- 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**/calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. 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**/calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums; balance-billing charges; cost sharing for chiropractic services; penalties for failure to obtain precertification; 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 www.hmsa.com/search/providers or call 1-800-776-4672 for a list of network 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 network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	20% coinsurance. Deductible does not apply.	Telehealth Visit: Not covered. All other: 30% coinsurance.	* 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. Emergency Room physician fees: 10% coinsurance. Deductible does not apply. All other: 30% coinsurance.	Oral chemotherapy drugs are not covered under the Plan; you must pay 100% for these drugs, even with a Contract Provider. * See Primary care visit (above).
	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.
	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.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-808-536-4408.	Generic drugs	Not covered.	Not covered.	• You must pay 100% of this service, even with a Contract pharmacy. • Certain over-the-counter preventive care drugs (as required under health reform) may be covered with no cost sharing under the Medical Plan. • Certain hemophilia medications are covered under the Plan's medical benefits no charge, no deductible for generic medications, or 10% coinsurance, no deductible for brand. Contact the Fund Office for network information.
	Preferred brand drugs	Not covered.	Not covered.	
	Non-preferred brand drugs	Not covered.	Not covered.	
	Specialty drugs	Not covered.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge. Deductible does not apply.	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	10% coinsurance. Deductible does not apply.	30% coinsurance	Precertification may be required.

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 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.
	Urgent care	10% coinsurance.	30% coinsurance.	None.
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.
	Physician/surgeon fees	Attending Provider: 10% coinsurance. Deductible does not apply. Consultation for a transplant: 10% coinsurance.	30% coinsurance.	None.
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).
	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.

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 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.	None.
	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.
If you need help recovering or have other special health needs	Home health care	No charge. Deductible does not apply.	30% coinsurance.	Limited to 150 visits per calendar year. Precertification is required for care longer than 30 days.
	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.
	Habilitation services	Not covered.	Not covered.	You must pay 100% of this service, even with a Contract Provider.
	Skilled nursing care	No charge.	30% coinsurance.	Limited to one physician visit per day, and 120 days per calendar year. Precertification is required. Private room covered only up to the cost of a semi-private room, unless medically necessary.
	Durable medical equipment	10% coinsurance	30% coinsurance.	Precertification is recommended.
	Hospice services	No charge. Deductible does not apply.	Not covered.	Covered if terminally ill.

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	Not covered.	Not covered.	You must pay 100% of this service, even with a Contract Provider.
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even with a Contract Provider.
	Children's dental check-up	Not covered.	Not covered.	You must pay 100% of this service, even with a Contract Provider.

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
- Cardiac Rehabilitation
- Cosmetic surgery
- Dental care (Adult and child)
- Glasses
- Habilitation services
- Long-term care
- Outpatient prescription drugs, including oral chemotherapy drugs
- Private duty nursing
- Routine eye care (Adult and child)
- 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.)

- Bariatric Surgery
- Chiropractic care (up to 12 visits per year, cost sharing does not apply to the medical plan's out-of-pocket limit)
- Hearing aids (one/ear every five years)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (see www.hmsa.com).

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/agencies/ebsa. 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/agencies/ebsa.

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	$70
The total Peg would pay is	**$1,180**

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

- **The plan's overall deductible** **$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	$140
What isn't covered	
Limits or exclusions	$4,470
The total Joe would pay is	**$4,610**

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	$10
The total Mia would pay is	**$260**

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