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 1-808-275-2520. 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.unitehere5trustbenefits.com or call 1-808-275-2520 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for y our costs for services this plan covers.
Are there services covered before you meet your deductible?	**Yes.**	This plan does not have a deductible. You do not have to meet a deductible amount before the plan pays for any services.
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?	**$2,800 per person / $8,400 per 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, prescription drug copayments, 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. For a list of preferred providers, see www.unitehere5trustbenefits.com or call 523-0199 (Oahu) or 1-866-772-8989 (Neighbor Island). For a list of participating pharmacies, please visit www.optumrx.com.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay 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
		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	10% co-insurance	20% co-insurance	----None----
	Specialist visit	10% co-insurance	20% co-insurance	----None----
	Preventive care/screening/ immunization	10% co-insurance for immunizations and well baby care visits No charge for TB test, mammography, routine pap smear, PSA test, colorectal cancer screening and well baby care lab tests	20% co-insurance	Age and frequency limitations may apply for well-baby care, preventive screenings, and certain immunizations. Refer to your Plan Document for additional information. Routine physical exam: Not Covered except for ages 6-19 years, one exam per calendar year. You may have to pay for services that aren't preventative. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% co-insurance	----None----
	Imaging (CT/PET scans, MRIs)	No charge	20% co-insurance	Prior authorization required for PET scans, MRAs and MRIs. If not obtained, benefit payments will be reduced by 10%.

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.Optumrx.com	Generic drugs	15 Day Supply (Retail): $6 60 Day Supply (Retail): $9 60 Day Supply (Mail Order): $9	100% of actual charges and can be reimbursed 100% of E.C. (Eligible Charges) after $4 copay*	*Limited to a 15 day supply through Direct Member Reimbursement (DMR)
	Preferred brand drugs	15 Day Supply (Retail): $18 60 Day Supply (Retail): $28 60 Day Supply (Mail Order): $28	100% of actual charges and can be reimbursed 100% of E.C. after $10 copay*	*Limited to a 15 day supply through DMR
	Non-preferred brand drugs	15 Day Supply (Retail): $18 60 Day Supply (Retail): $28 60 Day Supply (Mail Order): $28	100% of actual charges and can be reimbursed 100% of E.C. after $10 copay*	*Limited to a 15 day supply through DMR
	Specialty drugs	Medical Plan: 20% co-insurance Drug Plan: Generic or Brand copay applies	Medical Plan: 20% co-insurance Drug Plan: Generic or Brand copay applies	Prior authorization required for certain injectables. If not obtained, benefit payments will be reduced by 10%. Oral Specialty medications covered under prescription drug benefit; prior authorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% co-insurance	Prior authorization required for certain outpatient surgeries. If not obtained, benefit payments will be reduced by 10%.
	Physician/surgeon fees	No charge	20% co-insurance	
If you need immediate medical attention	Emergency room care	No charge	20% co-insurance	Covered only for true emergencies.
	Emergency medical transportation	10% co-insurance for ground and 20% co-insurance for air ambulance	20% co-insurance for ground and air ambulance	Coverage for air ambulance is limited to transport within the State of Hawaii; transport within continental U.S.A is covered when facilities in Hawaii are not equipped to furnish treatment.
	Urgent care	10% co-insurance	20% co-insurance	----None----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% co-insurance	Prior authorization required for non-emergency and non-maternity admissions. If not obtained,

[* For more information about limitations and exceptions, see the plan or policy document at www.unitehere5trustbenefits.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)	
				benefit payments will be reduced by 10%.
	Physician/surgeon fees	10% co-insurance (physician fee) No charge (surgeon fee)	20% co-insurance	----None----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% co-insurance	20% co-insurance	Prior authorization required for inpatient admissions. If not obtained, benefit payments will be reduced by 10%. All services require a treatment plan.
	Inpatient services	No charge (facility fee) 10% co-insurance (physicians and mental health professionals)	20% co-insurance	
If you are pregnant	Office visits	10 % co-insurance	20% co-insurance	Prior authorization required for more than 2 OB ultrasounds per pregnancy. If not obtained, benefit payments will be reduced by 10%.
	Childbirth/delivery professional services	10% co-insurance	20% co-insurance	
	Childbirth/delivery facility services	No charge	20% co-insurance	Notification to PSWA of maternity admission is required within 48 hours or by the next business day. If notice is not provided, benefit payments will be reduced by 10%.
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance	Up to 150 visits per calendar year. Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Rehabilitation services	20% co-insurance	20% co-insurance	Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	10% co-insurance	20% co-insurance	Up to 120 days per calendar year. Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Durable medical equipment	20% co-insurance	20% co-insurance	Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Hospice services	No charge	Not covered	Up to 150 days for a terminal illness. Prior authorization required. If not obtained, benefit payments will be reduced by 10%.

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 your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Covered under separate Vision plan.
	Children's glasses	Not covered	Not covered	Covered under separate Vision plan.
	Children's dental check-up	Not covered	Not covered	Covered under separate Dental plan.

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.)

Medical Plan

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Drug Plan:

- Cosmetic Medications (except those specified in the Plan Document)
- Outpatient Injectables
- Over the Counter (OTC) Medications (except those specified in the Plan Document)
- Sexual Dysfunction Medications

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

- Bariatric surgery
- Hearing aids

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 Trust administrator (BRMS) at 1-808-523-0199 or the Department of Labor's, Employee Benefits Security Administration at 1-866-444-3272 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 to submit a claim, appeal, or a grievance for any reason to your plan. You may file an appeal within 180 days following receipt of this notice, which must be in writing and addressed as follows: Board of Trustees, 560 N. Nimitz Highway, Suite 209, Honolulu, HI 96817. For more information about your rights, this notice, or assistance, contact: the Trust Administrator (BRMS) at 1-808-523-0199 or the Department of Labor's, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at www.unitehere5trustbenefits.com.]

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	$0
Specialist *[cost sharing]*	$23.53
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$23.53
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$23.53**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$121.46
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$490.00
Coinsurance	$121.46
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$611.46**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$147.82
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$147.82
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$147.82**

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