IMPORTANT NOTICE

This booklet is a summary of the benefits offered under the AFL Hotel and Restaurant Workers Health and Welfare Plan (the Plan). The provisions of this booklet are not intended to alter or extend the terms of the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund or the Plan as established in the Trust Fund documents, including the AFL Hotel and Restaurant Workers Health and Welfare Trust Agreement, the Plan Documents, and rules and regulations adopted by the Board of Trustees. Your benefit rights will be determined according to the terms of the Trust Fund and the Plan. In the case of any conflict between this booklet and the formal Trust Fund documents, the Trust Fund documents will govern.

The administration of the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund and the Plan is the responsibility of the Board of Trustees. All questions concerning the contents of this booklet or the terms of the Trust Fund should be directed to the Board of Trustees in care of the Contract Administrator at the address listed in this booklet. Any statements in this booklet relating to the Trust Fund will not bind the Trust Fund other than those made by or with the express authorization of the Board of Trustees.

The Board of Trustees has the full and sole discretionary authority to interpret, apply, and administer the Plan, and has the exclusive right to construe the terms of the Plan to determine eligibility for benefits and amounts of benefits under the Plan. Any interpretation or determination made by the Board of Trustees in the exercise of its discretion will be final and binding and will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

In order for the Trust Fund to provide the maximum possible benefits within the limits of its resources, the Board of Trustees reserves the right to alter or eliminate benefits as it deems necessary from time to time. The Trustees' decision on any such matters shall be final and binding. Since such changes may affect you and your dependents, please read this booklet and subsequent notices that are mailed to you carefully.

NOTICE OF GRANDFATHERED HEALTH PLAN STATUS

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund believes that its medical and prescription drug coverages, provided through the Kaiser Permanente Plan, the Comprehensive Medical Plan (self-funded), and the Indemnity Prescription Drug Plan (self-funded), are "grandfathered health plans" under the Patient Protection and Affordable Care Act of 2010 (PPACA or Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Fund Administrator at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, phone: (808) 523-0199 (Oahu) or 1 (866) 772-8989 (Neighbor Islands toll free). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

DISCLAIMER

None of the self-funded benefits described in this booklet are insured by any contract of insurance and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Trust Fund collected and available for such purpose. No participant or dependent shall have accrued or vested rights to benefits under this Plan.

AFL HOTEL AND RESTAURANT WORKERS HEALTH AND WELFARE TRUST FUND

560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817
Oahu: (808) 523-0199
Toll Free: 1 (866) 772-8989

BOARD OF TRUSTEES

Employer Trustees
Kevin Gleason
Julie Walker
Julie Nakayama

Union Trustees
Eric Gill
Ross Baniaga
Doryne Jardine

Employer Trustee Alternates
Carla Thomas
Eileen Caldwell

Union Trustee Alternates
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Mary Evans
Marsha Bruhn

CONTRACT ADMINISTRATOR
Benefit & Risk Management Services, Inc.

PLAN CONSULTANTS
Benefit Plan Solutions, Inc.
Horizon Actuarial Services, LLC

LEGAL COUNSEL
McCracken, Stemerman & Holsberry, LLP

COLLECTION ATTORNEY
Weinberg, Roger & Rosenfeld

AUDITOR
Lemke, Chinen & Tanaka, CPA, Inc.

CUSTODIAN BANK
First Hawaiian Bank

INVESTMENT CONSULTANT
Segal Marco Advisors

INFORMATION NEEDED	CONTACT THE FOLLOWING
Eligibility **Enrollment** **Benefits** **Claims and Appeals** **COBRA Program** **Plan documents** **Privacy Rights**	Trust Fund Office c/o Benefit & Risk Management Services, Inc. 560 North Nimitz Highway, Suite 209 Honolulu, Hawaii 96817 Oahu: 808-523-0199 Toll Free: 1-866-772-8989 *Administrator of the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund.*
Kaiser Permanente Plan	Kaiser Foundation Health Plan, Inc. 711 Kapiolani Boulevard Honolulu, Hawaii 96813 All Islands: 1-800-966-5955 *Provides prepaid medical and prescription drug benefits.*
Comprehensive Medical Plan (Self-funded) Participating Providers Prior Authorization Reviews Claims Processing	Pacific Southwest Administrators (PSWA) 560 North Nimitz Highway, Suite 217E Honolulu, Hawaii 96817 Oahu: 808-275-2520 Toll Free:1-844-808-2520 *Claims Administrator for Comprehensive Medical Plan.*
Indemnity Prescription Drug Plan (Self-funded) Participating Pharmacies Prior Authorization Reviews Claims Processing	OptumRx National Help Desk: 1-888-869-4600 *Pharmacy Benefit Manager for Indemnity Prescription Drug Plan.*

Indemnity Vision Care Plan (Self-funded) Participating Providers Claims Processing	Pacific Southwest Administrators (PSWA) 560 North Nimitz Highway, Suite 217E Honolulu, Hawaii 96817 Oahu: 808-275-2520 Toll Free: 1-844-808-2520 *Claims Administrator for Indemnity Vision Care Plan.*
HDS Dental Plan Participating Dentists Claims Processing and Appeals	Hawaii Dental Service 700 Bishop Street, Suite 700 Honolulu, Hawaii 96813-4196 Oahu: 808-529-9248 Toll Free: 1-844-379-4325 *Claims Administrator for HDS Dental Plan.*
DCCH Dental Plan	Dental Care Centers of Hawaii 92-230 Opuakii Place Kapolei, Hawaii 96707 Oahu: 808-284-6545 *Provides prepaid dental care benefits.*

AFL HOTEL AND RESTAURANT WORKERS HEALTH AND WELFARE PLAN

Dear Plan Participant:

This booklet has been published to provide an updated description of the benefits which eligible employees of the Kaiser Foundation Hospital, Inc. and the Kaiser Foundation Health Plan, Inc. are entitled to receive under the AFL Hotel and Restaurant Workers Health and Welfare Plan. The actual benefits for which you are eligible are determined by the contribution rate being paid by your employer and the Collective Bargaining Agreement. This booklet also includes information that must be made available to all participants under the Employee Retirement Income Security Act of 1974 (ERISA) and serves as the Summary Plan Description.

We recommend that you read this booklet and subsequent notices that are mailed to you carefully.

If you have any questions about the Plan, such as eligibility or benefits, please contact the Trust Fund Office.

Sincerely,
BOARD OF TRUSTEES

The following are important changes in your Health and Welfare benefits since the last booklet was issued. You were previously notified of these changes and their effective dates, and the changes have been incorporated in this booklet revision.

BENEFIT CHANGES

The items that have been changed, along with the page number where the complete text of the change is located, are as follows:

1. DEPENDENT ELIGIBILITY RULES

A. Effective December 2, 2013, state law legalized same sex marriages in Hawaii. Accordingly, Domestic Partners will no longer be eligible Dependents under the Plan, except that Domestic Partners who were enrolled in the Plan on January 1, 2014 are grandfathered under the Domestic Partners Rule (page 33). Same-sex Spouses may be enrolled as eligible Dependents if they are lawfully married and present a marriage license and any other documentation required by the Plan for enrollment of Spouses. A definition of “Spouse” was added to clarify that the term refers to individuals who are lawfully married under any

state law, including individuals married to a person of the same sex (page 32).

B. Effective January 1, 2014, dependent coverage is available to children under 26 years of age regardless of whether they may be eligible for other employer sponsored health coverage (page 32).

2. KAISER PERMANENTE PLAN

A. Effective January 1, 2016:

(1) In vitro fertilization is covered for unmarried women and women using a non-spousal sperm donor.

(2) Orthodontic services for treatment of orofacial anomalies due to birth defects are covered in accordance with State law (pages 47 and 58)

(3) Diagnosis and treatment of autism is covered in accordance with State law (pages 46 and 57).

B. Effective January 1, 2017, services, procedures, treatments and supplies related to gender reassignment will be covered when medically necessary.

3. COMPREHENSIVE MEDICAL PLAN (SELF-FUNDED)

A. Effective January 1, 2011:

(1) The maximum benefit amount of $120,000 per transplant for simultaneous kidney-pancreas transplants is eliminated (page 86).

(2) The maximum benefit amount of $5,000 per in vitro fertilization procedure is eliminated (page 96).

(3) The maximum benefit amount of $15,000 per calendar year for air ambulance services is eliminated (page 99).

(4) The maximum benefit amount of $10,000 per calendar year for human growth hormone therapy is eliminated (page 102).

B. Effective January 1, 2012, the Annual Maximum Benefit amount increased from $750,000 to $1,250,000 per person per calendar year.

C. Effective January 1, 2013, the Annual Maximum Benefit amount increased from $1,250,000 to $2,000,000 per person per calendar year.

D. Effective June 1, 2013, Plan rules relating to coordination of benefits with Medicare were clarified (page 109).

E. Effective January 1, 2014:

(1) The Annual Maximum Benefit amount of $2,000,000 per person per calendar year is eliminated (page 74).

(2) The Annual Copayment Maximum was increased from $2,500 per person and $7,500 per family unit to $2,800 per person and $8,400 per family unit (page 75).

(3) The requirement of 12 months of consecutive coverage immediately preceding a simultaneous kidney-pancreas transplant is eliminated (page 86).

(4) The requirement of 12 months of consecutive coverage immediately preceding an in vitro fertilization procedure is eliminated (page 96).

F. Effective July 1, 2014, the Human Papilloma Virus (HPV) quadrivalent vaccine is a covered immunization for eligible male beneficiaries (previously only covered for female beneficiaries) (page 83).

G. Effective January 1, 2016, annual physical exams and recommended screening tests are covered at 100% of Eligible Charges for children ages 6 through 18 years (previously not a benefit) (page 101).

H. Effective September 1, 2016, the Human Papilloma Virus (HPV) quadrivalent vaccine is a covered immunization for eligible beneficiaries through age 25 (previously covered through age 18) (page 83).

I. Effective January 1, 2017, Pacific Southwest Administrators (PSWA) replaced Hawaii-Mainland Administrators (HMA) as the Claims Administrator for the Comprehensive Medical Plan (page 74).

J. Effective July 1, 2017, in vitro fertilization requiring the use of donor sperm is covered for same sex married couples (page 96).

K. Effective September 15, 2017, diabetes self-management training and nutrition education classes are covered at 90% of Eligible Charges for services of a participating provider or 80% of Eligible Charges for services of a nonparticipating provider (previously not a benefit) (page 100).

L. Effective January 1, 2018, colorectal cancer screening is covered for Beneficiaries beginning at age 50, through age 75 (pages 93).

4. INDEMNITY PRESCRIPTION DRUG PLAN (SELF-FUNDED)

A. Effective April 1, 2013, oral specialty medications require Prior Authorization from the Pharmacy Benefits Manager (page 117).

5. INDEMNITY VISION CARE PLAN (SELF-FUNDED)

A. Effective January 1, 2013, vision care allowances are as follows:

	Allowance	**Frequency**
Eye exam by an Ophthalmologist (M.D.)	$ 50.00	Once every 12 months
Eye exam by an Optometrist (O.D.)	$ 45.00	Once every 12 months
Single vision lenses and frame	$105.00	Once every 24 months

	Allowance	Frequency
Multi-focal lenses and frame	$125.00	Once every 24 months
Contact lenses	$130.00	Once every 24 months
Frame only	$ 50.00	Once every 24 months

B. Effective January 1, 2016, vision care allowances were increased (page 125).

C. Effective January 1, 2017, Pacific Southwest Administrators (PSWA) replaced Hawaii-Mainland Administrators (HMA) as the Claims Administrator for the Indemnity Vision Care Plan (page 124).

6. HAWAII DENTAL SERVICE DENTAL PLAN

A. Effective January 1, 2017, dental benefits were enhanced as follows:

(1) Cleanings and periodontal maintenance for pregnant women and diabetics increased from two times to three times per calendar year (page 135).

(2) Benefits for the following services increased from 70% to 75% of the Allowed Amount: X-rays (other than bitewings), Fluoride, Space Maintainers, Routine Restorative, Crowns and Gold Restoration, Endodontics, Periodontics, Prosthodontics, Oral Surgery, and Adjunctive General Services.

B. Effective February 1, 2018, dental benefits were enhanced as follows:

(1) Cleanings and periodontal maintenance for diabetics increased from three times to four times per calendar year (page 135).

(2) Benefits for the following services increased from 75% to 80% of the Allowed Amount: X-rays (other than bitewings), Fluoride, Space Maintainers, Routine Restorative, Crowns and Gold Restoration, Endodontics, Periodontics, Prosthodontics, Oral Surgery, and Adjunctive General Services (page 135).

7. DENTAL CARE CENTERS OF HAWAII DENTAL PLAN (formerly GENTLE DENTAL)

A. Effective January 1, 2013, the office visit copayment increased from $10.00 to $11.00 per visit.

B. Effective January 1, 2015, the office visit copayment increased from $11.00 to $12.00 per visit and laboratory fees increased by 8% (page 138).

8. CLAIMS AND APPEALS PROCEDURES

A. Effective April 1, 2018, disability claims are subject to new claims and appeals procedures in accordance with Federal law (page 151-155).

