EUTF Medical Plan Summaries

EUTF Medical and Prescription Drug – PPO Plan Coverage

MEDICAL	HMSA 90/10 PPO Plan		HMSA 80/20 PPO Plan		HMSA 75/25 PPO Plan	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Calendar Year Deductible[2]	None	$100/person $300/family	None	$250/person $750/family	$300/person $900/family	
Calendar Year Maximum Out-of-Pocket Limit[2]	$2,000/person $4,000/family		$2,500/person $5,000/family		$5,000/person $10,000/family	
Lifetime Benefit Maximum	None		None		None	
Physician Office Visit	10%	30%	20%	40%	25%[3]	40%
Urgent Care Visit	10%	30%	20%	40%	25%[3]	40%
Emergency Room	10%	10%[3]	20%	20%[3]	25%	25%
Ambulance	10%	30%	20%	40%	25%	40%
Inpatient Hospital Services	10%	30%	20%	40%	25%	40%
Outpatient Surgery	10%	30%	20%	40%	25%	40%
Outpatient Testing, Lab, and X-ray Services	10%	30%	20%	40%	Lab: 25%[3] Diagnostic testing and X-ray: 25%	40%
Annual Preventive Health Evaluation	No charge	No charge[3]	No charge	No charge[3]	No charge[3]	No charge[3]
Well-Child Office Visit	No charge	30%[3]	No charge	40%[3]	No charge[3]	40%[3]
Preventive Screening	No charge	30%	No charge	40%	No charge[3]	40%
Inpatient Mental Health	10%	30%	20%	40%	Facility: 25%	40%
Outpatient Mental Health	10%	30%	20%	40%	Facility: 25%	40%
Chiropractic Services (administered through American Specialty Health, Inc.)	$15 for up to 20 visits per calendar year	Not covered	$15 for up to 20 visits per calendar year	Not covered	$15 for up to 20 visits per calendar year	Not covered

1 If you receive services from an out-of-network provider, you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge.

2 Amounts paid toward the deductible and the maximum out-of-pocket are measured on a calendar-year basis. However, if your new plan effective July 1, 2021, is with the same carrier, the amounts paid January 1, 2021–June 30, 2021, will apply to your new plan deductible and maximum out-of-pocket. No refunds will be issued. Under calendar-year deductible, "family" is defined as three or more persons. Under calendar-year maximum out-of-pocket, "family" is defined as two or more persons.

3 Deductible does not apply.

PRESCRIPTION DRUG	CVS Caremark[4] EUTF HMSA PPO Plans		
	In-Network Pharmacy	Out-of-Network Pharmacy[5]	Retail 90/Mail Order[6]
Calendar Year Maximum Out-of-Pocket Limit[7]	90/10 and 80/20 PPO Plans: $4,350/person, $8,700/family 75/25 PPO Plan: $3,150/person, $6,300/family		
Day Supply	30/60/90	30/60/90	30/60/90
Generic	$5/$10/$15	$5/$10/$15 + 20% of eligible charges	$5/$10/$10
Preferred Brand	$25/$50/$75	$25/$50/$75 + 20% of eligible charges	$25/$50/$50
Non-Preferred Brand	$50/$100/$150	$50/$100/$150 + 20% of eligible charges	$50/$100/$100
Preferred Insulin	$5/$10/$15	$5/$10/$15 + 20% of eligible charges	$5/$10/$10
Other Insulin	$25/$50/$75	$25/$50/$75 + 20% of eligible charges	$25/$50/$50
Preferred Diabetic Supplies	No copayment	20% of eligible charges	No copayment
Other Diabetic Supplies	$25/$50/$75	$25/$50/$75 + 20% of eligible charges	$25/$50/$50
Oral Contraceptives (up to a 12-month supply)	No copayment	20% of eligible charges	No copayment
Specialty Drugs/ Injectables[7]	30-day supply only $2,500/person calendar-year maximum out-of-pocket limit Specialty generic: 10% of eligible charges, up to $200/fill Specialty preferred brand: 20% of eligible charges, up to $300/fill Specialty non-preferred brand: 30% of eligible charges, up to $400/fill Oral oncology: $30		Retail 90: 30-day supply only Mail: Not covered

4 This plan is the prescription drug coverage for the HMSA PPO medical plans and is administered by CVS Caremark.

5 If you receive services from an out-of-network pharmacy, you are responsible for the copayment + coinsurance and any cost difference between the actual and the eligible charge. Mail order is not a benefit through out-of-network vendors.

6 For more information on Retail 90 and Mail Order, please call CVS Caremark at **1-855-801-8263**.

7 Applicable copayments and caps for specialty medications apply and are counted toward the total annual maximum out-of-pocket.

