Hawaii EUTF: Prescription Drug Benefit for Actives' HSTA VB Plan Coverage Period: 07/01/2014 – 06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.eutf.hawaii.gov or by calling EUTF at **1-808-586-7390 or toll-free at 1-800-295-0089**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	"$0."	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	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.
Is there an out-of-pocket limit on my expenses?	Yes, the **out-of-pocket limit for cost-sharing for all outpatient prescription drug copayments, coinsurance and deductibles per calendar year is $6,350**/person; **$12,700**/family (these amounts will be adjusted in accordance with law).	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 pay for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, non-covered expenses, penalties for failure to obtain precertification of drugs or dispense as written (DAW) specifications, expenses not considered to be essential health benefits do not count toward the **out-of-pocket limit**.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **in-network retail pharmacies, see** www.caremark.com **or call 1-855-801-8263.**	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**.
Do I need a referral to see a specialist?	No. For information on whether a referral is needed to see a specialist, refer to the separate Summary of Benefits and Coverage (SBC) documents that describe the HSTA VB medical plans.	You can see the **specialist** you choose without permission from this plan.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes. For services not covered by the plan, refer to the separate Summary of Benefits and Coverage (SBC) documents that describe the HSTA VB medical plans.	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**.

- **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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not applicable.	Not applicable.	For information on whether this is a covered service and your cost if you use an In-Network Provider or an Out-of-Network Provider, refer to the separate Summary of Benefits and Coverage (SBC) documents that describe the HSTA VB medical plans.
	Specialist visit	Not applicable.	Not applicable.	
	Other practitioner office visit	Not applicable.	Not applicable.	
	Preventive care/screening/ immunization	Not applicable.	Not applicable.	
If you have a test	Diagnostic test (x-ray, blood work)	Not applicable.	Not applicable.	
	Imaging (CT/PET scans, MRIs)	Not applicable.	Not applicable.	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from **Caremark** at www.caremark.com or call **1-855-801-8263**.	Generic drugs	For a 30-day supply: $5 copayment; For a 31-90 day supply: $9 copayment. FDA-approved Contraceptives: No charge for generic drugs.	You pay 100%. You must file a paper claim and the Plan will reimburse you the eligible charges minus the applicable copayment (noted to the left) plus 30% of the eligible charges. The Plan will not reimburse the difference between the eligible and actual charge.	• No deductible applies to outpatient prescription drugs. • Supply limits up to 90 days at either retail or mail order. • If the cost of the drug is less than the copay, you pay just the drug cost. • Some prescriptions are subject to preapproval, quantity limits or step therapy requirements. • The Dispense as Written (DAW2) Program requires you to use a generic equivalent drug when available. If you choose to purchase a brand drug when a generic drug is available, you pay the generic copayment plus the difference in cost between the brand and generic drug. • No coverage for blood glucose monitoring watch & continuous glucose monitoring devices, cosmetic drugs, fertility agents, immunizations, impotency drugs (excluding Muse), alcohol swabs, and experimental medications. • Only certain over-the-counter (OTC) drugs are covered, such as omeprazole and OTC drugs mandated by Health Reform.
	Preferred brand drugs	For a 30-day supply: $15 copayment; For a 31-90 day supply: $27 copayment.		
	Non-preferred brand drugs	For a 30-day supply: $15 copayment; For a 31-90 day supply: $27 copayment.		
	Specialty drugs	You pay a $5 copayment for generic drugs and a $15 copayment for preferred brand drugs. No coverage for non-preferred brand drugs.	Not covered.	To order specialty drugs contact Caremark Specialty pharmacy at 1-855-801-8263.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable.	Not applicable.	For information on whether this is a covered service and your cost if you use an In-Network Provider or an Out-of-Network Provider, refer to the separate Summary of Benefits and Coverage (SBC) documents that describe the HSTA VB medical plans.
	Physician/surgeon fees	Not applicable.	Not applicable.	
If you need immediate medical attention	Emergency room services	Not applicable.	Not applicable.	
	Emergency medical transportation	Not applicable.	Not applicable.	
	Urgent care	Not applicable.	Not applicable.	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable.	Not applicable.	
	Physician/ surgeon fee	Not applicable.	Not applicable.	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not applicable.	Not applicable.	For information on whether this is a covered service and your cost if you use an In-Network Provider or an Out-of-Network Provider, refer to the separate Summary of Benefits and Coverage (SBC) documents that describe the HSTA VB medical plans.
	Mental/Behavioral health inpatient services	Not applicable.	Not applicable.	
	Substance use disorder outpatient services	Not applicable.	Not applicable.	
	Substance use disorder inpatient services	Not applicable.	Not applicable.	
If you are pregnant	Prenatal and postnatal care	Not applicable.	Not applicable.	
	Delivery and all inpatient services	Not applicable.	Not applicable.	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Not applicable.	Not applicable.	For information on whether this is a covered service and your cost if you use an In-Network Provider or an Out-of-Network Provider, refer to the separate Summary of Benefits and Coverage (SBC) documents that describe the HSTA VB medical plans.
	Rehabilitation services	Not applicable.	Not applicable.	
	Habilitation services	Not applicable.	Not applicable.	
	Skilled nursing care	Not applicable.	Not applicable.	
	Durable medical equipment	Not applicable.	Not applicable.	
	Hospice service	Not applicable.	Not applicable.	
If your child needs dental or eye care	Eye exam	Not applicable.	Not applicable.	For information on whether this is a covered service and your cost if you use an In-Network Provider or an Out-of-Network Provider, refer to the separate Summary of Benefits and Coverage (SBC) documents that describe the HSTA VB medical plans. Also refer to VSP for vision services and your dental plan for dental care information.
	Glasses	Not applicable.	Not applicable.	
	Dental check-up	Not applicable.	Not applicable.	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