TABLE OF CONTENTS

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) 16
NAME OF THE PLAN 16
PLAN SPONSOR AND ADMINISTRATOR 16
PLAN IDENTIFICATION NUMBERS 16
TYPE OF PLAN 16
TYPE OF ADMINISTRATION 16
AGENT FOR SERVICE OF LEGAL PROCESS 16
NAME, TITLE AND PRINCIPAL PLACE OF BUSINESS ADDRESS OF PLAN TRUSTEES 17
APPLICABLE COLLECTIVE BARGAINING AGREEMENT 18
PLAN'S REQUIREMENTS FOR ELIGIBILITY AND BENEFITS 18
SOURCE OF CONTRIBUTIONS 18
FUNDING MEDIUM 18
PLAN YEAR 19
DISCRETIONARY AUTHORITY OF PLAN ADMINISRATOR 19
PLAN AMENDMENT AND TERMINATION 19

ELIGIBILITY RULES FOR ACTIVE EMPLOYEES 21
WHO IS ELIGIBLE 21
ESTABLISHING ELIGIBILITY 21
CONTINUING ELIGIBILITY 22
LOSS OF ELIGIBILITY 22
IF YOU ARE DISABLED AND UNABLE TO WORK 22
IF YOU ENTER THE ARMED FORCES 23
FAMILY AND MEDICAL LEAVE ACT (FMLA) 23
HOW TO CONTINUE YOUR COVERAGE IF YOU LOSE ELIGIBILITY 24
EMPLOYEE SELF-PAYMENT PROGRAM 24
COBRA PROGRAM 24

GENERAL INFORMATION 31
ENROLLMENT FORM 31
ELIGIBLE DEPENDENTS 32

SPECIAL ENROLLMENT PERIODS..34
QUALIFIED MEDICAL CHILD SUPPORT ORDERS 35

MEDICAL BENEFITS 36
CHOICE OF PLANS...36
OPEN ENROLLMENT PERIOD 37
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY
ACT OF 1996 (HIPAA) CREDITABLE COVERAGE 37
NEWBORNS' AND MOTHERS' HEALTH PROTECTION
ACT OF 1996 (NMHPA) 37
WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)...38
GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)...38
MENTAL HEALTH PARITY AND ADDICTION
EQUITY ACT OF 2008 (MHPAEA)...39
PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (PPACA)
GRANDFATHERED HEALTH PLAN STATUS....................................40

KAISER FOUNDATION HEALTH PLAN INC.
KAISER PERMANENTE PLAN 41
HOW TO USE THE KAISER PERMANENTE PLAN................................41
PERSONAL DOCTOR 41
LOCATIONS...41
OFFICE VISITS 42
EMERGENCY SERVICES 43
SERVICES OUTSIDE THE HAWAII REGION 44
BASIC MEDICAL BENEFITS (TABLE)...45
BENEFIT DESCRIPTION...47
ANNUAL COPAYMENT MAXIMUM 47
INPATIENT HOSPITAL CARE 48
PHYSICIAN VISITS 49
PREVENTIVE CARE 49
EMERGENCY CARE 50
URGENT CARE 51
OUTPATIENT LABORATORY, IMAGING & TESTING SERVICES 51
SURGERY 52
SKILLED NURSING FACILITY CARE 53
HOME HEALTH CARE 53

HOSPICE CARE 54
FAMILY PLANNING & INFERTILITY SERVICES 54
MATERNITY CARE 55
MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES 56
OUTPATIENT DRUGS 56
DRUG THERAPY SERVICES 57
OTHER MEDICAL SERVICES 57
COVERAGE EXCLUSIONS AND LIMITATIONS 61
EXCLUSIONS 61
LIMITATIONS 64
PRESCRIPTION DRUG BENEFITS 65
DISPUTE RESOLUTION 69
ADDITIONAL KAISER PERMANENTE INFORMATION 71
IMPORTANT KAISER PERMANENTE PHONE NUMBERS 73

COMPREHENSIVE MEDICAL PLAN (SELF-FUNDED) 74
UNDERSTANDING THE PLAN 74
ANNUAL AND LIFETIME BENEFIT MAXIMUMS 74
ANNUAL COPAYMENT MAXIMUM 75
CHOICE OF HEALTH CARE PROVIDERS 75
ELIGIBLE CHARGES 76
CARE MANAGEMENT PROGRAM 77
STANDARD MEDICAL PRACTICE 78
MEDICAL NECESSITY 78
PRIOR AUTHORIZATION 79
SURGICAL REVIEW 80
INPATIENT REVIEW 81
BENEFITS MANAGEMENT PROGRAM 81
MEDICAL PLAN BENEFITS 82
PHYSICIAN SERVICES 82
OUTPATIENT SURGICAL CENTER SERVICES 87
HOSPITAL INPATIENT SERVICES 88
SKILLED NURSING FACILITY SERVICES 89
HOME HEALTH CARE SERVICES 90
HOSPICE CARE SERVICES 91

OUTPATIENT DIAGNOSTIC TESTS, LABORATORY & X-RAY SERVICES 92
MATERNITY SERVICES 94
MENTAL ILLNESS & ALCOHOL OR DRUG DEPENDENCE SERVICES 97
EMERGENCY SERVICES 98
OTHER MEDICAL SERVICES 100
NON-EMERGENCY INTER-ISLAND TRAVEL BENEFITS 104
EXCLUSIONS AND LIMITATIONS OF COVERAGE 105
SERVICES NOT COVERED 105
IF HOSPITALIZED ON YOUR EFFECTIVE DATE 107
INCORRECT OR FALSE INFORMATION 107
COORDINATION OF BENEFITS 107
SPECIAL PROVISIONS RELATING TO MEDICAID 108
SPECIAL PROVISIONS RELATING TO MEDICARE 109
WORKERS COMPENSATION 109
THIRD PARTY LIABILITY 110
CLAIMS FILING AND PAYMENT 112
FILING CLAIMS 112
PAYMENT OF MEDICAL BENEFITS 112
OUT-OF-STATE MEDICAL SERVICES 113
REIMBURSEMENT FOR PAYMENTS MADE IN ERROR 113
CLAIMS AND APPEALS PROCEDURES 114

INDEMNITY PRESCRIPTION DRUG PLAN (SELF-FUNDED) 115
UNDERSTANDING THE PLAN 115
COVERED DRUGS 115
COVERAGE LIMITATIONS 116
DRUGS NOT COVERED 118
CLAIMS AND APPEALS PROCEDURES 118
INDEMNITY PRESCRIPTION DRUG BENEFIT PROGRAMS 119
POINT OF SERVICE PROGRAM 119
CENTRAL FILL PROGRAM 121
MAIL ORDER PROGRAM 122
DIRECT MEMBER REIMBURSEMENT PROGRAM 122

INDEMNITY VISION CARE PLAN (SELF-FUNDED) 124
WHO IS ELIGIBLE? 124
WHAT ARE THE VISION CARE BENEFITS? 124
EXCLUSIONS FROM COVERAGE 125
HOW ARE VISION CARE SERVICES PROVIDED? 126
HOW TO FILE A CLAIM 126
CLAIMS AND APPEALS PROCEDURES 127

DENTAL CARE BENEFITS 128
CHOICE OF PLANS 128
OPEN ENROLLMENT PERIOD 128

HAWAII DENTAL SERVICE PLAN 128
GETTING STARTED 128
SELECTING A DENTIST 130
HDS REPORTS AND PAYMENTS 132
CLAIMS APPEAL PROCESS 133
DUAL COVERAGE/COORDINATION OF BENEFITS 133
FRAUD AND ABUSE PROGRAM 134
PLAN EXCLUSIONS 134
SUMMARY OF DENTAL BENEFITS 135
HOW TO ACCESS INFORMATION AND CONTACT HDS 136

DENTAL CARE CENTERS OF HAWAII PLAN (DCCH) 138
UNDERSTANDING THE PLAN 138
MAJOR BENEFITS AND COVERED SERVICES 138
PLAN EXCLUSIONS 140
OFFICE FACILITIES 140
QUESTIONS ABOUT YOUR COVERAGE 141

DEATH BENEFITS FOR ACTIVE EMPLOYEES (SELF-FUNDED) 142
COVERAGE 142
BENEFICIARY 142
HOW TO A FILE A CLAIM 143

CLAIMS AND APPEALS PROCEDURES 144
SELF-FUNDED MEDICAL, DRUG AND VISION CLAIMS (Comprehensive Medical Plan, Indemnity Prescription Drug Plan and Indemnity Vision Care Plan) 144
DESIGNATION OF AN AUTHORIZED REPRESENTATIVE 144
INITIAL CLAIMS 144
Urgent Care Claims 144
Pre-Service Claims 145
Post-Service Claims 145
Extensions for Pre-Service and Post-Service Claims 146
Concurrent Care Claims 146
INITIAL BENEFIT DETERMINATION 146
APPEALS 147
Your Right to Information 148
Appeal of an Urgent Care Claim 148
Appeal of a Pre-Service Claim 148
Appeal of a Post-Service Claim 149
NOTIFICATION OF DETERMINATION ON APPEAL 149
INSURED CLAIMS (Kaiser Permanente, HDS, DCCH) 150
DISABILITY CLAIMS 151
DESIGNATION OF AN AUTHORIZED REPRESENTATIVE 151
INITIAL CLAIMS 151
INITIAL BENEFIT DETERMINATION 152
APPEAL OF A DENIED CLAIM 153
NOTIFICATION OF DETERMINATION ON APPEAL 154
SELF-FUNDED DEATH BENEFIT CLAIMS 156
ELIGIBILITY AND OTHER APPEALS 157
EXHAUSTION OF ADMINISTRATIVE REMEDIES/ LIMITATION OF TIME TO FILE A LAWSUIT 158

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION 159

STATEMENT OF ERISA RIGHTS 162

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

NAME OF THE PLAN

AFL Hotel and Restaurant Workers Health and Welfare Plan

PLAN SPONSOR AND ADMINISTRATOR

Board of Trustees
AFL Hotel and Restaurant Workers Health and Welfare Trust Fund
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817-5315
Phone: (808) 523-0199 (Oahu)
Toll free: 1-(866) 772-8989 (Neighbor Islands)

Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan, and if so, the sponsor's address. A complete list of employers and employee organizations sponsoring the Plan may be obtained by Plan participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by Plan participants.

PLAN IDENTIFICATION NUMBERS

Assigned by Internal Revenue Service (EIN) - 99-6008823
Assigned by Plan Sponsor - Plan No. 501

TYPE OF PLAN

Employee Welfare Benefit Plan, providing medical, prescription drug, vision care, dental, and death benefits.

TYPE OF ADMINISTRATION

The Board of Trustees has engaged Benefit & Risk Management Services, Inc. at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817-5315, to serve as Contract Administrator for the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund.

AGENT FOR SERVICE OF LEGAL PROCESS

Benefit & Risk Management Services, Inc.
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817-5315

Service of legal process may also be made upon a Plan Trustee.

NAME, TITLE AND PRINCIPAL PLACE OF BUSINESS ADDRESS OF PLAN TRUSTEES

EMPLOYER TRUSTEES

Kevin M. Gleason
Senior Director, Labor
Marriott International, Inc.
585 9th Street, Suite 345
Oakland, California 94607

Julie Walker
Director of Human Resources
Hilton Hawaiian Village
2005 Kalia Road
Honolulu, Hawaii 96815

Julie Nakayama
Director of Finance
Kyo-ya Company, LLC
2255 Kalakaua Avenue
Honolulu, Hawaii 96815

Carla Thomas (Alternate)
Principal
CT/HR Consulting
4626 Ehako Street
Kalaheo, Hawaii 96741

Eileen Caldwell (Alternate)
Area Director of Human Resources
Marriott International, Inc.
2155 Kalakaua Avenue, Suite 300
Honolulu, Hawaii 96815

UNION TRUSTEES

Eric Gill
Financial Secretary – Treasurer
UNITE HERE Local 5
1516 South King Street
Honolulu, Hawaii 96826

Ross Baniaga
Comptroller
UNITE HERE Local 5
1516 South King Street
Honolulu, Hawaii 96826

Doryne Jardine
Member and Staff Service Supervisor
UNITE HERE Local 5
1516 South King Street
Honolulu, Hawaii 96826

Daniel Kerwin (Alternate)
Lead Organizer
UNITE HERE Local 5
1516 South King Street
Honolulu, Hawaii 96826

Mary Evans (Alternate)
Lead Organizer
UNITE HERE Local 5
1516 South King Street
Honolulu, Hawaii 96826

Marsha Bruhn (Alternate)
Lead Organizer
UNITE HERE Local 5
1516 South King Street
Honolulu, Hawaii 96826

APPLICABLE COLLECTIVE BARGAINING AGREEMENT

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund is maintained pursuant to Collective Bargaining Agreements between UNITE HERE Local 5 and certain Hawaii hotels, restaurants, and other employers.

For the Kaiser Permanente bargaining unit, participants and beneficiaries may obtain a copy of the Collective Bargaining Agreement upon written request to the Contract Administrator or may examine a copy at the Trust Fund Office.

PLAN'S REQUIREMENTS FOR ELIGIBILITY AND BENEFITS

The Plan's requirements for eligibility and a description of circumstances that may result in disqualification or denial or loss of benefits are described in the section on ELIGIBILITY RULES FOR ACTIVE EMPLOYEES beginning on page 21 of this booklet.