The CVS Caremark prescription drug plan is bundled with the HMSA medical plan that you select. If you change from one HMSA medical plan to another during open enrollment, your drug maximum out-of-pocket (MOOP) may change on the effective date of your new plan selection. All applicable in-network drug copayments and coinsurance are accumulated on a calendar-year basis toward an annual MOOP amount, and once the MOOP amount is met, you will no longer pay applicable copayments and coinsurance for covered prescription drugs for the remainder of the calendar year while enrolled in that plan. If you change to a plan with a higher MOOP amount, you are responsible for meeting the new MOOP level, but all prior applicable copayments and coinsurance paid toward one CVS Caremark plan can be credited toward the new MOOP amount for the new plan. If you change to a plan with a lower MOOP amount, there are no refunds for copayments or coinsurance that was paid toward the higher MOOP of the prior plan that are over the amounts of the new MOOP for the new plan.

All copayments and coinsurance paid are applied to the applicable MOOP amount based upon the plan the member is enrolled in at the time.

Please note: Maintenance medications must be filled in a 90-day supply. Medications prescribed for treatment that are not approved by the Food and Drug Administration (FDA) are excluded from the plan.

EUTF Medical and Prescription Drug – HMO Plan Coverage

MEDICAL	Kaiser Permanente Comprehensive HMO[1]	Kaiser Permanente Standard HMO[1]	HMSA HMO
Calendar Year Deductible	None	None	None
Calendar Year Maximum Out-of-Pocket Limit[2]	$2,000/person $6,000/family	$2,500/person $7,500/family	$1,500/person $3,000/family
Lifetime Benefit Maximum	None	None	None
Physician Office Visit	$15	$20	$15
Urgent Care Visit	$15 (in area) 20% (out of area)	$20 (in area) 20% (out of area)	$15
Emergency Room	$50	$100	$100
Ambulance	20%	20%	20%
Inpatient Hospital Services	No charge	15%	No charge
Outpatient Surgery	Medical Office: $15 Ambulatory Surgery Center: $15	Medical Office: $20 Ambulatory Surgery Center: 15%	Medical Office: $15 Ambulatory Surgery Center: No charge
Outpatient Testing, Lab, and X-ray Services	$15/day	Basic lab and imaging: $20 Specialty lab and imaging: 20% Diagnostic testing: 20%	Lab: No charge Diagnostic testing: No charge X-ray: $15 per X-ray
Annual Physical Exam	No charge	No charge	No charge
Well-Child Office Visit	No charge	No charge	No charge
Preventive Screening	No charge	No charge	No charge
Inpatient Mental Health	No charge	15%	No charge
Outpatient Mental Health	$15	$20	Facility: No charge
Chiropractic Services (administered through American Specialty Health, Inc.)	$15 for up to 20 visits per calendar year	$15 for up to 20 visits per calendar year	$15 for up to 20 visits per calendar year

1 **Kaiser Permanente Members only:**

1. Except for certain situations described in your Group Medical and Hospital Service Agreement, all claims, disputes, or causes of action arising out of or related to your Group Medical and Hospital Service Agreement, its performance, or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your Group Medical and Hospital Service Agreement.
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.
3. Genetic testing and counseling covered if identified on the USPSTF list of Grade A and B recommendations.

2 **HMSA HMO Members:** Amounts paid toward the maximum out-of-pocket are measured on a calendar-year basis. However, if your new plan effective July 1, 2021, is with the same carrier, the amounts paid January 1, 2021–June 30, 2021, will apply to your new plan maximum out-of-pocket. No refunds will be issued.

Kaiser Permanente Members: Amounts paid toward the maximum out-of-pocket, including both medical and prescription drug costs, are measured on a calendar-year basis. However, if your new plan effective July 1, 2021, is with the same carrier through EUTF, the amounts paid January 1, 2021–June 30, 2021, will apply to your new plan maximum out-of-pocket. No refunds will be issued.

PRESCRIPTION DRUG	Kaiser Permanente Comprehensive HMO		Kaiser Permanente Standard HMO		CVS Caremark/HMSA HMO[3]	
	HMO Network	Mail Order	HMO Network	Mail Order	HMO Network	Retail 90 & Mail Order[4]
Calendar Year Maximum Out-of-Pocket Limit	Applies toward the medical maximum out-of-pocket limit		Applies toward the medical maximum out-of-pocket limit		$4,350/person $8,700/family	
Day Supply	30/60/90		30/60/90		30/60/90	
Generic	Tier 1: $5/$10/$15 Tier 2: $10/$20/$30	Tier 1: $5/$10/$10 Tier 2: $10/$20/$20	Tier 1: $5/$10/$15 Tier 2: $15/$30/$45	Tier 1: $5/$10/$10 Tier 2: $15/$30/$30	$5/$10/$15	$5/$10/$10
Preferred Brand	$35/$70/$105	$35/$70/$70	$50/$100/$150	$50/$100/$100	$25/$50/$75	$25/$50/$50
Non-Preferred Brand	$35/$70/$105	$35/$70/$70	$50/$100/$150	$50/$100/$100	$50/$100/$150	$50/$100/$100
Preferred Insulin	$35/$70/$105	Not available through Mail Order	$50/$100/$150	Not available through Mail Order	$5/$10/$15	$5/$10/$10
Other Insulin	Generic: $10/$20/$30		Generic: $15/$30/$45		$25/$50/$75	$25/$50/$50
Preferred Diabetic Supplies	Appropriate drug copays apply		50% of applicable charges		No copayment	
Other Diabetic Supplies	Appropriate drug copays apply		50% of applicable charges		$25/$50/$75	$25/$50/$50
Specialty Drugs/ Injectables	Retail: $75 (up to a 30-day supply) Mail: Not all specialty drugs can be mailed		Retail: $75 (up to a 30-day supply) Mail: Not all specialty drugs can be mailed		30-day supply only $2,500/person calendar-year maximum out-of-pocket limit Specialty generic: 10% of eligible charges, up to $200/fill Specialty preferred brand: 20% of eligible charges, up to $300/fill Specialty non-preferred brand: 30% of eligible charges, up to $400/fill	Retail 90: 30-day supply only Mail: Not covered

