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, call 1-808-536-4408. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-808-536-4408 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. Outpatient prescription drugs, chiropractic care, dental and vision, emergency room facility, certain preventive services from a Non-Contract Provider, and the following services when received from a Contract Provider: PCP/specialist visits, preventive services, laboratory, x-ray/imaging, emergency room facility, inpatient hospital, mental health/substance abuse services, skilled nursing facility, hospice services, home health care, and outpatient surgery are some of the services 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 Contract Provider and Non-Contract Provider combined: $2,500**/individual, **$7,500**/family. **Prescription drugs: Contract Pharmacies: $5,400**/individual, **$8,300**/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 Out-of-Pocket Limit: Premiums; balance-billing charges; cost sharing for outpatient prescription drugs; vision, dental, and chiropractic services; penalties for failure to obtain precertification; and health care this plan doesn't cover. Prescription Drug Out-of-Pocket Limit: Premiums; balance-billing charges; cost sharing for medical services/supplies; coinsurance for drugs filled at a Non-Contract pharmacy; penalties for failure to obtain precertification; and drugs this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.hmsa.com/search/providers or call 1-800-776-4672 for a list of Contract Providers. For HMSA Online Care, call 1-866-939-6013. For certain hemophilia medications, call 1-808-536-4408 for a list of Contract 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 contract provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance. Deductible does not apply.	Telehealth Visit: Not covered. All other: 30% coinsurance.	A spouse with primary coverage through Kaiser who does not use a Kaiser provider pays 30% coinsurance if using a Contract Provider and 50% coinsurance if using a non-Contract Provider, except for emergency care and ACA preventive care from a Contract Provider. Telehealth visits are covered only from a Contract Provider or the HMSA Online Care program.
	Specialist visit	10% coinsurance. Deductible does not apply.	Telehealth Visit: Not covered. All other: 30% coinsurance.	
	Preventive care/screening/ immunization	• ACA Preventive care, Annual Preventive Health Evaluation, no charge. Deductible does not apply. • Travel immunizations: 10% coinsurance.	• Telehealth Visit: Not covered. • Well-child immunizations: no charge. Deductible does not apply. • Well-child care visits/lab tests & contraceptive services under the medical plan: 30% coinsurance. Deductible does not apply. • All other preventive services or immunizations: 30% coinsurance.	Plan covers without cost sharing all preventive services and supplies described at https://www.healthcare.gov/what-are-my-preventive-care-benefits/ when obtained from a Contract Provider. You may have to pay for services that aren't preventive care. Ask your provider if the services needed are preventive. Then check what your plan will pay for. You pay coinsurance for additional services covered under the Health Appraisal Program (e.g., some physical exams). * See Primary care visit (above).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient: 10% coinsurance. Deductible does not apply. Inpatient: No charge. Deductible does not apply.	30% coinsurance.	Precertification may be required. * See Primary care visit (above).
	Imaging (CT/PET scans, MRIs)	Outpatient: 10% coinsurance. Deductible does not apply. Inpatient: No charge. Deductible does not apply.	30% coinsurance.	Precertification may be required. * See Primary care visit (above).
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.OptumRx.com	Generic drugs	No charge.	No charge.	• Deductible does not apply. • You must pay 100% at a Non-Contract pharmacy, and submit your claim to the Fund for reimbursement of the amount you paid, less the applicable coinsurance. • Specialty drugs limited to 30-day supply. • If you use the Safeway retail pharmacy or the OptumRx mail service program, you will receive a 90-day supply of your generic, brand, or specialty drug at no charge. • Spouses who have primary coverage through Kaiser must pay 100% for all outpatient prescription drugs, even from Contract pharmacies. • Coinsurance counts toward the prescription drug out-of-pocket limit for Contract pharmacies. • No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate and if filled at a Contract pharmacy). • Certain hemophilia medications are covered under the Plan's medical benefits at no charge, no deductible for generic medications, or 10% coinsurance, no deductible for brand. Contact the HMSA for network information. • Oral chemotherapy drugs are covered through the Plan's prescription drug benefit.
	Brand drugs	10% coinsurance.	10% coinsurance.	
	Specialty drugs	Generic: No charge. Brand: 10% coinsurance.	Generic: No charge. Brand: 10% coinsurance.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge. Deductible does not apply.	30% coinsurance	Precertification may be required. * See Primary care visit (above).
	Physician/surgeon fees	10% coinsurance. Deductible does not apply.	30% coinsurance	Precertification may be required. * See Primary care visit (above).
If you need immediate medical attention	Emergency room care	10% coinsurance. Deductible does not apply to facility charges.	10% coinsurance. Deductible does not apply to facility charges.	• If you do not have an emergency medical condition, treatment is not covered. • Professional/physician charges may be billed separately. • Take-home drugs or supplies such as crutches or braces are not covered.
	Emergency medical transportation	Ground: No charge. Air: 10% coinsurance.	30% coinsurance; except Air: 10% coinsurance.	Only ground and intra-island or inter-island air ambulances services to the nearest adequate hospital to treat your illness or injury are covered. * See Primary care visit (above).