SOURCE OF CONTRIBUTIONS

For the Kaiser Permanente bargaining unit, the funds out of which all benefits and expenses are paid are contributed by 1) the Kaiser employers who are parties to the Collective Bargaining Agreement and 2) active and retired participants (i.e., self-payments and COBRA payments). The amount of employer contributions is calculated by multiplying the flat monthly contribution rate specified in the Collective Bargaining Agreement by the number of covered active employees. The portion of the employer contribution that is allocated for retirees is maintained in a separate account. The amount of employee contributions (self-payments and COBRA payments) is set by the Trustees from time to time.

FUNDING MEDIUM

Monthly contributions by each employer are transmitted to the Custodian Bank for the Trust Fund. A portion of the total contributions is held in a checking account out of which premium payments are made to insurance carriers that provide benefits under the terms of the Plan, and benefits are paid to or on behalf of participants. Self-funded medical and vision care benefits are paid by the Trust Fund through the Claims Administrator, Pacific Southwest Administrators (PSWA), which handles the claims administration services for these programs. Self-funded Indemnity Prescription Drug benefits are paid by the Trust Fund through the Pharmacy Benefits Manager, OptumRx. Death benefits are paid directly by the Trust Fund. Funds in excess of those needed for immediate requirements, including benefit payments, insurance premiums and administrative expenses of the Trust Fund, are held in accounts and investments in accordance with investment guidelines determined by the Trustees.

PLAN YEAR

The Plan's fiscal records are kept on a calendar year basis, January 1 through December 31.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR

The Board of Trustees is the Plan Administrator and has the full discretionary authority to interpret, apply, and administer the Plan, and has the exclusive right to construe the terms of the Plan to determine eligibility for benefits and amounts of benefits under the Plan. Any interpretation or determination made by the Board of Trustees in the exercise of its discretion will be final and binding and will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

PLAN AMENDMENT AND TERMINATION

The Trust Agreement for the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund gives the Board of Trustees the authority to: 1) terminate the Plan, 2) amend the eligibility requirements, and 3) amend or eliminate benefits available under the Plan, at any time. NOTE: For the Kaiser Permanente bargaining unit, eligibility requirements for Active participants are established by the Collective Bargaining Agreement.

For example, benefits may be amended or eliminated if the Board of Trustees determines that the Trust Fund does not have the funds to pay for the benefits being provided.

The Trust Fund may be terminated or amended at any time by a majority of the Employer Trustees and a majority of the Union Trustees.

The termination of the Plan, or any part of the Plan, shall not by itself terminate the Trust Fund.

If Plan benefits are amended or eliminated, participants and beneficiaries are eligible for only those benefits which are available after the amendment or elimination of benefits. Participants and beneficiaries have the obligation to read all participant and beneficiary notices issued pertaining to the amendment or elimination of benefits.

If the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund is terminated, benefits will be provided to participants and beneficiaries who have satisfied the eligibility requirements established by the Board of Trustees only as long as funds are available. Benefits under the Trust Fund are not vested or guaranteed. Participants and beneficiaries have the obligation to read the Summary Plan Description (SPD) and all participant and beneficiary notices issued pertaining to the termination of the Trust Fund, and once notified of the termination of the Plan, should contact the insurance carriers of your choice for information on conversion to an individual plan offered by the respective insurance carriers, if applicable.

Upon the termination of the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund, any assets remaining shall be used to satisfy all obligations first, and any remaining Trust Fund assets may be used to pay for benefits and for expenses of administration incident to providing said benefits as the Plan may provide. Participants and beneficiaries have no right to any remaining assets of the Trust Fund.

ELIGIBILITY RULES FOR ACTIVE EMPLOYEES

WHO IS ELIGIBLE

In order to qualify for benefits, as determined by the Board of Trustees, you must work in the UNITE HERE Local 5 bargaining unit for Kaiser Foundation Hospital, Inc. or Kaiser Foundation Health Plan, Inc. (the “Employer”), who has a signed collective bargaining agreement obligating the Employer to contribute to the Trust Fund on your behalf at the negotiated monthly contribution rate.

> There is no dual coverage under the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund. If you work for both a hotel industry employer and Kaiser Foundation Hospital or Kaiser Foundation Health Plan with AFL benefits, you must select one plan under which you will be covered. Your selection will remain in effect until the next open enrollment effective date. However, if you lose coverage under the plan you selected, you may request enrollment in the other plan within 30 days of your loss of coverage if you meet the eligibility requirements under that plan.

ESTABLISHING ELIGIBILITY

You will be eligible for benefits on the first day of the calendar month following the month in which your employer makes the required contribution on your behalf.

Example: *Your employer makes the required contribution in February. You will be eligible for benefits effective March 1st, the first day of the calendar month following the month in which your employer made the contribution.*

The benefits for eligible participants are as follows:

1. Medical
2. Prescription drug
3. Vision care
4. Dental care
5. Death Benefit

CONTINUING ELIGIBILITY

Once you become eligible for benefits, your eligibility will continue on a month-to-month basis as long as your employer continues to make the required contributions to the Trust Fund on your behalf. Each succeeding contribution for your work in a given month will cover you for the calendar month following the month in which the contribution was made.

LOSS OF ELIGIBILITY

You will continue to be eligible for benefits provided your employer continues to make the required contributions to the Trust Fund. You will lose eligibility on the earliest of the following dates:

1. The last day of the calendar month in which your employment with a contributing employer is terminated or you change to a non-benefit eligible employment status; or
2. The first day of the calendar month following the month in which your employer fails to make the required contribution to the Trust Fund on your behalf; or
3. The date this Plan terminates.

Note: If your coverage is terminated because your employer fails to make the required contribution, your coverage will be reinstated **prospectively** on the first day of the calendar month following the month in which your employer makes the required contribution.

Your enrolled dependents will lose eligibility on the earlier of:

1. The last day of the calendar month in which they cease to qualify as an eligible dependent under the terms of the Plan, or
2. The last day of the calendar month for which you had eligibility under the terms of the Plan.

IF YOU ARE DISABLED AND UNABLE TO WORK

If you are on a medical disability leave of absence, you will be covered for medical and prescription drug benefits only, for the first three months from the date your sick leave is exhausted provided your employer makes the required contributions on your behalf for those three months. For the remainder of your medical disability leave, you will have the option to continue your coverage under the Employee Self-Payment Program or the COBRA program.

IF YOU ENTER THE ARMED FORCES

When you enter the Armed Forces, you must notify the Trust Fund Office, in writing, no later than 30 days following your date of entry. Coverage for you and your eligible dependents will be continued until the end of the month for which the required employer contribution was last paid.

Example: Your employer made the required contribution in February, making you eligible for benefits during the month of March. You enter active military service in February. Your eligibility will end March 31st, the last day of the month for which the required employer contribution was last paid.

After the end of that month, you may elect to continue coverage for yourself and your eligible dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended, or forgo continued coverage if it is not needed.

To continue coverage during a military leave of at least 31 days, you must self-pay an amount which does not exceed 102% of the actual cost of the benefits, as determined by the Board of Trustees. The maximum amount of time that coverage may be continued through self-payments is 24 months. Your coverage will continue until your discharge from military service or 24 months, whichever occurs first, as long as you continue to make timely payments. Self-payments must be received by the Trust Fund Office within 30 days after the first day of the period covered by the payment, and by the 15th day of each subsequent month of coverage. Failure to make timely payments will result in termination of coverage.

Regardless of whether you elect to continue coverage, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting period or exclusions (e.g. pre-existing condition exclusion) except for service-connected illnesses or injuries.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund has agreed to allow those contributing employers who are required to provide family and medical leave for their employees, pursuant to the Family and Medical Leave Act or applicable State law, to make contributions to the Trust Fund to continue coverage for those employees while they are on such family and medical leave. If your employer is required to provide you with family and medical leave and you are eligible for family and medical leave benefits, your coverage will continue under the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund provided your employer continues to make monthly contributions to the Trust Fund on your behalf. Contact your employer for further information on the Family and Medical Leave Act.

HOW TO CONTINUE YOUR COVERAGE IF YOU LOSE ELIGIBILITY

When your eligibility for coverage under the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund terminates, you may elect to continue your coverage under one of the following options:

1. Employee Self-Payment Program, or
2. COBRA Program.

In addition, if you are covered under the Kaiser Permanente Plan, a conversion option may be available to you.

EMPLOYEE SELF-PAYMENT PROGRAM (Does not apply to retirees)

If you become ineligible for benefits, you can continue your coverage for medical and prescription drug benefits for not more than 12 consecutive months by making self-payments to the Trust Fund. If you select the Employee Self-Payment Program, you give up your option to use the COBRA Program.

The amount you must pay each month under the Employee Self-Payment Program is established by the Board of Trustees.

Your contribution must be received by the Trust Fund Office by the 15th day of the month prior to the month for which payment is being made. Payment for the first month of self-payment coverage must be made within 15 days of your notification from the Trust Fund Office of your loss of eligibility, or by the 30th day of the month, whichever is sooner. FAILURE TO MAKE SELF-PAYMENTS BY THE DUE DATE SHALL RESULT IN THE LOSS OF COVERAGE.

Contact the Trust Fund Office on Oahu at (808) 523-0199 or 1 (866) 772-8989 (toll free) if you wish to make a self-payment. The Trust Fund Office will tell you the amount of your payment and explain the payment procedure.

COBRA PROGRAM

The AFL Hotel and Restaurant Workers Health and Welfare Plan, in compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended, currently offers qualified employees and dependents of employees who lose coverage as a result of a “Qualifying Event” the opportunity to continue coverage for a specified period of time.

Who is entitled to COBRA Continuation Coverage, When, and for How Long?

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees may elect COBRA on behalf of their eligible spouses and covered parents/legal guardians may elect COBRA for an eligible minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment and Open Enrollment rights.

1. "**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any employee or the spouse or dependent child of an employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a dependent child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

   - A child of the covered employee, who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO) during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.

   - A person who becomes the new spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is **not** a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new spouse is not entitled to elect COBRA for him/herself.

2. "**Qualifying Event**": Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under this Plan, (e.g. employee continues working even though entitled to Medicare) then COBRA Continuation Coverage is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary, and the maximum period of COBRA coverage based on that Qualifying Event:

Continued Coverage For	Qualifying Event	Maximum Period of Coverage
You and your eligible dependents	Voluntary or involuntary termination of your (the Participant's) employment for reasons other than gross misconduct	18 months[1, 2]
You and your eligible dependents*	You become ineligible for coverage due to a reduction in your employment hours	18 months[1, 2]
Your dependents	You die	36 months
Your spouse	You divorce or legally separate	36 months
Your dependent children	Your dependent children no longer qualify as dependents (for example, they reach age 26 or are no longer disabled)	36 months
Your dependents	You become covered for Medicare benefits	36 months[3]

1. Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become totally disabled within the meaning of Title II or Title XVI of the Social Security Act. This additional 11 months is available to employees and enrolled dependents if notice of disability is provided to the Trust Fund Office within 60 days after the Social Security determination of disability is issued and before the initial 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage. The extended COBRA coverage period of up to 29 months for disability not only applies to the disabled beneficiary but also to all other Qualified Beneficiaries covered with the disabled

beneficiary through the same initial Qualifying Event.

2. For a qualified spouse or dependent child whose continuation is due to an employee's termination of employment or reduction in employment hours, the continuation period may be extended if another Qualifying Event occurs during the initial 18-month COBRA period. Coverage may be extended for up to 36 months from the date they first qualified.

3. The employee's qualified spouse and dependent children who are Qualified Beneficiaries (but not the employee) become entitled to COBRA coverage for a maximum period that ends 36 months after the employee becomes entitled to Medicare. This is only available where the employee had a termination of employment or reduction in hours within the 18-month period after the employee becomes entitled to Medicare.

Notices Related to COBRA Continuation Coverage

The Trust Fund Office will determine the occurrence of a Qualifying Event in the event of your termination of employment or reduction in hours. The Qualifying Event in these cases will be the date of your loss of coverage under the Plan. Your employer is responsible for notifying the Trust Fund Office within 30 days in the event of your death, termination of employment, reduction in hours, or entitlement to Medicare benefits.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs**.

That written notice must be sent to the Trust Fund Office located at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, phone (808) 523-0199 or (866) 772-8989. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is not received by the Trust Fund Office within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Electing COBRA Continuation Coverage

When the Trust Fund Office receives notice or otherwise determines that a Qualifying Event has occurred, the Trust Fund Office will notify you regarding COBRA continuation coverage within 14 days or such other deadline as determined by the Trustees. You, your spouse, and/or dependent children will have 60 days after the date your coverage under the Trust Fund terminates or the date the Trust Fund Office sends notice to you, your spouse, and/or dependent children, whichever is later, in which to elect COBRA continuation coverage (the "election period").

Each Qualified Beneficiary is entitled to make his or her own independent election to continue coverage under COBRA. A Qualified Beneficiary who is the covered employee may elect COBRA on behalf of the other Qualified Beneficiaries. However, if the covered employee rejects COBRA Continuation Coverage, the covered employee's spouse and/or dependent children have their own independent right to elect COBRA Continuation Coverage. If the Qualified Beneficiary is a minor child, the child's parent or legal guardian may make the election.

If a Qualified Beneficiary waives coverage under the COBRA Program, the Qualified Beneficiary can revoke the waiver at any time before the end of the election period.

If you are covered under another employer's group health plan or Medicare prior to your COBRA election, your prior coverage will not disqualify you from being able to elect COBRA.

