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, visit www.teamsters-hma.com or by calling 1-866-331-5913. 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.teamsters-hma.com or call 1-866-331-5913 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are 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-benefit/.
Are there other deductibles for specific services?	Yes. $100 per person / $300 per family for Other Medical Benefits	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.
What is the out-of-pocket limit for this plan?	$2500 per person / $7500 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-billing 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. Please visit www.teamsterstrustbenefits.com or call 842-0392 for a list of network providers and participating pharmacies.	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
		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	No charge	20% co-insurance	You may have to pay for services that aren't preventive. 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)	20% coinsurance (outpatient) 10% coinsurance (inpatient) No charge (outpatient)[1]	20% coinsurance	X-rays for injuries within 48 hours of diagnosis or injury: No charge in-network, 20% coinsurance out-of-network. [1]Laboratory and Screening Radiology Services related to a recommended Preventive Health Care services.
	Imaging (CT/PET scans, MRIs)	20% coinsurance (outpatient) 10% coinsurance (inpatient)	20% coinsurance	Prior authorization required for PET Scans, MRAs, and MRIs. If not obtained, benefit payments will be reduced by 10%.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optum.com	Generic drugs	15-day retail: $5 60-day retail: $8 90-day mail order: $8	100% of actual charges and can be reimbursed up to 100% of E.C. (Eligible Charges), limited to a 30 day supply through Direct Member Reimbursement (DMR)	A generic drug will be substituted for a brand name drug, except when a Physician directs that substitution is not permissible. If you choose a brand name drug that has a generic equivalent, you must pay the applicable copayment plus the cost difference between the brand name drug and its generic equivalent.
	Preferred brand drugs	15-day retail: $15 60-day retail: $24 90-day mail order: $24	100% of actual charges and can be reimbursed up to 75% of E.C. for brand name drugs and up to 80% of E.C. for non-substitutable brand name drugs, limited to a 30 day supply through DMR	
	Non-preferred brand drugs	15-day retail: $15 60-day retail: $24	100% of actual charges and can be reimbursed up to	

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)	
		90-day mail order: $24	75% of E.C. for brand name drugs and up to 80% of E.C. for non-substitutable brand name drugs, limited to a 30 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	Medical Plan: Deductible applies for medical in-network and out-of-network. Prior authorization required for certain outpatient injections. If not obtained, benefit payments will be reduced by 10%. Drug Plan: Coverage limited to oral specialty medications. Prior authorization required for certain oral specialty medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	None
	Physician/surgeon fees	10% coinsurance No charge[1]	20% coinsurance	Prior authorization required for certain outpatient surgeries. If not obtained, benefit payments will be reduced by 10%. [1]Surgical & Anesthesia services related to a recommended Preventive Health Care service.
If you need immediate medical attention	Emergency room care	No charge (facility) 10% coinsurance (physician)		Covered only for true emergencies.
	Emergency medical transportation	10% coinsurance for ground; 20% coinsurance for air ambulance	20% coinsurance for ground and air ambulance	Deductible applies for in-network and out-of-network air ambulance services. Emergency air ambulance limited to interisland transportation within the State of Hawaii.
	Urgent care	10% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Prior authorization is required for elective admissions. 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)	
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral Health Outpatient services	10% coinsurance No charge[1]	20% coinsurance	Prior authorization required for inpatient admissions. If not obtained, benefit payments will be reduced by 10%. All services require a treatment plan. [1]Outpatient visits related to a recommended Preventive Health Care service.
	Mental/Behavioral Health Inpatient services	No charge	20% coinsurance	
	Substance Abuse Disorder Outpatient service	10% coinsurance No charge[1]	20% coinsurance	
	Substance Abuse Disorder Outpatient service	No charge	20% coinsurance	
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	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% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	Notification of maternity admission within 48 hours is required. If 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% coinsurance	Up to a maximum 150 visits per calendar year. Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Rehabilitation services	20% coinsurance	20% coinsurance	Deductible applies for in-network and out-of-network. Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	10% coinsurance	20% coinsurance	Up to a maximum 120 days per calendar year. Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Durable medical equipment	20% coinsurance	20% coinsurance	Deductible applies in-network and out-of-network. Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Hospice services	No charge	Not covered	Up to a maximum 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 (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Outpatient prescription drugs
- Private-duty nursing
- Routine eye care (Adult)
- 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: Hawaii Insurance Department, the Department of Labor's, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform , the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov, or for more information contact the plan at 1-877-384-2875. 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. For more information about your rights, this notice, or assistance, contact:

HMA Customer Services Department, 1440 Kapiolani Boulevard, Suite 1020, Honolulu, HI 96814 at 1-877-384-2875.

OptumRx, P.O. Box 751, Pearl City, HI 96782 at (808) 947-8510

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

* For more information about limitations and exceptions, see the plan or policy document at www.teamsters-hma.com.

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.

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 coinsurance	10%
Hospital (facility) coinsurance	0%
Other coinsurance	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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$470
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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 coinsurance	10%
Hospital (facility) coinsurance	0%
Other coinsurance	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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$560
Coinsurance	$480
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	$0
Specialist coinsurance	10%
Hospital (facility) coinsurance	0%
Other coinsurance	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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$220
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$320**

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