This is an outpatient drug summary only. For information on whether the following services are a covered service and any limitations on coverage, refer to the separate Summary of Benefits and Coverage (SBC) documents that describe the HSTA VB Medical plans.

Contact EUTF at 1-800-295-0089 for information on Acupuncture, Bariatric Surgery, Chiropractic care, Cosmetic surgery, Dental care (Adult), Hearing aids, Infertility treatment, Long-term care, Non-emergency care when traveling outside the U.S., Private duty nursing, Routine eye care (Adult), Routine foot care and Weight loss programs.

Other Covered Services
(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

This is an outpatient drug summary only. For information on whether the following services are a covered service and any limitations on coverage, refer to the separate Summary of Benefits and Coverage (SBC) documents that describe the HSTA VB Medical plans.

Contact EUTF at 1-800-295-0089 for information on Acupuncture, Bariatric Surgery, Chiropractic care, Cosmetic surgery, Dental care (Adult), Hearing aids, Infertility treatment, Long-term care, Non-emergency care when traveling outside the U.S., Private duty nursing, Routine eye care (Adult), Routine foot care and Weight loss programs.

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 EUTF at 1-800-295-0089. 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 EUTF at 1-800-295-0089.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This Plan or policy (meaning the Hawaii EUTF outpatient prescription drug benefit plus the medical plan benefit) does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage (meaning the Hawaii EUTF outpatient prescription drug benefit plus the medical plan benefit) does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-295-0089.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-295-0089.

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

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** $**
- **Patient pays** $10

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$10
Coinsurance	$0
Limits or exclusions	$0
Total	**$10**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $**
- **Patient pays** $200

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$200
Coinsurance	$0
Limits or exclusions	$0
Total	**$200**

****IMPORTANT NOTE:**
These coverage examples address outpatient prescription drug costs only!
For information on medical plan costs, refer to the separate Summary of Benefits and Coverage (SBC) documents that describe the HSTA VB medical plans.

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.

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