The COBRA Continuation Coverage that Will Be Provided

The continued coverage under the COBRA Program includes the medical, prescription drug, vision care, and dental benefit coverage described in this booklet. Once a selection is made as to your choice of medical and dental plans, coverage cannot be changed except during the annual open enrollment period.

Paying for COBRA Continuation Coverage (the Cost of COBRA)

To continue coverage under the COBRA Program, you and/or your dependents must pay an amount equal to 102% of the actual cost of the benefits, as determined by the Board of Trustees. However, if you or your dependent is determined to be disabled by the Social Security Administration, the payment amount will increase to 150% of the actual cost of the benefits, as determined by the Board of Trustees, beginning with the 19th month of coverage.

The first COBRA payment must be received by the Trust Fund Office within 45 days after the COBRA election date and must include payment for the period from the date that coverage is terminated under the Trust Fund through the date that COBRA election is made. Subsequent payments must be received by the Trust Fund Office within 30 days after the first day of the period covered by the payment.

Addition of Newly Acquired Dependents

If, while you (the employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 30 days after the date of marriage, birth, adoption, or placement for adoption. If you fail to request enrollment within this 30-day period, retroactive coverage will not be made. Coverage for your new dependent will not be effective until the first day of the calendar month following the date of notification and receipt of the proper documentation by the Trust Fund Office. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the Trust Fund Office to add a dependent.

Loss of Other Group Health Plan Coverage

If, while you (the employee) are enrolled for COBRA Continuation Coverage, your spouse or dependent child loses coverage under another group health plan, you may enroll your spouse or dependent child for coverage for the balance of the period of COBRA Continuation Coverage. Your spouse or dependent child must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA health care plan and declined, your spouse or dependent child must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll your spouse or dependent child within 30 days after the termination of the other coverage or within 60 days after the termination of coverage under Medicaid or CHIP in accordance with Federal law. If you fail to request enrollment during this 30-day or 60-day special enrollment period, you must wait until the next open enrollment period. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

When COBRA Ends

If COBRA is elected, the continued coverage will begin on the date that coverage under the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund would otherwise be lost and end on the earliest of the following dates:

1. The last day of the applicable maximum coverage period described above;
2. The first day of the payment period for which timely payment of premium is not made (a payment is considered timely only if made within 30 days of the date it is due);
3. The date the AFL Hotel and Restaurant Workers Health and Welfare Plan ceases to provide any health coverage;
4. The first day on which the individual becomes covered under Medicare; or
5. The first day on which the individual becomes covered under another employer's group health plan. (Exception - If the new group plan contains an exclusion or limitation with respect to any pre-existing condition of the individual, then COBRA coverage may be continued until the earlier of the end of the exclusion or limitation period, or the occurrence of one of the other events stated above.)

If you have any questions about your COBRA rights and obligations, please contact the Trust Fund Office.

GENERAL INFORMATION

ENROLLMENT FORM

In order to be covered for benefits, you (the employee) must have a current Trust Fund enrollment form on file at the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund Office. If you have not done so already, you should complete the enrollment form, listing your choice of medical plan and dental plan, your beneficiary or beneficiaries, and all your eligible dependents. If you are married, you must submit a copy of your marriage certificate. If you have dependent children, you must submit a copy of their birth certificates and guardianship or adoption papers, if applicable.

Newly hired employees and employees of employers who have just signed the Collective Bargaining Agreement should obtain the Trust Fund enrollment form from the UNITE HERE Local 5 Union Office, their Personnel Office, or the Trust Fund Office. The completed enrollment form must be returned to the Trust Fund Office. No premiums or benefits will be paid on your behalf until the Trust Fund Office receives your enrollment form. Upon receipt of the completed form, you and your eligible dependents will be enrolled in the applicable medical and dental plans. No retroactive enrollment will be made.

Important Notice

It is important to keep the Trust Fund Office informed of any change in your personal or family situation, or contact information. You or your dependents must notify the Trust Fund Office and submit the proper documentation as required by the Trust Fund if any of the following events occur:

- You or your family members change mailing addresses or telephone numbers.
- You get married, divorced, widowed, legally separated or end a grandfathered Domestic Partnership.
- You wish to add an additional dependent child (such as a new baby or an adopted child).
- You become disabled.
- You or your dependent(s) become eligible for Medicare.
- You have other health care coverage.

ELIGIBLE DEPENDENTS

Eligible dependents include your legal spouse as defined by the Plan and children under 26 years of age.

The term "Spouse" or "Legal Spouse" shall refer to individuals who are lawfully married, as recognized under the laws of the jurisdiction in which the marriage was entered into and who are not legally separated.

The term "children" includes natural children, stepchildren, legally adopted children, children under legal guardianship, and children placed in the home in anticipation of adoption. Coverage is available to an eligible dependent child without regard to marital or student status, dependency upon you (or anyone else) for financial support, or residency with you.

You must submit an "Application for Dependent Addition" for each dependent added for coverage. The Board of Trustees may require any information necessary, including a birth certificate, marriage certificate, or the signing of an affidavit, to determine the eligibility of a dependent under this section.

To add a new spouse or dependent child, you must notify the Trust Fund Office by submitting proper documentation, in writing, within 30 days of the date of marriage, birth, adoption, or placement for adoption. Coverage will be effective on the date of the event. If you do not notify the Trust Fund Office within this 30-day period, retroactive coverage will not be made and coverage for your spouse or dependent child will be effective on the first day of the month following the date of notification to the Trust Fund Office.

If Your Child is Disabled

A dependent child who, upon attaining age 26, has a mental or physical disability which was incurred prior to age 19 and which renders the child incapable of self-support, will continue to be covered for benefits as long as 1) such child remains unmarried, disabled, and incapable of self-support and 2) you remain an eligible participant under the Plan; provided that the child was covered under the Plan prior to age 26. You must, however, submit satisfactory proof to the Trust Fund of his or her incapacity upon the child's attaining age 26 and when requested periodically thereafter. A disabled dependent child of a newly hired employee who was covered under the employee's plan immediately preceding coverage under the Trust Fund will be covered for benefits as long as such child remains unmarried, disabled, and incapable of self-support provided satisfactory proof of prior coverage is submitted to the Trust Fund within 30 days of eligibility. Coverage for a disabled dependent child under this provision shall terminate upon the earliest of the following: 1) the child's marriage, 2) the child becoming capable of self-support, 3) failure to provide proof of continued disability when requested, or 4) termination of your eligibility.

Domestic Partners

Effective December 2, 2013, state law legalized same sex marriages in Hawaii. Accordingly, Domestic Partners will no longer be eligible Dependents under the Plan, except that Domestic Partners who were enrolled in the Plan on January 1, 2014 are grandfathered under the Domestic Partners Rule. Same-sex Spouses may be enrolled as eligible Dependents if they are lawfully married and present a marriage license and any other documentation required by the Plan for enrollment of Spouses.

NOTE: The Trust Fund will continue to cover Domestic Partners or reciprocal beneficiaries of Kaiser Foundation Health Plan or Kaiser Foundation Hospital employees who were grandfathered into the Trust Fund by Trustees' action of December 9, 2004 and who meet the following requirements:

1. The Domestic Partner or reciprocal beneficiary is not eligible to receive health insurance coverage from any other source; and

2. The Domestic Partner or reciprocal beneficiary must enroll in the Kaiser Permanente Plan offered by the Trust Fund.

If a Dependent Ceases to be Eligible for Dependent Coverage

A spouse who loses eligibility upon divorce, legal separation, or dissolution of a Domestic Partnership, or a child who ceases to be eligible for dependent coverage under the Trust Fund, may continue coverage by electing and making payments under the COBRA program, as described in the COBRA Program section, or if enrolled in the Kaiser Permanente Plan, may apply in writing or call Kaiser Foundation Health Plan, Inc. for conversion to an Individual or Family Plan offered directly by Kaiser within 30 days of the date the change in eligibility status occurs.

Limitations on Dependent Coverage

1. No person who permanently resides outside of the United States of America may be eligible for coverage under the Trust Fund.
2. An eligible person may be covered either as an employee or as a dependent of an employee under the Trust Fund but not both.
3. If both husband and wife are covered as employees, either (but not both) may cover the children as dependents under the Trust Fund.

SPECIAL ENROLLMENT PERIODS

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following special enrollment rules will be applicable:

1. If you initially declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and/or your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you fail to request enrollment during this special 30-day period, coverage for yourself and/or your dependents will not be effective until the next open enrollment period following the date of notification to the Trust Fund Office.
2. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependents in this Plan. However, you must request enrollment within 30 days after the date of marriage, birth, adoption, or placement for adoption for coverage to be effective on the date of the event. If you fail to request enrollment during this special 30-day period, retroactive coverage will not be made. Coverage for yourself and/or your dependents will not be effective until the first day of the month following the date of notification and submission of the proper documentation to the Trust Fund Office in accordance with Plan rules.
3. If your and/or your dependent's Medicaid or State Children's Health Insurance Program (CHIP) coverage is terminated due to loss of eligibility, or if you and/or your dependent become eligible for a premium assistance subsidy through Medicaid or CHIP for coverage under this Plan, you may enroll yourself and/or your dependents in this Plan within 60 days of such event. If you fail to request enrollment during this special 60-day period, coverage for yourself and/or your dependents will not be effective until the next open enrollment period following the date of notification to the Trust Fund Office.

To request special enrollment or obtain more information, contact the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund Office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund is required to provide benefits in accordance with the requirements of a "qualified medical child support order." A qualified medical child support order is a judgment, decree, or order (including a court approved domestic relations settlement agreement) issued by a court or administrative agency authorized to issue child support orders that requires a group health plan to provide coverage to the child(ren) of a plan participant pursuant to state domestic relations law.

The Trust Fund has adopted procedures for determining whether a medical child support order is "qualified". A copy of these procedures will be provided to the interested parties when an order is received by the Trust Fund or will be provided, free of charge, upon written request.

In order to be "qualified", the order must clearly specify:

1. The name and last known address of the participant and each affected child (except that the mailing address of a state official may be substituted for that of a child);
2. A reasonable description of the type of coverage to be provided to the child, or the manner in which such type of coverage is to be determined; and
3. The period to which the order relates.

Additionally, an order is "qualified" only if it does not require the Trust Fund to provide any type or form of benefit, or any option, not otherwise provided by the Plan (except to the extent required by-law).

Medical child support orders shall be delivered to the Administrator of the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund. The Trust Fund will determine whether or not the order is "qualified" and notify the participant and alternate recipient(s) of such determination. An alternate recipient is any child of a participant who is recognized under a medical child support order as having a right to enrollment in the Plan.

If a medical child support order is determined to be "qualified," each alternate recipient named in the order who is not already enrolled in the Plan will be enrolled. The alternate recipient's benefit options will be as specified in the order or, if no options are specified in the order, as selected by the participant. For further information on medical child support orders, contact the Trust Fund Office.

MEDICAL BENEFITS

CHOICE OF PLANS

Depending on the Collective Bargaining Agreement with your employer and where you live, you may choose one of the following two medical-hospital-surgical plans:

1. The Kaiser Permanente Plan, or
2. The Trust Fund's Comprehensive Medical Plan (self-funded).

Kaiser Permanente's Hawaii service area is limited to the state of Hawaii. You must live or work within the Hawaii service area to enroll in the Kaiser Permanente Plan. If you move outside the Kaiser Permanente Hawaii service area, you will not be allowed to continue coverage under the Kaiser Permanente Plan and must enroll in the Comprehensive Medical Plan.

If you choose the Kaiser Permanente Plan, you will be eligible for Kaiser Permanente's prescription drug benefits and the Indemnity Plan vision care benefits for appliances only.

If you choose the Comprehensive Medical Plan, you will be eligible for the Indemnity Plan prescription drug and vision care benefits.

The principal benefit provisions of the Kaiser Permanente Plan and the Comprehensive Medical Plan are summarized in this booklet. You should compare the benefits carefully before choosing a medical plan.

If you are a new employee, you should make sure that the Trust Fund Office has received your Trust Fund enrollment form which lists your dependents and choice of medical and dental plans.

How to Obtain Benefits

The medical plan you select will send you a member ID card. Contact the Trust Fund Office if you have not received, or have lost, your member ID card.

You should have your member ID card available whenever you schedule or seek medical care. If you are a Kaiser Permanente Plan member, show your Kaiser Permanente member ID card whenever you go to the Kaiser Permanente Hospital or Clinic for services. If you are a Comprehensive Medical Plan member, show the doctor, hospital, or laboratory your AFL Medical ID card issued by the Trust Fund Office.

If you do not have your membership card, be sure to tell the provider in advance that you are a Kaiser Permanente Plan member or a Comprehensive Medical Plan member and you belong to the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund. You should also ask the doctor or facility rendering services to contact the Trust Fund Office to confirm your eligibility.

OPEN ENROLLMENT PERIOD

You may change medical plans during the annual open enrollment period. If you wish to change plans, contact the Trust Fund Office during the month of November of any year. The change will become effective January 1st of the following year. No change between medical plans may be made at any other time, except if:

1. You are enrolled in the Kaiser Permanente Plan and subsequently move outside the Hawaii service area, or
2. You meet one of the requirements specified in the Special Enrollment Periods section beginning on page 34 of this Summary Plan Description.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) - CREDITABLE COVERAGE

This Federal law was designed to help employees maintain access to health coverage as they change employers or when they leave their employer and seek an individual plan. If you enroll in a new health plan within 63 days of your prior coverage, you will receive credit for time covered under your prior coverage.

