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 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 Examinations 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% coinsurance	30% coinsurance	--- None ---
	Specialist visit	20% coinsurance	30% coinsurance	--- None ---
	Preventive care (Physical Exams)	100% of charge less plan allowance	100% of charge less plan allowance	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. Deductible does not apply to Physical exams.
	Preventive care (Well Child Physician Visits)	20% coinsurance	30% coinsurance	Age and frequency limitations apply. Deductible does not apply to Well Child Physician Visits.
	Screening (Well Child Lab Tests, Pap Smears, PSA Tests, Tuberculin Tests, Mammography)	20% coinsurance	30% coinsurance	Age and/or frequency limitations may apply. Deductible does not apply to Well Child Lab Tests.
	Immunization	20% coinsurance	30% coinsurance	Immunizations administered by a network pharmacy are covered under the prescription drug coverage. Influenza vaccine is covered for Participants at no charge if received at any Safeway pharmacy. Deductible does not apply to Well Child Immunizations.
If you have a test	Diagnostic test (x-ray, blood work) Inpatient	10% coinsurance	30% coinsurance	--- None ---
	Outpatient	20% coinsurance	30% coinsurance	--- None ---
	Imaging (CT/PET scans, MRIs) Inpatient	10% coinsurance	30% coinsurance	---None ---
	Outpatient	20% coinsurance	30% coinsurance	Prior authorization required for Outpatient PET Scans, MRAs, and MRIs. If not obtained,

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

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)	
				benefit payments will be reduced by 10%.
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 compounded 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 compounded medications over $200.
	Non-preferred brand drugs	**Retail** 15 Day Supply: 20% coinsurance 30 Day Supply: 20% coinsurance	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 compounded medications over $200.
	Specialty drugs	Medical Plan[1]: 20% coinsurance Drug Plan[2]: 30 Day Supply limit: Generic or Brand retail copayment applies	Medical Plan[1]: 30% coinsurance 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 coverage; 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 Facility fee	10% coinsurance	30% coinsurance	Covered only for emergency medical conditions.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
	Emergency medical transportation (Air or ground)	20% coinsurance	30% coinsurance	Air ambulance service is limited to interisland transportation within the State of Hawaii.

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

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)	
	Urgent care	20% coinsurance	30% coinsurance	--- None ---
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	Outpatient services	20% coinsurance	30% coinsurance	--- None ---
	Inpatient services Facility fee	10% coinsurance	30% coinsurance	Prior authorization required for inpatient admissions. If not obtained, benefit payments will be reduced by 10%.
	Inpatient Physician and Professional services	20% coinsurance	30% coinsurance	--- None ---
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%.
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 more information about limitations and exceptions, see the plan or policy document at www.hma-hi.com/UFCW.

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)	
				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
- Outpatient Injectable Medications
- 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	**$10,780**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$50
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,920**

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	**$4,730**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$870**

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	**$2,240**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$50
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$560**

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