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/UFCW 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 visit www.hma-hi.com/UFCW or call 1-866-331-5913 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$50 per person / $150 per family for in-network services $100 per person / $300 per family for out-of-network services	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.
Are there services covered before you meet your deductible?	Yes. Well-Child Care Visits and Physical Examination 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.
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?	$3500 per person / $10,500 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.hma-hi.com/UFCW or call 808-951-4694 (Oahu) or 1-866-331-5913 (Neighbor Islands) for a list of network providers.	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	20% co-insurance	30% co-insurance	--- None ---
	Specialist visit	20% co-insurance	30% co-insurance	
	Preventive care/screening/ Immunization	100% of charge less plan allowance for physical exams[1,4] 20% coinsurance for immunizations[2] 20% coinsurance for well child care visits and immunizations[3,4]	100% of charge less plan allowance for physical exams[1,4] 30% coinsurance for immunizations 30% coinsurance for well child care visits and immunizations[3,4]	[1] Physical exams covered for Participants only: No charge (once every 2 years) for ages under 22; covered up to $190 (once every 2 years) for ages 22-39, and up to $255 (once every year) for ages 40 and over. [2] Influenza vaccine is covered for Participants with no copayment if received at any Safeway pharmacy. [3] Well child care: Age and frequency limitations apply. [4] Deductible does not apply for these services.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance (inpatient) 20% coinsurance (outpatient)	30% coinsurance	--- None ---
	Imaging (CT/PET scans, MRIs)	10% coinsurance (inpatient) 20% coinsurance (outpatient)	30% coinsurance	Prior authorization required for PET Scans, MRAs, and MRIs. If not obtained, benefit payments will be reduced by 10%.

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

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	**Retail** 15 Day Supply: $6 30 Day Supply: $7 60 Day Supply: $8	Not covered	**Mail Order** 60 Day Supply: $9 90 Day Supply: $10 Prior authorization required for all compound medications over $200.
	Preferred brand drugs	**Retail** 15 Day Supply: $18 30 Day Supply: $21 60 Day Supply: $24	Not covered	**Mail Order** 60 Day Supply: $27 90 Day Supply: $30 Prior authorization required for all compound medications over $200.
	Non-preferred brand drugs	**Retail** 15 Day Supply: 20% of Eligible Charges 30 Day Supply: 20% of Eligible Charges	Not covered	**Central Fill** 15 Day Supply: $18 60 Day Supply: $24 **Mail Order** 60 Day Supply: $27 90 Day Supply: $30 Prior authorization required for all compound medications over $200.
	Specialty drugs	Medical Plan[1]: 20% co-insurance Drug Plan[2]: 30 Day Supply limit: Generic or Brand retail co-pay applies	Medical Plan[1]: 30% co-insurance Drug Plan: Not covered	[1]Medical Plan: Prior authorization required for certain outpatient injections. If not obtained, benefit payments will be reduced by 10%. [2]Oral Specialty medications covered under prescription drug benefit; prior authorization required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Prior authorization required for certain outpatient surgeries. If not obtained, benefit payments will be reduced by 10%.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance (facility fee) 20% coinsurance (physician services)	30% coinsurance	Covered only for true emergencies.
	Emergency medical transportation	20% coinsurance for ground or air ambulance	30% coinsurance for ground or air ambulance	Emergency air ambulance limited to interisland transportation within the State of Hawaii.
	Urgent care	20% coinsurance	30% coinsurance	--- None ---

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

If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Prior authorization is required for non-emergency and non-maternity admissions. If not obtained, benefit payments will be reduced by 10%.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	--- None ---
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral Health Outpatient services	20% coinsurance	30% coinsurance	Prior authorization required for inpatient admissions. All services require a treatment plan. If not obtained, benefit payments will be reduced by 10%.
	Mental/Behavioral Health Inpatient services	10% coinsurance (facility fee) 20% coinsurance (physician services)	30% coinsurance	
	Substance Abuse Disorder Outpatient services	20% coinsurance	30% coinsurance	
	Substance Abuse Disorder Inpatient services	10% coinsurance (facility fee) 20% coinsurance (physician services)	30% coinsurance	
If you are pregnant	Office visits	20% coinsurance	30% 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	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Notification of maternity admission is required within 48 hours or by the next business day. If not provided, benefit payments will be reduced by 10%.

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

If you need help recovering or have other special health needs	Home health care	20% coinsurance	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	30% coinsurance	Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Habilitation services	Not covered	Not covered	Not a Covered Benefit
	Skilled nursing care	20% coinsurance	30% 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	30% coinsurance	Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
	Hospice services	20% coinsurance	Not covered	Up to a maximum 150 days per calendar year for a terminal illness. Prior authorization required. If not obtained, benefit payments will be reduced by 10%.
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

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

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 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 1-866-331-5913.

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.

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

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	$50
Specialist coinsurance	20%
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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	$50
Copayments	$28
Coinsurance	$1,631
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,769**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$50
Specialist coinsurance	20%
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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	$50
Copayments	$490
Coinsurance	$615
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,211**

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

The plan's overall deductible	$50
Specialist coinsurance	20%
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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	$50
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$435**

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