Procedure for Requesting and Receiving a HIPAA Certificate of Creditable Coverage

A certificate of creditable coverage will be provided upon receipt of a written request that is received by the Trust Fund Office within two years after the date coverage ended under the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund. The written request must be mailed or faxed to the Trust Fund Office located at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, FAX (808) 537-1074, and should include the name of the individual for whom a certificate is requested (including your spouse and dependent children) and the address where the certificate should be mailed. A copy of the certificate will be mailed by the Trust Fund to the address indicated.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NMHPA)

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, health plans and insurance issuers may not, under Federal law, require that

a provider obtain authorization from the health plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits under the Kaiser Permanente Plan or the Comprehensive Medical Plan, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications in all stages of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayments, and/or coinsurance applicable to other medical and surgical benefits provided under these plans.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

Effective January 1, 2010, the following provisions apply to the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund. Under GINA, group health plans and health insurance issuers generally may not:

- Adjust premium or contribution amounts for the covered group on the basis of genetic information;
- Request or require an individual or a family member to undergo a genetic test;
- Request, require, or purchase genetic information for underwriting purposes;
- Request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment or coverage under the plan.

However, a doctor or health care professional who is providing health care services to you may request that you undergo a genetic test, which you voluntarily agree to, for treatment of a health condition. Then, the group health plan and health insurance issuer may obtain and use the results of a genetic

test to make a determination regarding payment for medically necessary health care services, provided only the minimum amount of information necessary is requested.

In addition, group health plans may request, but not require, a participant or beneficiary to undergo a genetic test for research purposes if certain conditions are met, including that:

- The request is made in writing;
- The research complies with Federal and State laws;
- The plan clearly indicates to the participant or beneficiary that compliance with the request is voluntary; and
- The plan indicates that noncompliance will have no effect on eligibility or benefits.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)

Effective January 1, 2010, provisions of the Mental Health Parity and Addiction Equity Act of 2008 apply to mental health and substance abuse disorder benefits provided through the Kaiser Permanente Plan and the Comprehensive Medical Plan. This Federal law generally requires that financial requirements and treatment limitations that apply to mental health and substance abuse disorder benefits cannot be more restrictive than the financial requirements and treatment limitations that apply to medical/surgical benefits.

Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (PPACA) –GRANDFATHERED HEALTH PLAN STATUS

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund believes that its medical and prescription drug coverages, provided through the Kaiser Permanente Plan, the Comprehensive Medical Plan (self-funded), and the Indemnity Prescription Drug Plan (self-funded), are "grandfathered health plans" under the Patient Protection and Affordable Care Act of 2010 (PPACA or Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Fund Administrator at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, phone: (808) 523-0199 (Oahu) or 1 (866) 772-8989 (Neighbor Islands toll free). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 (866) 444-3272 or *www.dol.gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

KAISER FOUNDATION HEALTH PLAN INC.

KAISER PERMANENTE®

The Kaiser Permanente Plan is designed to provide quality medical care at a reasonable cost. Kaiser Permanente provides patient centered care. This means that your personal doctor and care team will work closely with you to provide care you need, monitoring your health, managing medications, notifying you of needed health screenings or lab tests, and coordinating care with specialists and other health care providers.

When you join, you and other enrolled members of your family are encouraged to follow a health maintenance program with covered benefits such as annual health evaluations, eye examinations for glasses, and pediatric checkups. When an illness does occur, your benefit coverage enables your personal Kaiser Permanente physician to provide the necessary services.

HOW TO USE THE KAISER PERMANENTE PLAN

PERSONAL DOCTOR

You must obtain your medical care directly from Kaiser Permanente facilities, physicians, and designated providers. You may choose and change your personal doctor at any time. Your personal Kaiser Permanente physician is responsible for your medical care and arranges consultations with other specialists, as necessary. All care and services need to be coordinated by a Kaiser Permanente physician.

LOCATIONS

You may live or work in the Kaiser Permanente Hawaii service area and enroll (or continue to be enrolled) in a Kaiser Permanente plan.

For your convenience, Kaiser Permanente operates twelve (12) outpatient facilities on Oahu, five (5) on Maui, three (3) on the Big Island, and one (1) on Kauai. You can obtain care at the facility or facilities of your choice. Members on Oahu receive hospital care at the Moanalua Medical Center. Members on Hawaii Island, Maui, Kauai, Molokai and Lanai receive hospital care at a designated hospital on your island.

Hospital Facilities

Hawaii Island
- Hilo Medical Center
- Kona Community Hospital

Kauai
- Samuel Mahelona Memorial Hospital
- West Kauai Medical Center

Maui
- Maui Memorial Medical Center
- Kula Hospital

Lanai
- Lanai Community Hospital

For some medical conditions, your physician may coordinate care for you on Oahu at Moanalua Medical Center.

For detailed information on the Kaiser Permanente physicians and locations, please contact Kaiser Permanente Member Services at **1-(800)-966-5955** or **711** (TTY hearing / speech impaired), or visit the website at kp.org/doctorsandlocations.

OFFICE VISITS

You may schedule routine visits to physicians or other health professionals by calling in advance or using a computer or mobile device at kp.org/appointments to arrange appointments.

In cases of sudden illness, you can be seen by a physician that same day by calling one of Kaiser Permanente's conveniently located facilities and describing your condition. Referrals to non-Kaiser Permanente physicians and hospitals may be made for very specialized care.

You don't need a doctor's referral to make appointments for the following services and departments within Kaiser Permanente:

- Alcohol and drug treatment
- Allergy
- Audiology
- Bariatric medicine
- Behavioral health services
- Cosmetic dermatology
- Cosmetic plastic surgery
- Eye examinations for glasses and contact lenses
- Family practice
- Health education
- Internal medicine
- Medication counseling
- Obstetrics-gynecology
- Occupational health services
- Pediatrics

- Physical therapy
- Social work
- Sports medicine
- Tobacco telephone counseling
- Travel medicine

EMERGENCY SERVICES

A medical emergency is a potentially life-threatening situation that requires immediate medical attention. These conditions might include, but are not limited to:

- Suspected heart attack
- Suspected stroke
- Extreme difficulty in breathing
- Severe pain
- Bleeding that will not stop
- Major burns
- Seizures
- Sudden onset of severe headache
- Suspected poisoning

If you think you are experiencing an emergency, go immediately to the nearest emergency department. If you need an ambulance, call 911. Do not call Kaiser Permanente and waste precious time.

Your Kaiser Permanente plan defines an “Emergency Medical Condition” as an illness or injury that reveals itself through severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

If you are admitted to a non-Kaiser Permanente facility, you or a family member must notify Kaiser Permanente within 48 hours after care begins (or

as soon as reasonably possible) by calling the phone number on the back of your Kaiser Permanente identification card or your claim for payment may be denied. Kaiser Permanente may arrange for your transfer to a Kaiser Permanente facility as soon as it is medically appropriate to do so.

SERVICES OUTSIDE THE HAWAII REGION

At a non-Kaiser Permanente facility (or non-health plan designated facility), benefits are limited to care authorized under a written referral, urgent care, emergency care, or care for qualified out-of-area dependents.

Please have your Kaiser Permanente ID card with you at all times. If you are admitted to a hospital, you or a family member must call the toll-free number found on the back of your ID card within 48 hours of your hospital admittance or your claim may be denied.

Visiting Member Services at Mainland Kaiser Permanente Facilities

Services at other Kaiser Permanente Region facilities in California, Colorado, Georgia, Maryland, Oregon, Virginia, Washington, and Washington D.C. are provided while you are temporarily visiting the area. For specific information about visiting member services, call the Away from Home Travel Line at (951) 268-3900* (or 711 TTY) or visit kp.org/travel.

* This number can be dialed from within and outside the United States. If you are calling from outside the U.S., you must dial the U.S. country code "001" for landlines and "+1" for mobile before the phone number. Long-distance charges may apply and collect calls cannot be accepted. This phone line is closed on major holidays.

Moving Out of the Service Area

If you are relocating to another Kaiser Permanente service area, you should contact the Trust Fund Office to discuss your plan/coverage options. If you move outside the Hawaii service area, Kaiser Permanente may terminate your membership. Until that time, you will only be covered for initial emergency care and urgent care in accordance with your Health Plan benefits.

BASIC MEDICAL BENEFITS

The following medical and prescription drug benefits are insured under an insurance contract issued by Kaiser Foundation Health Plan, Inc. The services provided by Kaiser Permanente include the payment of claims, when necessary, and the handling of claims appeals.

The following is for informational purposes only and is only a summary of medical benefits available under the Kaiser Permanente Plan and your payment obligations. Its contents are subject to the provisions of the Group Agreement, Kaiser Permanente Hawaii's Guide to Your Health Plan and applicable riders and amendments, which contain all the terms and conditions of membership and benefits. These documents are on file with the Trust Fund Office. Please refer to these documents for specific questions about coverage.

PLAN BENEFITS	MEMBER COPAYMENT
ANNUAL COPAYMENT MAXIMUM	$2,000 per member $6,000 per family
INPATIENT HOSPITAL CARE	None
PHYSICIAN VISITS	$15 per visit
PREVENTIVE CARE	
• Well-child care visits (birth to 5 years)	None
• Annual preventive care visit (physical exam) (6 years and older)	None
• Annual gynecological exam (female members)	None
• Preventive screenings	None
• Routine immunizations	None
• Hearing exam (for correction)	$15 per visit
• Vision exam (for glasses)	$15 per visit
EMERGENCY CARE	
Within Hawaii Service Area	$30 per visit
Outside Hawaii Service Area	20% of applicable charges
URGENT CARE	
• Within Hawaii Service Area	$15 per visit
• Outside Hawaii Service Area	20% of applicable charges
OUTPATIENT LABORATORY, IMAGING & TESTING SERVICES	$15 per department per day
OUTPATIENT SURGERY AND PROCEDURES	$15 per visit
SKILLED NURSING FACILITY CARE	None
HOME HEALTH CARE	None
HOSPICE CARE	None

PLAN BENEFITS	MEMBER COPAYMENT
FAMILY PLANNING & INFERTILITY SERVICES • Family planning visits • Infertility consultation • Artificial insemination • In vitro fertilization	 $15 per visit $15 per visit $15 per visit 20% of applicable charges
FAMILY PLANNING & INFERTILITY SERVICES (continued) • Contraceptive drugs and devices (FDA approved) to prevent pregnancy • Interrupted pregnancy	 50% of applicable charges $15 per visit
MATERNITY CARE (Routine obstetrical care, delivery and hospital stay for mother and newborn)	None
MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES • Outpatient services • Inpatient services	 $15 per visit None
OUTPATIENT DRUGS & DRUG THERAPY • Skilled administered drugs • Self-administered drugs (See page 66) • Diabetes supplies • Tobacco cessation drugs and products • Drug therapy services	 None $12 per prescription 50% of applicable charges None Applicable charges
OTHER MEDICAL SERVICES	
Ambulance services	20% of applicable charges
Autism care	$15 per visit
Blood and blood processing	None (Medical office) Included in applicable charge if provided in any other setting (e.g. Hospital, ER, etc.)
Diabetes equipment	50% of applicable charges
Dialysis	10% of applicable charges
Health education services	$15 per visit
Hyperbaric oxygen therapy	Applicable charges
Internal prosthetics, devices and aids	None (Medical office) Included in applicable charge if provided in any other setting (e.g. Hospital, ER, etc.)
Medical foods	20% of applicable charges

PLAN BENEFITS	MEMBER COPAYMENT
Orthodontic care for treatment of orofacial anomalies from birth	$15 per visit
Physical, Occupational & Speech therapy	$15 per visit
Pulmonary rehabilitation	Applicable charges
Radiation therapy	$15 per visit
Transplant services	Applicable charges

BENEFIT DESCRIPTION

ANNUAL COPAYMENT MAXIMUM

Your out-of-pocket expenses for covered Basic Health Services are capped each year by an Annual Copayment Maximum. When the total of your copayment amounts reach $2,000 per member or $6,000 per family unit (three or more members) in any calendar year, you are no longer responsible for copayment amounts for eligible covered services for the remainder of the calendar year.

All payments are credited toward the calendar year in which the medical services were received. You must retain your receipts as proof of your payments and when the maximum amount has been paid, present these receipts to Kaiser's Business Office at Moanalua Medical Center, Honolulu, Waipio or Wailuku Clinics, or to the cashier at other clinics. After verification that the Annual Copayment Maximum has been paid, you will be given a card which indicates that no additional copayment amounts for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits.

