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 EUTF at **808-586-7390 or toll free at 1-800-295-0089.** 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.eutf@hawaii.gov. or call 1-800-295-0089 to request a copy.

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 services covered before you meet your deductible?	Not applicable.	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
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
What is the out-of-pocket limit for this plan?	**$4,350**/person; **$8,700**/family	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, out-of-network penalties, 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**.
Will you pay less if you use a network provider?	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 you 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.

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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	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 administered by HMSA.
	Specialist 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.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	**Retail or Mail Order** (30-day supply): $5 copayment/prescription **Retail or Mail Order** (31-90 day supply): $9 copayment/prescription	You pay 100%. You must then 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. • Up to 90 day supply at either retail or mail order. • No charge for generic FDA-approved contraceptives from a participating provider. • No charge for diabetic supplies from a participating provider. • 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.
	Preferred brand drugs	**Retail or Mail Order** (30-day supply): $15 copayment/prescription **Retail or Mail Order** (31-90 day supply): $27 copayment/prescription		
	Non-preferred brand drugs	**Retail or Mail Order** (30-day supply): $15 copayment/prescription **Retail or Mail Order** (31-90 day supply): $27 copayment/prescription		

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)	
				• Blood glucose monitoring watch & continuous glucose monitoring devices, cosmetic drugs, fertility agents, immunizations, impotency drugs (excluding Muse), alcohol swabs, and experimental medications are not covered. • Only certain over-the-counter (OTC) drugs are covered, such as omeprazole and OTC drugs mandated by Health Reform
	Specialty drugs	Subject to the applicable generic/brand name copays listed above. $0 copayment for oral oncology medications.	Subject to the applicable generic/brand name copays listed above.	To order specialty drugs contact Caremark Specialty pharmacy at 1-855-801-8263.
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 administered by HMSA.
	Physician/surgeon fees	Not applicable.	Not applicable.	
If you need immediate medical attention	Emergency room care	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 fees	Not applicable.	Not applicable.	
If you need mental health, behavioral health, or substance abuse services	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 administered by
	Inpatient services	Not applicable.	Not applicable.	
If you are pregnant	Office visits	Not applicable.	Not applicable.	

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)	
	Childbirth/delivery professional services	Not applicable.	Not applicable.	HMSA.
	Childbirth/delivery facility services	Not applicable.	Not applicable.	
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 administered by HMSA.
	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 services	Not applicable.	Not applicable.	
If your child needs dental or eye care	Children's 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 administered by HMSA.
	Children's glasses	Not applicable.	Not applicable.	
	Children's dental check-up	Not applicable.	Not applicable.	

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.)

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.

Medications that are prescribed for treatment that are not approved by the Federal Drug Administration (FDA) are not covered by the plan.

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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
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: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 x 61565 or www.cciio.cms.gov. 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: EUTF at 1-800-295-0089.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-295-0089.
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
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-295-0089

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

****IMPORTANT NOTE:**
The coverage examples on the next page are not completed. For information on total medical and prescription drug plan costs for the coverage examples, refer to the separate Summary of Benefits and Coverage (SBC) documents that describe the HSTA VB medical plans.

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

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	**$ 0**

In this example, Peg would pay:

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

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

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	**$0**

In this example, Joe would pay:

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

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

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

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	**$**

In this example, Mia would pay:

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

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