3 This plan is the prescription drug coverage for the HMSA HMO medical plans and is administered by CVS Caremark. Applicable copayments and caps for specialty medications apply and are counted toward the total annual maximum out-of-pocket.

4 For more information on Retail 90 and Mail Order, please call CVS Caremark at **1-855-801-8263**.

The CVS Caremark prescription drug plan is bundled with the HMSA medical plan that you select. If you change from one HMSA medical plan to another during open enrollment, your drug maximum out-of-pocket (MOOP) may change on the effective date of your new plan selection. All applicable In-network drug copayments and coinsurance are accumulated on a calendar-year basis toward an annual MOOP amount, and once the MOOP amount is met, you will no longer pay applicable copayments and coinsurance for covered prescription drugs for the remainder of the calendar year while enrolled in that plan. If you change to a plan with a higher MOOP amount, you are responsible for meeting the new MOOP level, but all prior applicable copayments and coinsurance paid toward one CVS Caremark plan can be credited toward the new MOOP amount for the new plan. If you change to a plan with a lower MOOP amount, there are no refunds for copayments or coinsurance that was paid toward the higher MOOP of the prior plan that are over the amounts of the new MOOP for the new plan.

Please note: Maintenance medications must be filled in a 90-day supply. Medications prescribed for treatment that are not approved by the Food and Drug Administration (FDA) are excluded from the plan.

EUTF Medical and Prescription Drug – Supplemental Plan Coverage

MEDICAL	HMA Supplemental Plan
Plan Year Benefit Maximum	All Services: $2,750 per person, including the Prescription Drug Sublimit listed below
Physician Office Visit	Copayment/Coinsurance covered
Urgent Care Visit	Copayment/Coinsurance covered
Emergency Room	Copayment/Coinsurance covered
Ambulance	Copayment/Coinsurance covered
Inpatient Hospital Services	Copayment/Coinsurance covered
Outpatient Surgery	Copayment/Coinsurance covered
Outpatient Testing, Lab, and X-ray Services	Copayment/Coinsurance covered
Annual Physical Exam	Copayment/Coinsurance covered
Well-Child Office Visit	Copayment/Coinsurance covered
Preventive Screening	Copayment/Coinsurance covered
Inpatient Mental Health	Copayment/Coinsurance covered
Outpatient Mental Health	Copayment/Coinsurance covered
PRESCRIPTION DRUG	**HMA Supplemental Plan**
Plan Year Benefit Maximum Prescription Drug Sublimit	$250 per person
Prescription Drug Copayment Reimbursement	Shall not exceed $20 per 30-day supply, $40 per 60-day supply, and $60 per 90-day supply Count toward the Plan Year Benefit Maximum

This supplemental medical and prescription drug plan is always the secondary payer. All covered services must first be paid by the primary medical and prescription drug plan before receiving any supplemental plan reimbursements. This plan does not coordinate benefits, preauthorizations are not required, and ID cards will not be provided.

Claims can easily be submitted online at **hma-hi.com/eutf**. All claim submissions require an Explanation of Benefits (EOB) from your primary medical plan or pharmacy receipts and labels for all prescription drug reimbursements. Claims may also be submitted by mail or fax. Please mail a claim form, along with any supporting EOBs or receipts, to HMA Claims Dept., P.O. Box 135005, Honolulu, HI 96801-5005. Please fax any claims to **1-808-951-4620**.

Please note:

- To ensure proper posting, please use a separate claim form for each covered member and for services incurred in different plan years.
- This supplemental plan does not cover chiropractic benefits.
- All reimbursement payments are made payable to the covered individual who receives the services. For all minors under the age of 18, reimbursement payments are made payable to the primary Subscriber of the plan.

Please contact the EUTF Customer Service team at **1-866-437-1992** for any assistance. Visit **hma-hi.com/eutf** for all plan documents and additional helpful information.