Your payments for the following services **do not apply** toward meeting the Annual Copayment Maximum. You are responsible for these amounts even after you have met your Annual Copayment Maximum:

- Fit Rewards or any fitness programs
- Bariatric surgery program
- Complementary alternative services such as chiropractic, acupuncture, massage therapy, or naturopathy
- Cosmetic plastic surgery
- Cosmetic dermatology
- Dental services
- Dressings and casts
- Health education services, classes or support groups
- Lasik eye surgery
- Medical social services
- Sexual dysfunction drugs

- Payments for services subject to a maximum once you reach the maximum
- Take-home supplies
- Travel immunizations
- Any amounts you owe in addition to your copayments for covered services
- Payments you make for non-covered or excluded services or services for which coverage has been exhausted

INPATIENT HOSPITAL CARE

You are covered for prescribed Hospital care, surgical procedures, hospital room and board (private room when medically necessary) and hospital ancillary services during your inpatient hospital stay. A single copayment applies for all covered services. Inpatient Hospital care includes:

- General nursing care and special duty nursing
- Physicians' care
- Surgical procedures
- Respiratory therapy
- Anesthesia
- Medical supplies
- Use of operating and recovery rooms
- Intensive care room and related care
- Isolation care room and related care
- Medically necessary care provided in an intermediate care unit at an acute care facility
- Special diet
- Laboratory, imaging and testing
- Radiation therapy
- Chemotherapy
- Physical, occupational and speech therapy
- Administered drugs
- Internal prosthetics and devices
- External prosthetic devices and braces ordinarily furnished by a hospital
- Blood
- Durable medical equipment ordinarily furnished by a hospital

Observation: Covered when prescribed by a physician without charge.

PHYSICIAN VISITS

<u>Office Visit</u>: Covered, for primary and specialty care at medical offices within the Service Area for evaluation and management which may include examination, history or medical decision making. Office visits also include physician consultations for surgical, obstetrical, pathological, radiological or other medical conditions, as determined by a physician. Routine pre-surgical and post-surgical office visits in connection with a covered surgery are provided without charge.

<u>House Calls</u>: Covered within the Service Area when a physician determines that necessary care is best provided in the home. Physician house calls include physician consultations and visits by a specialty physician.

PREVENTIVE CARE

<u>Well Child Care</u>: Well-child office visits are provided without charge to members at birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, and 5 years of age. All other office visits for health maintenance will be provided upon payment of the Office Visit copay.

<u>Annual Preventive Care Physical Exam</u>: One preventive care office visit per year is provided without charge for members 6 years of age and older.

<u>Annual Gynecological Exam</u>: One gynecological exam per year is provided without charge for female members. You may receive your annual exam from a physician who specializes in obstetrics or gynecology without referral or prior authorization.

<u>Preventive Screenings</u>: The following preventive screening services are provided without charge:

- Anemia and lead screening for children
- Chlamydia detection
- Colorectal cancer screening
- Fecal occult blood test
- Lipid evaluation
- Screening mammography
- Newborn metabolic screening
- Osteoporosis screening
- Routine well child screening
- Cervical cancer screening
- Diabetes screening

<u>Routine Immunizations</u>: Prescribed immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) for disease

prevention, including influenza and pneumococcal, and for children 5 years of age and younger are provided without charge. Your office visits for prescribed immunizations are provided without charge.

Unexpected mass immunizations: Covered at 50% of applicable charges.

Travel immunizations: Not covered.

Hearing Exam: Covered, to determine the need for hearing correction.

Vision Exam: Covered, to determine the need for glasses. You may receive a vision exam without referral.

EMERGENCY CARE

You are covered for Emergency Services within and outside the Hawaii Service Area. Emergency Services are those medically necessary services available through the emergency department to medically screen, examine and stabilize the patient for Emergency Medical Conditions.

An “Emergency Medical Condition” is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention will result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or place the health of the individual in serious jeopardy.

Examples of an Emergency Medical Condition include chest pain or other heart attack signs, poisoning, loss of consciousness, convulsions or seizures, broken back or neck, heavy bleeding, sudden weakness on one side, severe pain, breathing problems, drug overdose, severe allergic reaction, severe burns, and broken bones.

Examples of non-emergencies are colds, flu, earaches, sore throats, and using the emergency room for convenience or during normal office hours for medical conditions that can be treated in a medical office.

Emergency Services are covered for initial emergency treatment only. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered unless treatment meets the criteria for Emergency Services. Payment is limited to Emergency Services which are required before the patient can be transported without medically harmful circumstances to a Kaiser Permanente facility; except that Health Plan, at its option, may continue inpatient coverage in lieu of transferring the patient. If you are admitted to a non-Kaiser Permanente facility, you (or your family) must notify the Health Plan office within 48 hours of admission in order for care to be covered.

URGENT CARE

Within the Service Area: Urgent Care, including after hour care, is available from Kaiser Permanente physicians and non-Kaiser physicians in facilities designated by the Health Plan.

Outside the Service Area: When you are temporarily outside the Service Area, Urgent Care may be received from non-Kaiser Permanente physicians and facilities.

"Urgent Care" means medically necessary services for a condition that requires prompt medical attention but is not an Emergency Medical Condition. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered unless treatment meets the criteria for Urgent Care. Payment is limited to Urgent Care which is required before the patient can be transported without medically harmful consequences to a Kaiser Permanente facility; except that Health Plan, at its option, may continue inpatient coverage in lieu of transferring the patient. If you are admitted to a non-Kaiser Permanente facility, you (or your family) must notify the Health Plan office within 48 hours of admission in order for care to be covered.

OUTPATIENT LABORATORY, IMAGING & TESTING SERVICES

Laboratory: Covered, for prescribed basic and specialty laboratory services including interpretation of labs and related materials. Examples of basic lab tests include:

- Thyroid test
- Throat cultures
- Urine analysis
- Fasting blood sugar and A1c for diabetes monitoring
- Electrolytes
- Drug screening
- Blood type and cross match
- Cholesterol tests
- Hepatitis B
- Prostate Specific Antigen (PSA) screening

Examples of specialty lab tests include:

- Tissue samples
- Cell studies
- Chromosome studies
- Pathology
- Testing for genetic diseases

Imaging: Covered, for prescribed general and specialty imaging including interpretation of imaging and related materials. Examples of general imaging include:

- X-ray
- Diagnostic mammography

Examples of specialty imaging include:

- Computerized tomography (CT) scan
- Interventional radiology
- MRI
- Nuclear medicine
- PET
- Ultrasound

Allergy Testing: Covered. Allergy treatment materials that require skilled administration are provided without charge.

Diagnostic Testing: Covered, for prescribed diagnostic testing including interpretation of tests to diagnose an illness or injury. Examples of diagnostic testing include:

- Electrocardiograms (EKG or ECG)
- Electroencephalograms (EEG)
- Pulmonary function studies
- Sleep studies
- Treadmills

SURGERY

Outpatient Surgery and Procedures: Covered, for prescribed outpatient surgical procedures performed in a medical office, ambulatory surgery center (ASC) or Hospital-based setting. A single copayment applies for all covered services.

Inpatient Surgical Procedures: Prescribed inpatient surgical procedures are covered under INPATIENT HOSPITAL CARE.

Anesthesia: Covered, as required by a physician and when appropriate for your condition. Anesthesia services are included in the applicable copayment for OUTPATIENT SURGERY AND PROCEDURES and INPATIENT HOSPITAL CARE. Office visits will be subject to the copayment for PHYSICIAN VISITS.

Anesthesia and hospital services for dental procedures for children with serious mental, physical or behavioral problems are also covered.

Reconstructive Surgery: Covered, if a physician determines that the surgery is medically feasible and (i) will result in significant improvement in

physical function (such as bariatric surgery and surgery to correct congenital anomalies); or (ii) will correct significant disfigurement following an injury or medically necessary surgery; or (iii) is performed incident to a covered mastectomy. Your copayment for the surgery is determined based on whether it is performed as an inpatient or outpatient surgical procedure.

SKILLED NURSING FACILITY CARE

You are covered for prescribed skilled nursing care that is provided or arranged at approved facilities. A single copayment applies for all covered services. The following services are included:

- Nursing care
- Room and board (including semi-private rooms)
- Medical social services
- Medical supplies
- Durable medical equipment and external prosthetic devices and braces ordinarily furnished by a skilled nursing facility

Medicare guidelines are used to determine when skilled nursing services are covered except that a prior three-day stay in an acute care hospital is not required. Up to 60 days per Benefit Period of prescribed skilled nursing care are provided without charge. A Benefit Period begins when a member is admitted to a hospital or skilled nursing facility at a skilled or acute level of care. This Benefit Period ends when the member has not been an inpatient of a hospital or an inpatient of a skilled nursing facility for 60 consecutive days.

HOME HEALTH CARE

Home health care is covered when all these statements are true:

- A physician determines that it is feasible to maintain effective supervision and control of your care in your home.
- Care is prescribed in writing by a physician to treat an illness or injury while you are homebound, as defined by Medicare.
- Home health care is medically necessary care that can be safely and effectively provided in your home by health care personnel.
- The attending physician approves a plan of treatment for you.

Home health care does not include custodial care or homemaker care.

Note: You pay a PHYSICIAN VISIT copayment for each physician house call.

HOSPICE CARE

A hospice program provides supportive and palliative care (generally in a home setting) for patients who are diagnosed as terminally ill and who have a life expectancy of six months or less. Medicare guidelines and Health Plan criteria are followed to determine benefits, level of care and eligibility for hospice care. Hospice care includes:

- Residential room and board expenses at a licensed hospice facility
- Nursing care (excluding private duty nursing)
- Physical and occupational therapy, respiratory therapy and therapy for speech language pathology
- Medical social services
- Home health aide services
- Medical supplies and drugs
- Physician care
- Short-term inpatient care limited to respite care, pain control, and acute and chronic symptom management
- Hospice referral visits during which a patient is advised of hospice care options
- Counseling and coordination of bereavement services
- Services of volunteers

While under hospice care, you are not eligible for other Plan benefits for the terminal condition except physician visits. You are eligible for all covered benefits unrelated to the terminal condition.

Hospice coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. The attending physician must certify the patient as terminally ill at the beginning of each period.

Note: You pay a PHYSICIAN VISIT copayment for each physician visit.

FAMILY PLANNING & INFERTILITY SERVICES

Family Planning Visits: Covered, includes abortion counseling and information on birth control.

Infertility Consultation: Coverage is limited to only the initial consultation visit and prescribed labs and diagnostic tests. Labs and diagnostic tests will be subject to the copayment for OUTPATIENT LABORATORY, IMAGING AND TESTING SERVICES.

Artificial Insemination: Covered, to determine infertility status.

In vitro fertilization: Covered, when provided or arranged by your Kaiser Permanente physician. Coverage is limited to a one-time only benefit for one

out-patient in vitro fertilization procedure while you are a Kaiser Plan member. If you received benefits for in vitro fertilization under any Kaiser Permanente plan, you are not eligible for in vitro fertilization benefits under this plan. In vitro fertilization services are not covered when a surrogate is used.

In vitro fertilization must meet state law requirements and Health Plan requirements and criteria. The cost of donor sperm, donor eggs, equipment and of collection, storage and processing of sperm or eggs are not covered.

The in vitro procedures must be performed at a medical facility that conforms to the American College of Obstetricians and Gynecologist guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

You may be referred for these services to a specialized facility within Hawaii. These services must have prior authorization.

<u>Contraceptive drugs and devices (FDA approved) for the prevention of pregnancy</u>: Covered when prescribed and obtained at a Kaiser pharmacy within the Service Area. Benefits are limited to one contraceptive method per period of effectiveness. No refund is given if an implant or device is removed.

<u>Interrupted pregnancy</u>: Covered for medically indicated or elective pregnancy terminations (including abortion drugs such as RU-486). Elective pregnancy termination is limited to two per member per lifetime.

<u>Sterilization services</u>: Covered, for voluntary sterilization including tubal ligation for women and vasectomy for men. Your copayment is determined based on whether the surgery is performed as an inpatient or outpatient procedure. Reversal of sterilization is not covered.

MATERNITY CARE

Covered, for routine prenatal visits, delivery, and one postpartum visit. You have inpatient benefits for maternity as follows:

- 48 hours from time of delivery for a vaginal delivery, or
- 96 hours from time of delivery for a cesarean delivery

All newborns are covered for nursery care services for the first 48 or 96 hours after birth. Newborns are covered after the first 48 or 96 hours if added to your coverage.

Newborns with congenital defects and birth abnormalities are covered for the first 31 days of birth even if not added to your coverage. These newborns are covered after 31 days of birth only if added to your coverage.

Home phototherapy equipment for newborns is covered without charge when prescribed by a physician, preauthorized in writing and obtained from sources designated by Health Plan.

MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES

All care will be provided under an approved individualized treatment plan.

Mental Health - Outpatient services: Care by physicians and mental health professionals that is performed, prescribed or directed by a physician including diagnostic evaluation, psychological testing, counseling and psychiatric treatment. Coverage also includes day treatment and partial hospitalization services in a specialized mental health treatment unit or facility.

Mental Health – Inpatient services: Hospital care and medical care as prescribed by a physician including room and board, psychiatric nursing care, group and individual therapy, electro-convulsive therapy, drug therapy, drugs and medical supplies. Coverage also includes non-hospital residential care in a specialized mental health treatment unit or facility.

Chemical Dependency – Detoxification: Prescribed medical and hospital care for the medical management of the withdrawal process including outpatient, inpatient and specialized facility care.

Chemical Dependency - Outpatient services: Care by physicians and other health care professionals that is performed, prescribed or directed by a physician including diagnostic evaluation and counseling. Coverage also includes day treatment and partial hospitalization services in a specialized alcohol or chemical dependence treatment unit or facility.

Chemical Dependency – Inpatient services: Hospital care and medical care as prescribed by a physician including room and board, nursing care, group and individual therapy, drug therapy, drugs and medical supplies. Coverage also includes non-hospital residential care in a specialized alcohol or chemical dependence treatment unit or facility.

