## Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. $2,000 per person $6,000 per family</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, prescription drug copayments, penalties for failure to obtain prior authorization for services and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of preferred providers, see <a href="http://www.teamsters-hma.com">www.teamsters-hma.com</a> or call 1-877-384-2875. For a list of participating pharmacies, please visit <a href="http://www.catamaranrx.com">www.catamaranrx.com</a>.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes, you need a referral to see a specialist.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan’s permission before you see the specialist.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 6. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>
Teamsters (Active) Self-Funded HMO Medical Plan

Coverage Period: 09/01/2013 – 08/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Participant + Dependents

Plan Type: HMO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$14 co-pay</td>
<td>Not covered</td>
<td>---None---</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$14 co-pay</td>
<td>Not covered</td>
<td>Referral by Primary Care Physician (PCP) required. No referral needed for OB/GYN annual exams.</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Covered under separate chiropractic plan.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>Limited to 8 well-child care visits (birth to age 2). Limited to one preventive care office visit per calendar year (age 2 or older). $10 per dose for immunizations (age 19 or older).</td>
</tr>
<tr>
<td>If you have a test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$14 co-pay per outpatient service</td>
<td>Not covered</td>
<td>Charges for inpatient services are included in the Hospital facility or skilled nursing care fee.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$14 co-pay per outpatient service</td>
<td>Not covered</td>
<td>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.</td>
</tr>
</tbody>
</table>

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## Teamsters (Active) Self-Funded HMO Medical Plan
### Coverage Period: 09/01/2013 – 8/31/2014

### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Participant + Dependents  |  **Plan Type:** HMO

**Questions:** Call 1-877-384-2875 or visit us at www.teamsters-hma.com

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
</table>
| Generic drugs                         |                                | 15 Day Supply (Retail): $12  
30 Day Supply (Retail): $14  
60 Day Supply (Retail): $28  
90 Day Supply (Retail): $42  
90 Day Supply (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 Supply (Retail): $12  
30 Day Supply (Retail): $14  
60 Day Supply (Retail): $28  
90 Day Supply (Retail): $42  
90 Day Supply (Mail Order): $28 | Not covered                     |                                                      |
| Non-preferred brand drugs             |                                | 15 Day Supply (Retail): $12  
30 Day Supply (Retail): $14  
60 Day Supply (Retail): $28  
90 Day Supply (Retail): $42  
90 Day Supply (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. |

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If you need drugs to treat your illness or condition, more information about **prescription drug coverage** is available at www.catamaranrx.com

---
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>Not covered</td>
<td>Prior authorization required for certain outpatient surgeries. Copay applies when procedure is performed in a physician's office.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$14 co-pay per visit</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you need urgent care</td>
<td>Emergency room services</td>
<td>$30 co-pay per visit</td>
<td>20% co-insurance</td>
<td>Benefit is for initial treatment only. Covered only for true emergencies.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% co-insurance for ground and 10% co-insurance for air ambulance</td>
<td>Not covered</td>
<td>Emergency air ambulance limited to State of Hawaii.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$14 co-pay per visit</td>
<td>20% co-insurance</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$100 co-pay per admission</td>
<td>Not covered</td>
<td>Prior authorization required for elective admissions.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>Not covered</td>
<td>---None---</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$14 co-pay per visit</td>
<td>Not covered</td>
<td>Prior authorization required for inpatient admissions. All services require a treatment plan. Non-hospital residential services: $100 per admission.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$100 co-pay per admission</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$14 co-pay per visit</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$100 co-pay per admission</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>Not covered</td>
<td>Prior authorization required for more than 3 OB ultrasounds.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$100 co-pay per admission</td>
<td>Not covered</td>
<td>Prior authorization required.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td></td>
<td>No charge</td>
<td>Not covered</td>
<td>Prior authorization required. 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 days period of care.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td></td>
<td>$14 co-pay per visit outpatient.</td>
<td>Not covered</td>
<td>Prior authorization required. Charges for inpatient services are included in the Hospital facility or skilled nursing care fee.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
<td>***** None *****</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>No charge</td>
<td>Not covered</td>
<td>Maximum 120 days of confinement per calendar year. Prior authorization required.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>20% co-insurance for initial provision and replacement</td>
<td>Not covered</td>
<td>Prior authorization required. Hearing Aids: One device per ear every 3 years.</td>
</tr>
<tr>
<td>Hospice service</td>
<td></td>
<td>No charge</td>
<td>Not covered</td>
<td>Prior authorization required.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
<td>Covered under separate vision plan.</td>
</tr>
<tr>
<td>Glasses</td>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
<td>Covered under separate vision plan.</td>
</tr>
<tr>
<td>Dental check-up</td>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
<td>Covered under separate dental plan.</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)</th>
<th>Services Your Plan DOES Cover (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Plan:</td>
<td>Drug Plan:</td>
</tr>
<tr>
<td>• Acupuncture</td>
<td>• Cosmetic Medications (except those specified in the Plan Document)</td>
</tr>
<tr>
<td>• Chiropractic care</td>
<td>• Outpatient Injectables</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
<td>• Over The Counter (OTC) Medications (except those specified in the Plan Document)</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
<td>• Sexual Dysfunction Medications</td>
</tr>
<tr>
<td>• Habilitation services</td>
<td></td>
</tr>
<tr>
<td>• Infertility treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td></td>
<td>• Hearing aids</td>
</tr>
</tbody>
</table>

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State Laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-384-2875. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U. S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

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

Catamaran Customer Service, 1600 Kapiolani Boulevard, Suite 1322, Honolulu, HI 96814 at 1-888-869-4600 (prescription drug benefits only).

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

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

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Teamsters (Active) Self-Funded HMO Medical Plan
Coverage Period: 09/01/2013 – 8/31/2014
Coverage for: Participant+Dependents | Plan Type: HMO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,180
- **Patient pays:** $360

Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$7,540</td>
</tr>
</tbody>
</table>

Patient pays:

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$360</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$360</td>
</tr>
</tbody>
</table>

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,460
- **Patient pays:** $940

Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,400</td>
</tr>
</tbody>
</table>

Patient pays:

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$250</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$390</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$940</td>
</tr>
</tbody>
</table>

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

✔ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✔ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.