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.hma-hi.com/Teamsters-HMO or by calling 1-877-384-2875. 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.hma-hi.com/Teamsters-HMO or call 1-877-384-2875 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?	No.	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?	$2,000 per person / $6,000 per family (Medical Plan) $2,000 per person / $4,000 per family (Drug Plan)	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, 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. See 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	$14 copayment per visit	Not covered	None
	Specialist visit	$14 copayment per visit	Not covered	Referral by Primary Care Physician (PCP) required. No referral needed for OB/GYN annual exams.
	Preventive care/screening/ immunization	No Charge	Not covered	Preventive care is defined in accordance with the Affordable Care Act. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$14 copayment per outpatient service	Not covered	Charges for inpatient services are included in the Hospital facility or Skilled nursing care fee.
	Imaging (CT/PET scans, MRIs)	$14 copayment per outpatient service	Not covered	Prior authorization required for PET Scans, MRAs and MRIs. If not obtained, benefit payments may be denied. Charges for inpatient services are included in the Hospital facility or Skilled nursing care fee.
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: $12 30-day retail: $14 60-day retail: $28 90-day retail: $42 90-day mail order: $28	Not covered	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: $12 30-day retail: $14 60-day retail: $28 90-day retail: $42 90-day mail order: $28	Not covered	
	Non-preferred brand drugs	15-day retail: $12 30-day retail: $14 60-day retail: $28 90-day retail: $42 90-day mail order: $28	Not covered	
	Specialty drugs	Medical Plan: No Charge Drug Plan: Generic or Brand copay applies	Not covered	Medical Plan: Skilled administration is required. $14 co-pay per office visit 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	$14 copayment per visit	Not covered	Prior authorization required for certain outpatient surgeries. If not obtained, benefit payments may be denied. $14 copayment applies when procedure is performed in a physician's office. Charges for procedures performed in a Hospital setting or ambulatory surgery center are included in the facility fee.
If you need immediate medical attention	Emergency room care	$30 copayment per visit	$30 copayment per visit	Benefit is for initial treatment only. Covered only for true emergencies.
	Emergency medical transportation	20% coinsurance for ground and 10% coinsurance for air ambulance	Not covered	Emergency air ambulance limited to interisland transportation within the State of Hawaii.
	Urgent care	$14 copayment per visit	20% coinsurance	If the beneficiary is admitted to a hospital, HMA must be notified within 48 hours or by the next business day. Follow up treatment from a provider that is not contracted or recognized by the plan is not covered unless treatment meets the criteria for emergency or urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copayment per admission	Not covered	Prior authorization is required for elective admissions. If not obtained, benefit payments may be denied.
	Physician/surgeon fees	No charge	Not covered	None

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 mental health, behavioral health, or substance abuse services	Mental/Behavioral Health Outpatient services	$14 copayment per visit	Not covered	Prior authorization required for inpatient admissions. If not obtained, benefit payments may be denied. Non-hospital residential services: $100 per admission.
	Mental/Behavioral Health Inpatient services	$100 copayment per admission	Not covered	
	Substance Abuse Disorder Outpatient services	$14 copayment per visit	Not covered	
	Substance Abuse Disorder Inpatient services	$100 copayment per admission	Not covered	
If you are pregnant	Office visits	No charge (routine obstetrical care)	Not covered	$14 copayment per visit for non-routine obstetrical care.
	Childbirth/delivery professional services	No charge	Not covered	Prior authorization required for more than 3 OB ultrasounds. If not obtained, benefit payments may be denied.
	Childbirth/delivery facility services	$100 copayment per admission	Not covered	For maternity admissions, HMA must be notified within 48 hours or by the next business day.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Prior authorization required. If not obtained, benefit payments may be denied. If a beneficiary requires home health care visits for more than 30 days, the beneficiary's physician must recertify that additional visits are required and must provide a continuing plan of treatment at the end of each 30-day period of care.
	Rehabilitation services	$14 copayment per visit outpatient	Not covered	Prior authorization required. If not obtained, benefit payments may be denied. Charges for inpatient services are included in the Hospital facility or skilled nursing care fee.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No charge	Not covered	Prior authorization required. If not obtained, benefit payments may be denied. Maximum 120 days of confinement per calendar year.
	Durable medical equipment	20% coinsurance for initial provision and	Not covered	Prior authorization required. If not obtained, benefit payments may be denied. Hearing

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)	
		replacement		Aids: One device per ear every 3 years.
	Hospice services	No charge	Not covered	Prior authorization required. If not obtained, benefit payments may be denied.
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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, 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.

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 copayment	$14
Hospital (facility) copayment	$100
Other copayment	$14

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	$ 440
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$500**

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 copayment	$14
Hospital (facility) copayment	$100
Other copayment	$14

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	$0
Copayments	$980
Coinsurance	$350
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1390**

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

The plan's overall deductible	$0
Specialist coinsurance	$14
Hospital (facility) copayment	$100
Other copayment	$14

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	$0
Copayments	$130
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$290**

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