OUTPATIENT DRUGS

Skilled administered drugs: Covered, for prescribed drugs that require skilled administration by medical personnel, such as injections and infusions. Your copayments for immunizations and contraceptive drugs and devices are described elsewhere. Prescribed drugs administered during an Outpatient Surgery, or while you are receiving Inpatient Hospital care, Skilled Nursing Facility care, Emergency care, dialysis treatment, or Radiation Therapy, are included in the applicable copayment for such care.

Self- administered drugs: Covered under Prescription Drug Rider. See page 66.

Chemotherapy drugs: Covered, for infusions or injections that require skilled administration by medical personnel and self-administered oral chemotherapy drugs. In accordance with state law, oral chemotherapy drugs are provided at the same or lower copayment as intravenous chemotherapy.

Diabetic supplies (such as blood glucose test strips, lancets, syringes and needles): Covered for up to a 30 consecutive day supply when prescribed and obtained at a Kaiser pharmacy within the Service Area. Diabetes supplies necessary to operate diabetes equipment are covered under DIABETES EQUIPMENT.

Tobacco cessation drugs and products: Covered for up to a 30 consecutive day supply when prescribed and obtained at a Kaiser pharmacy within the Service Area. Member must meet Health Plan requirements for smoking cessation classes or counseling.

DRUG THERAPY SERVICES

Chemotherapy: Covered, to treat infections or malignancy. No charge for skilled administered drugs. Your copayment for this therapy is determined based on where the service is received (e.g. Medical office - $15 per visit).

Growth Hormone therapy: No charge for skilled administered drugs. Your copayment for this therapy is determined based on where the service is received (e.g. Medical office - $15 per visit).

Home IV / Infusion therapy: No charge for the therapy and IV drugs that are self-administered intravenously. Self-administered injections are subject to the copayment for SELF-ADMINISTERED DRUGS.

Inhalation therapy: Your copayment for this therapy is determined based on where the service is received (e.g. Medical office - $15 per visit).

OTHER MEDICAL SERVICES

Ambulance services: Air ambulance and ground ambulance services are covered within and outside the Hawaii Service Area when deemed medically necessary by a physician. The following statements must be true:

- Ambulance is medically necessary if use of any other means of transport would result in the death or serious impairment of your health.
- Your condition requires Emergency Care.
- The air ambulance must be for the purpose of transporting you to the nearest medical facility designated by Health Plan for medically necessary acute care.
- Your condition requires an air ambulance for safe transport.

Autism care: Covered, in accord with Hawaii state law when prescribed by a physician. Care must be provided under an approved treatment plan. Benefits are limited to diagnosis and treatment of autism and applied behavioral analysis.

Blood and blood processing: Covered, for blood and blood processing including collection, processing and storage of autologous blood for a scheduled surgery when prescribed by a physician. Blood is limited to units of whole blood, red cell products, cryoprecipitates, platelets, plasma, and fresh frozen plasma. Rh immune globulin is covered under SKILLED ADMINISTERED DRUGS.

Diabetes equipment: Covered, when prescribed by a physician, preauthorized in writing and obtained from sources designated by Health Plan. Diabetes equipment is limited to glucose meters and external insulin pumps, and the supplies necessary to operate them. Coverage is limited to the standard item of equipment in accord with Medicare guidelines that adequately meets the medical needs of the member. Convenience and luxury items and features are not covered.

Dialysis: Covered, for medical and Hospital care for acute renal failure and chronic renal disease. A single copayment applies for all covered services. Equipment, training and medical supplies required for home dialysis are provided without charge.

Health education services: Health education services include patient education classes directed toward members with specific diagnosed medical conditions whereby members are taught self-care skills to understand, monitor, manage and/or improve their condition. Examples of conditions include asthma, diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and behavioral health conditions.

Hyperbaric oxygen therapy: Hyperbaric oxygen therapy must be preauthorized except when used to treat an Emergency Medical Condition. Your copayment for this therapy is determined based on where the service is received (e.g. Medical office - $15 per visit).

Internal prosthetics, devices and aids (such as pacemakers, hip joints, surgical mesh, stents, bone cement, bolts, screws, and rods): Covered, when prescribed by a physician, preauthorized in writing and obtained from sources designated by Health Plan. Fitting and adjustment of these devices, including repairs and replacement other than due to misuse or loss, is included in coverage. Coverage is limited to the standard prosthetic model in accord with Medicare guidelines that adequately meets the medical needs of the member. Convenience and luxury items and features are not covered.

Medical foods: Covered, for the treatment of an inborn error of metabolism in accord with state law.

Orthodontic care for treatment of orofacial anomalies resulting from birth defects or birth defect syndromes: Covered, for members up to 26 years of age when prescribed by a physician and provided in accord with state law and Health Plan guidelines. Coverage is limited to a maximum benefit per treatment phase set annually by the Hawaii insurance commissioner.

Physical, Occupational & Speech therapy: Covered for short-term therapy in accord with Health Plan's medical policy. Therapy is covered only when:

- The diagnosis and medical records document the need for therapy.
- The therapy is ordered by a physician under an individual treatment plan.
- In the judgment of a physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy.
- The therapy is provided by or under the supervision of a physician-designated licensed physical, occupational or speech therapist, as appropriate.
- The therapy is skilled and necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury.
- The therapy is to restore neurological and/or musculoskeletal function required to perform normal activities of daily living.
- Occupational therapy is limited to hand rehabilitation and medical care to achieve improved self-care and other customary activities of daily living.
- Speech-language therapy is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin.
- Speech language therapy is provided on a one-to-one basis.
- The therapy is not for deficits due to developmental delay.
- The therapy does not duplicate services provided by another therapy or available through schools and/or government programs.

Maintenance therapy is not covered.

Pulmonary rehabilitation: Covered, for prescribed pulmonary rehabilitation when preauthorized in writing. Your copayment for this therapy is determined based on where the service is received (e.g. Medical office - $15 per visit).

Radiation therapy: Covered for prescribed radiation therapy such as radium therapy, radioactive isotope therapy, specialty imaging and skilled administered drugs. A single copayment applies for all covered services.

Transplant services: Covered transplants include kidney, pancreas, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, small bowel, small bowel-liver transplants, small bowel and multivisceral transplants, and stem-cell transplants.

The following are excluded from coverage: 1) Non-human and artificial organs and their implantation; and 2) bone marrow transplants associated with high-

dose chemotherapy for the treatment of solid tumors, except for germ cell tumors and neuroblastoma in children.

Benefits for transplant recipients include transplant evaluations, medical and hospital care, and prescribed post-surgical immunosuppressive drugs required as a result of a covered transplant.

Health Plan will pay for medical services for living organ and tissue donors and prospective donors if the medical services meet all of the following requirements. Health Plan pays for these medical services as a courtesy to donors and prospective donors, and this document does not give donors or prospective donors any of the rights of Kaiser Permanente members.

- Regardless of whether the donor is a Kaiser Permanente member or not, the terms, conditions, and Supplemental Charges of the transplant-recipient Kaiser Permanente member will apply. Supplemental Charges for medical services provided to transplant donors are the responsibility of the transplant-recipient Kaiser Permanente member to pay, and count toward the transplant-recipient Kaiser Permanente member's limit on Supplemental Charges.
- The medical services required are directly related to a covered transplant for a Kaiser Permanente member and required for a) screening of potential donors, b) harvesting the organ or tissue, or c) treatment of complications resulting from the donation.
- For medical services to treat complications, the donor receives the medical services from Kaiser Permanente practitioners inside a Health Plan Region or Group Health service area.
- Health Plan will pay for emergency services directly related to the covered transplant that a donor receives from non-Kaiser Permanente practitioners to treat complications.
- The medical services are provided not later than three months after donation.
- The medical services are provided while the transplant recipient is still a Kaiser Permanente member, except that this limitation will not apply if the Kaiser Permanente member's membership terminates because he or she dies.
- Health Plan will not pay for travel or lodging for donors or prospective donors.
- Health Plan will not pay for medical services if the donor or prospective donor is not a Kaiser Permanente member and is a member under another health insurance plan, or has access to other sources of payment.

  The above policy does not apply to blood donors.

COVERAGE EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

When a service is excluded or non-covered, all services that are necessary or related to the excluded or non-covered service are also excluded. “Service” means any treatment, diagnosis, care, procedure, test, drug, injectable, facility, equipment, item, device, or supply. The following services are excluded:

- **Acupuncture**.
- **Alternative medical services** not accepted by standard allopathic medical practices such as: hypnotherapy, behavior testing, sleep therapy, biofeedback, massage therapy, naturopathy, rest cure and aroma therapy.
- **Artificial aids and corrective appliances** such as external prosthetic devices, braces, orthopedic aids, hearing aids, and corrective lenses and eyeglasses except that physicians provide the professional services to determine the need therefore and attempt to make arrangements whereby they may be obtained.
- **All blood, blood products, blood derivatives, and blood components** whether of human or manufactured origin and regardless of the means of administration, except units of whole blood, red cell products, cryoprecipitates, platelets, plasma and fresh frozen plasma. Donor directed units are not covered.
- **Cardiac rehabilitation**.
- **Chiropractic services**.
- Services for **confined members** (confined in criminal institutions or quarantined), unless the services would be covered as Emergency Services.
- **Contraceptive foams and creams, condoms** or other non-prescription substances used individually or in conjunction with any other prescribed drug or device.
- **Cosmetic services**, such as plastic surgery to change or maintain physical appearance, which is not likely to result in significant improvement in physical function, including treatment for complications resulting from cosmetic services. However, Kaiser Permanente physician services to correct significant disfigurement resulting from an injury or medically necessary surgery, incident to a covered mastectomy, or cosmetic service provided by a physician in a Health Plan facility are covered.

- **Custodial services or services in an intermediate level care facility**.
- **Dental care services**, such as dental implants, dental appliances, orthodontia, dental x-rays, care relating to Temporomandibular Joint Dysfunction (TMJ) or Craniomandibular Pain Syndrome (CPS).
- **Durable medical equipment**, such oxygen-dispensing equipment, hospital beds, and wheelchairs used in the member's home (including an institution used as his or her home), except as described in the Medical Benefits section.
- **Employer or Governmental Responsibility**: services that an employer is required by law to provide or that are covered by Workers' Compensation or employer liability law; services for any military service-connected illness, injury or condition when such services are reasonably available to the member at a Veterans Affairs facility; services required by law to be provided only by, or received only from, a government agency.
- **Experimental or investigational services**.
- **Eye examinations** for contact lenses and vision therapy, including orthoptics, visual training and **eye exercises.**
- **Eye surgery** solely for the purpose of correcting refractive error of the eye, such as Photo-refractive keratectomy (PRK), lasek eye surgery and lasik eye surgery.
- **Routine foot care**, unless medically necessary.
- **Health education**: specialized health promotion classes and support groups (such as weight management and bariatric surgery program).
- **Homemaker services**.
- **Infertility services** including services related to conception by artificial means such as ovum transplants, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT); services to reverse voluntary, surgically-induced infertility and stand-alone ovulation induction services.

- **Non FDA-approved drugs and devices**.
- **Certain exams and services**. Certain services and related reports/paperwork in connection with third party requests, such as those for: employment, participation in employee programs, sports, camp, insurance, disability, licensing, or on court-order, or for parole or probation. Physical examinations that are authorized and deemed medically necessary by a Kaiser Permanente physician and are coincidentally needed by a third party are covered according to the member's benefits.
- Long-term **physical therapy, occupational therapy, speech therapy**; maintenance therapies; unskilled therapy and physical, occupational, and speech therapy deficits due to developmental delay.
- **Services not generally and customarily available in the Hawaii service area**.
- **Services and supplies not medically necessary**. A service or item is medically necessary (in accord with medically necessary state law definitions and criteria) only if, 1) recommended by the treating Kaiser Permanente physician or treating Kaiser Permanente licensed health care practitioner, 2) is approved by Kaiser Permanente's medical director or designee, and 3) is for the purpose of treating a medical condition, is the most appropriate delivery or level of service (considering potential benefits and harms to the patient), and known to be effective in improving health outcomes. Effectiveness is determined first by scientific evidence, then by professional standards of care, then by expert opinion. Coverage is limited to the services which are cost effective and adequately meet the medical needs of the member.
- All services, drugs, injections, equipment, supplies, and prosthetics related to treatment of **sexual dysfunction**, except evaluations and health care practitioners' services for treatment of sexual dysfunction.
- **Take-home supplies** for home use, such as bandages, gauze, tape, antiseptics, ace type bandages, drug and ostomy supplies, catheters and tubing.
- Services for injuries or illness caused or alleged to be caused by **third parties or in motor vehicle accidents**.
- **Transportation** (other than covered ambulance services), **lodging, and living expenses**.
- **Travel immunizations** (serum).
- **Services for which coverage has been exhausted, services not listed as covered, or excluded services**.

