HAWAII LABORERS' HEALTH AND WELFARE TRUST FUND

FREQUENTLY ASKED QUESTIONS - SELF-FUNDED COMPREHENSIVE MEDICAL PLAN

1. WHY IS IT IMPORTANT TO GO TO A PARTICIPATING PROVIDER?

You save a lot of money when you go to a participating provider! When you see a non-participating provider for services:

- ✓ The plan will not pay out benefits until an annual deductible ($100 for active construction; $200 for active non-construction; $200 for all retirees) has been met
- ✓ You are responsible for a higher portion of the cost of the service
- ✓ The doctor does not discount the cost of their services
- ✓ You might have to pay in full for services and file a claim yourself to get reimbursed

Example of cost of services with a non-participating provider:

Doctor's Billed Charges (what the doctor wants to charge):	$300
Plan's Eligible Charge or EC (what the doctor is contracted to charge if they are participating with the Self-funded Medical Plan):	$100
Discount between Billed Charge and EC:	$200

In-Network: (you see a participating provider)	
Doctor's Billed Charges	$300
Doctor discounts the difference between Billed & EC	- $200
Plan pays 90% of $100 EC	-$90
You Owe the balance	**$10**

Out-of-Network: (you see a non-participating provider)	
Doctor's Billed Charges	$300
Doctor does NOT discount the difference between Billed & EC	n/a
Plan pays 80% of $100 EC	-$80
You Owe the balance * deductible may also apply	**$220***

* See benefit booklet for exceptions to this example.

2. WHERE CAN I GET THE MOST CURRENT LISTING OF PARTICIPATING PROVIDERS?

The Provider Directory can be found on our website at: https://pacadmin.com/provider-directory or contact the Provider Services Department at the Administrator's Office to request a Provider Directory.

Provider Services Department (808) 441-8730
(888) 520-8078 – toll free

3. WHY IS IT IMPORTANT TO HAVE A FAMILY DOCTOR OR PRIMARY CARE PHYSICIAN (PCP)?

Primary Care Physicians provide you with routine medical care and care for non-life threating urgent illnesses or injuries. When you go to your doctor regularly for annual check-ups and regular screenings, your PCP establishes a history file for you. This allows your PCP to better diagnose you when you are ill. Going to your PCP regularly will help detect early signs of potential diseases that can be treated and sometimes cured when detected early. PCPs include doctors who practice Family Medicine, Internal Medicine, Pediatricians, and some OBGYNs.

Be sure to establish care with a PCP so you have someone to call if you are sick or need urgent (non-life-threating care for an illness or injury).

4. WHAT IS THE DIFFERENCE BETWEEN EMERGENCY CARE AND URGENT CARE?

Emergency Services:
An emergency is a situation that ***requires immediate action because it poses a threat to life or health***. Some examples include (but are not limited to): heart attack, poisoning, loss of consciousness, un-controlled bleeding, and convulsions.

Your benefits do **NOT** cover E.R. visits that are not considered to be an emergency. Use of the Emergency Room for what is determined to be a non-Emergency will not be covered and you will be charged in full.

Urgent Care Services:
For symptoms ***requiring immediate attention but not considered an emergency***, you can contact your Primary Care Physician, or utilize Urgent Care centers, located conveniently across the State. Urgent Care centers are open 24/7 and services are covered the same as an office visit. For toothaches and related dental concerns, please contact your family dentist.

5. WHO DO I CONTACT FOR MORE INFORMATION ABOUT MY HEALTH & WELFARE BENEFITS?

Member Services Department: (808) 441-8700 or toll free (888) 520-8078

HAWAII LABORERS' HEALTH AND WELFARE TRUST FUND

FREQUENTLY ASKED QUESTIONS - DRUG BENEFITS

(Self-Funded Comprehensive Medical Plan Members Only)

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1. WHEN AM I ELIGIBLE FOR DRUG COVERAGE?

Active Members: As long as you are eligible for Health & Welfare benefits, you are also automatically eligible for prescription drug coverage.

2. WHO PROVIDES MY DRUG BENEFITS?

Optum Rx

3. WHICH ID CARD DO I SHOW THE PHARMACIST?

Show your Optum Rx Member ID card. Optum will send a Member ID card to you directly.

4. WHAT ARE MY BENEFITS?

You pay a co-payment for a 30-day supply: $5 Generic / $15 Brand

If you have a chronic condition and have a prescription for 90 days or more, you can get a 90-day supply* at a discount (mail order options also available): $9 Generic / $27 Brand

* Pick-up: available through Central Fill Program at Times, Safeway, or Long's pharmacies only
Mail Order: contact the Administrator's office for an Optum Rx Mail Order form

5. WHY DID I GET A DIFFERENT DRUG THAN WHAT MY DOCTOR PRESCRIBED?

Your doctor may have prescribed a brand-name drug, but your drug plan requires that you try the generic equivalent first. A generic drug is a medication with the exact same active ingredient as the brand-name drug, is taken the same way and offers the same effect, at a lower cost to you and the Plan.

Please refer to your Summary Plan Description for more information about covered and non-covered drugs and other details.

Call your Administrator's office Members Services Department: (808) 441-8700; (888) 520-8078 – toll free