	Urgent care	10% coinsurance.	30% coinsurance.	* See Primary care visit (above).
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance. Deductible does not apply.	30% coinsurance.	Precertification is required. Private room covered only up to the cost of a semi-private room, unless medically necessary. * See Primary care visit (above).
	Physician/ surgeon fees	Attending Provider: 10% coinsurance. Deductible does not apply. Consultation for a transplant: 10% coinsurance.	30% coinsurance.	* See Primary care visit (above).
If you need mental health, behavioral health, or substance abuse services	Outpatient services	• Office visits (including telehealth visit): 10% coinsurance. Deductible does not apply. • All other: No charge. Deductible does not apply.	Telehealth Visit: Not covered. All other: 30% coinsurance	* See Primary care visit (above).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
	Inpatient services	10% coinsurance. Deductible does not apply.	30% coinsurance.	Precertification is required (waived for Contract Provider residential treatment admission). Private room covered only up to the cost of a semi-private room, unless medically necessary. * See Primary care visit (above).
If you are pregnant	Office visits	No charge. Deductible does not apply.	Telehealth Visit: Not covered. All other: 30% coinsurance	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the type of services, a coinsurance may apply. * See Primary care visit (above).
	Childbirth/delivery professional services	10% coinsurance. Deductible does not apply.	30% coinsurance	* See Primary care visit (above).
	Childbirth/delivery facility services	10% coinsurance. Deductible does not apply.	30% coinsurance.	Private room covered only up to the cost of a semi-private room, unless medically necessary. Precertification is required-only if stay is longer than 48 hours for vaginal delivery or 96 hours for C-section. * See Primary care visit (above).
If you need help recovering or have other special health needs	Home health care	No charge. Deductible does not apply.	30% coinsurance	Precertification required for care longer than 30 days. Limited to 150 visits per calendar year. * See Primary care visit (above).
	Rehabilitation services	Outpatient: 10% coinsurance. Inpatient: No charge. Deductible does not apply.	Outpatient: 30% coinsurance Inpatient: 30% coinsurance.	Precertification required for inpatient admission (waived for Contract Provider in State of Hawaii). Cardiac and pulmonary rehabilitation are not covered. Private room covered only up to the cost of a semi-private room, unless medically necessary. * See Primary care visit (above).
	Habilitation services	Not covered.	Not covered.	You must pay 100% of this service, even with a Contract Provider.
	Skilled nursing care	No charge. Deductible does not apply.	30% coinsurance.	Limited to 120 days per calendar year. Precertification is required. Private room covered only up to the cost of a semi-private room, unless medically necessary. * See Primary care visit (above).
	Durable medical equipment	10% coinsurance.	30% coinsurance	Precertification is recommended. * See Primary care visit (above).
	Hospice services	No charge. Deductible does not apply.	Not covered.	Covered if terminally ill. * See Primary care visit (above).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$5 copayment/exam.	No charge up to $50/exam, then 100% coinsurance.	If elected, coverage is available through a separate vision plan. Medical deductible does not apply. You must pay 100% at a Non-Contract Provider, and submit your claim to the Fund for reimbursement of the amount you paid, less the applicable coinsurance. Limited to one exam and pair of frames every 12 months. Cost sharing does not apply to the medical plan's out-of-pocket limit.
	Children's glasses	No charge up to $200/frame at retail (up to $70 at Costco Optical), then 100% coinsurance. No charge for standard prescription lenses. Contact lenses payable in lieu of glasses after a $60 copayment/fitting, up to $175 for contact lenses, then 100% coinsurance.	No charge up to $70/frame, then 100% coinsurance. No charge up to $50 for single vision lenses ($75 for bifocal or $100 for trifocal lenses). Contact lenses payable in lieu of glasses up to $130, then 100% coinsurance.	
	Children's dental check-up	No charge.	Any balance-billing amount charged by Non-Contract provider.	If elected, dental coverage is available through a separate dental plan. Medical deductible does not apply. Retirees and their dependents limited to $2,000/person annual maximum. Cost sharing does not apply to the medical plan's out-of-pocket limit.

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 • Habilitation services	• Long-term care • Private-duty nursing	• Routine foot care • Weight loss programs (except as required by 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 • Chiropractic care (up to 12 visits per year, cost sharing does not apply to the medical plan's out-of-pocket limit)	• Dental care (Adult) (under separate dental plan; retirees and their dependents limited to $2,000/person annual maximum) • Hearing aids (one/ear every five years) • Infertility treatment	• Non-emergency care when traveling outside the U.S. (see www.hmsa.com) • Routine eye care (Adult) (under separate vision plan)

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 (808) 536-4408. 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.

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** **0-10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$1,110
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,170**

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** **0-10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$230
The total Joe would pay is	**$630**

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** **10%**
- **Other coinsurance** **0-10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$250**

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