensive cardiac rehabilitation benefit will be covered on a per qualifying event basis at the same benefit level as physical and occupational therapy – outpatient.
	<u>Habilitation services</u>	Not covered.	Not covered.	You must pay 100% of this service, even In-Network, <u>this exclusion will not be applied to speech therapy or Habilitative services as a treatment of developmental delays if the services are Medically Necessary.</u>
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 120 days per calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	<u>Hospice services</u>	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 <u>plan</u> 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 <u>plan</u> 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.)

- Cosmetic surgery
- Dental care (Adult and Child – payable under a separate dental plan if elected)
- 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.)**

- Acupuncture
- Bariatric surgery (requires preauthorization)
- Chiropractic care
- Habilitation services
- 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](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 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](http://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, kwijjigo holne' (800) 251-5014.

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*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 plan's overall <u>deductible</u>	\$100
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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
<b>The total Peg would pay is</b>	<b>\$1,380</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$100
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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
<b>The total Joe would pay is</b>	<b>\$920</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$100
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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
<b>The total Mia would pay is</b>	<b>\$610</b>

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