LIMITATIONS

Benefits and services are subject to the following limitations:

- **Unusual circumstances:** Services may be curtailed because of major disaster, epidemic, or other circumstances beyond Kaiser Permanente's control such as a labor dispute or a natural disaster.
- **Refusal to accept treatment:** Coverage is not provided for treatment of conditions for which a member has refused recommended treatment for personal reasons when Kaiser Permanente physicians believe no professionally acceptable alternative treatment exists. Coverage will cease at the point the member stops following the recommended treatment.
- **Third party liability or motor vehicle accidents:** Kaiser Permanente has the right to recover the cost of care for a member's injuries or illness caused by another person or in an auto accident from a judgment, settlement, or other payment paid to the member by an insurance company, individual, or other third party. You must furnish information about the existence and terms of any third party insurance policy or motor vehicle insurance policy covering the injury or illness and complete and submit all claims, releases, and other documents necessary to comply with State or Federal law. It is your responsibility to ensure that charges you incur are paid either by the third party or a motor vehicle insurance carrier.
- **Surrogacy health services:** Kaiser Permanente has the right to recover the cost of care for surrogacy health services. Surrogacy health services are services the member receives related to conception, pregnancy, or delivery in connection with a surrogacy arrangement. The member must reimburse Kaiser Permanente for the cost of surrogacy health services out of the compensation the member or the member's payee are entitled to receive under the surrogacy arrangement.
- **Coordination of benefits:** If members have medical coverage with another health plan or insurance company, Kaiser Permanente will coordinate benefits with the other coverage in accordance with the current rules of the National Association of Insurance Commissioners (NAIC).

PRESCRIPTION DRUG BENEFITS

The Kaiser Permanente Prescription Drug Plan partially covers the cost of drugs for which a prescription by a Kaiser Permanente licensed prescriber is required by law when such prescriptions are purchased at a Kaiser Permanente facility within the Hawaii service area. The drug benefit includes only the drugs listed on the Kaiser Permanente list of covered drugs (Formulary) that meet Formulary criteria and restrictions. Any other drugs will not be covered unless medically necessary and prescribed and authorized by a Kaiser Permanente licensed prescriber. Kaiser Permanente pharmacies may substitute a chemical or generic equivalent unless prohibited by the Kaiser Permanente licensed prescriber. If a member wants a brand name drug that has a generic equivalent, or a member requests a drug that is not on the Formulary, the member will be charged for these drugs since they are not covered under the Prescription Drug Plan.

If you have any questions on a particular drug, contact Member Services and/or a clinic pharmacy.

BENEFITS	MEMBER CHARGES
For each prescription or refill, when the quantity does not exceed: • A 30-day consecutive supply of a prescribed drug, or • An amount as determined by the Formulary. Self-administered drugs are covered only when all of the following criteria are met: • Prescribed by a Kaiser Permanente physician or licensed prescriber, or a prescriber Kaiser Permanente designates, • The drug is one for which a prescription is required by law, • On the Kaiser Permanente Hawaii Drug Formulary and used in accordance with Formulary criteria, guidelines, or restrictions, • Obtained at pharmacies in the Hawaii service area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc., or pharmacies designated by Kaiser Permanente, • The drug does not require administration by or observation by medical personnel.	$12.00 per prescription
Insulin	$12.00 per prescription
Mail Order Service Members may request refills of maintenance drugs through the mail order service, in which members are entitled to a 90-day supply for two copayments. (Prescription must have been previously filled at a Kaiser Permanente pharmacy).	Refills (up to a 90-day supply) $24 per refill

HOW TO REQUEST MAIL ORDER REFILLS

You can order refills at your convenience, 24/7, using one of the methods below:

- For the quickest turnaround time, order online at kp.org. To enroll for online refill services, register at kp.org/registernow.

- Order via the automated prescription refill service by calling (808) 643-7979, press 1 or 711 TTY. Have your Kaiser Permanente member ID and prescription number available (located on the prescription label).
- Order by using a mail-order envelope, available at all Kaiser Permanente locations.
- Order via the Pharmacy Refill Center (open Monday to Friday, 8:30 a.m. to 5:00 p.m.) by calling (808) 643-7979, press 3 then press 5. TTY users may call 1-877-447-5990.

Prescriptions are mailed to your address on Kaiser Permanente Pharmacy files and will not be mailed to addresses outside the state of Hawaii. **Please order your prescription in advance, when you have approximately 21 days left of your existing medication. Allow 7-10 business days for delivery.** The mail order program does not apply to the delivery of certain pharmaceuticals (i.e. narcotics, tranquilizers, bulky items, medication affected by temperature, and injectables). Items available through the mail order service are subject to change at any time without notice and may be subject to state and other licensing restrictions.

PRESCRIPTION DRUG PLAN EXCLUSIONS

The following are excluded from coverage:

- Drugs for which a prescription is not required by law (e.g., over-thecounter drugs) including condoms, contraceptive foams and creams, or other non-prescription substances used individually or in conjunction with any other prescribed drug or device. This exclusion does not apply to tobacco cessation drugs and products as described in the prescribed drugs section of the Medical Benefits.
- Drugs in the same therapeutic category as a non-prescription drug, as approved by Kaiser Permanente's Pharmacy & Therapeutics Committee.
- Drugs obtained from a non-Kaiser Permanente pharmacy.
- Non-prescription vitamins.
- Drugs when used primarily for cosmetic purposes.
- Medical supplies such as dressings and antiseptics.
- Reusable devices such as blood glucose monitors and lancet cartridges (covered under Medical Benefits).
- Diabetes supplies such as blood glucose test strips, lancets, syringes and needles (covered under Medical Benefits).
- Non-formulary drugs unless specifically prescribed and authorized by

a Kaiser Permanente physician or licensed prescriber, or a prescriber Kaiser Permanente designates.

- Brand name drugs requested by a member when there is a generic equivalent.
- Prescribed drugs that are necessary for or associated with excluded or non-covered services.
- Drugs related to sexual dysfunction.
- Drugs to shorten the duration of the common cold.
- Drugs related to enhancing athletic performance (such as weight training or bodybuilding).
- Any packaging other than the dispensing pharmacy's standard packaging.
- Immunizations, including travel immunizations.
- Contraceptive drugs and devices to prevent unwanted pregnancies (covered under Medical Benefits).
- Abortion drugs such as RU-486 (covered under Medical Benefits).
- Replacement of lost, stolen, or damaged drugs.

Your Kaiser Permanente membership contract entitles you to a maximum one-month supply per prescription. However, as a convenience to you, Kaiser Permanente pharmacies will dispense as much as a three-month's supply of certain prescriptions upon request. This is done in good faith, presuming you will remain a Kaiser Permanente member for the next three months. If you terminate your membership with Kaiser Permanente before the end of the three-month period, you will be billed the retail price for your remaining drugs. For example, if you end your membership after two months, you will be billed for the remaining one-month's supply.

DISPUTE RESOLUTION

ERISA CLAIMS

If your request for payment or coverage is denied, a written notice that tells you the specific reasons for the denial will be issued. The notice will describe your appeal rights and how to file an appeal. You must submit your appeal within 180 days of the date of the denial notice to:

Kaiser Foundation Health Plan Inc.
Attention: Regional Appeals Office
711 Kapiolani Boulevard
Honolulu, Hawaii 96813

Please call Member Services if you have any questions about the appeals process. A copy of Kaiser Permanente's claims and appeals procedures may be obtained from Member Services.

You may appoint someone to file the appeal on your behalf. If you choose to appoint a representative, you must name this person in writing. An *Appointment of Representative* form may be obtained from Member Services.

Internal Review

Appeals related to claims for payment will be processed through two levels of internal review. When an appeal is received, Kaiser Permanente will complete the first level review and provide a written decision within 30 days. If you are not satisfied with the first level review decision, you may request a second level review within 60 days of the date of the decision letter. The second level review will be conducted by Kaiser Permanente's Regional Appeals Committee. A written decision on the second level review will be provided within 30 days of the receipt of your request.

If you do not agree with the second level review decision, you may request external review as described below and/or file suit in federal court under Section 502(a)(1)(B) of ERISA. If a suit is filed, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person or entity you sued to pay these costs and fees. If you are not successful, the court may order you to pay these costs and fees, for example, if the court finds that your claim is frivolous.

External Review

After exhausting Kaiser Permanente's internal appeals process, you have the right to submit a request for external review to the State Insurance Commissioner if you disagree with Kaiser Permanente's final internal determination.

External reviews are limited to situations where:

1. The complaint is **not** for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and
2. The complaint relates to an adverse action. An adverse action is a determination by the Health Plan that a health care service that is a covered benefit has been reviewed and denied, reduced, or terminated because it does not meet Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.

Requests for external review must be submitted to the Insurance Commissioner within 130 days of receipt of Kaiser Permanente's final internal determination at the following address:

State of Hawaii DCCA
Insurance Division – External Appeals
335 Merchant Street, 2nd Floor
Honolulu, Hawaii 96813

Or by facsimile to 808-587-5379

You can reach the Health Insurance Branch of the Hawaii Insurance Division by calling 808-586-2804.

If your request is determined to be eligible for external review, the Insurance Commissioner will assign your case to an Independent Review Organization (IRO). Once assigned, the IRO will notify you within five business days that the external appeal has been opened for review. The IRO will be provided all the documents and information that Kaiser Permanente considered in making its final internal decision. You or your authorized representative may submit additional written information to the IRO within five business days of your receipt of the notice from the IRO.

The IRO will send you its decision in writing within 45 days of receiving your external review request. The IRO's decision is binding on you and Kaiser Permanente except for any additional remedies that may be available under applicable federal or state law.

Binding Arbitration

Although ERISA benefit claims are not required to be resolved by binding arbitration, you may make a voluntary election to use binding arbitration to resolve these claims instead of a court trial. To initiate arbitration, you must send a written demand for arbitration to Kaiser Permanente at the following address:

Kaiser Foundation Health Plan Inc.
711 Kapiolani Boulevard
Honolulu, Hawaii 96813

In arbitration, one person or a panel of arbitrators (the arbitrator) reviews the positions of the parties and makes the final decision to resolve the issue. No other parties may be joined in the arbitration.

Before arbitration starts, both parties (you and Kaiser Permanente) must agree on the person or panel to be the arbitrator. The arbitration hearing will be held in Hawaii and the arbitration will be conducted in accord with the rules of Dispute Prevention and Resolution, Inc., unless the parties agree to any other arbitration service and rules.

The arbitrator will make a decision as quickly as possible and will give both parties a copy of this decision. **The decision of the arbitrator is final and binding. The parties give up the right to jury or court trial.**

The arbitrator's fee and expenses of the arbitration service will be paid one-third by you and two-thirds by Kaiser Permanente. You must pay your attorney's or witness' fees, if you have any, and Kaiser Permanente must pay theirs.

The preceding is only a summary of Kaiser Permanente's ERISA claims appeals process. For a complete description of Kaiser Permanente's claims and appeals procedures, please refer to the Kaiser Permanente Group Agreement which is on file at the Trust Fund Office. You may also call Member Services to request a copy of Kaiser Permanente's claims and appeals procedures.

ADDITIONAL KAISER PERMANENTE INFORMATION

MEMBER SERVICES

When you have questions concerning your Health Plan, call Member Services:

- **1 (800) 966-5955** (All islands)
- **711 TTY** (Hearing/speech impaired)

Phone line hours:

- Monday through Friday, 8:00 a.m. – 5:00 p.m.
- Saturday, 8:00 a.m. - 12:00 noon

Member Services can assist you with inquiries such as:

- Your benefits
- Claims and billing

- Filing an appeal
- Updating your address and contact information
- Replacing your ID card

Kaiser Permanente provides:

- Free aids and services to people with disabilities to communicate effectively with Kaiser Permanente such as qualified sign language interpreters and written information in other formats, such as large print, audio, and accessible electronic formats.
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Services to talk to an interpreter.

IDENTIFICATION CARDS

You will need your Kaiser Permanente identification card to get care at Health Plan facilities or with contracted providers and to fill prescriptions. Please carry it with you at all times. If you lose or damage your ID card, call Member Services **1 (800) 966-5955** or **711** TTY to request a replacement. Smart phone users may also register for a digital membership card at kp.org/registernow. New or returning members should carry a temporary ID, which is the pink copy of the completed enrollment form.

YOUR CURRENT ADDRESS

It is vitally important that Kaiser Permanente has your current address and phone number. Kaiser Permanente may need to contact you in a case of a family member's emergency. Notify Member Services of any changes.

CLAIMS FOR BENEFITS

Specific information about Kaiser Permanente's claims procedures are contained in the Kaiser Permanente Member Handbook which is provided to you at no charge.

CONVERSION PRIVILEGE

If your Kaiser Permanente Plan membership through the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund is terminated for any reason, please contact the Trust Fund Office for options on continuing coverage through Kaiser Permanente. For details on how to apply for an individual plan, call Kaiser Permanente Member Services at **1 (800) 966-5955** or **711** TTY.

IMPORTANT KAISER PERMANENTE PHONE NUMBERS

MEMBER SERVICES **1-800-966-5955**

Service assistance, individual plan enrollment, benefit information, out-of-plan emergency claims, contract and policy interpretations

PATIENT FINANCIAL SERVICES ....**808-432-5340 / 1-888-597-5340**

Industrial, No-Fault, Tri-Care, and billing concerns

24/7 NURSE ADVICE AND CARE .... Oahu: **808-432-2000**

Maui: **808-243-6000**

Hawaii Island: **808-334-4000**

Kauai: **808-246-5600**

HEARING / SPEECH IMPAIRED ASSISTANCE .... **711 TTY**

AWAY FROM HOME TRAVEL LINE.................................... **951-268-3900***

***** This number can be dialed from within and outside the United States. If you are calling from outside the U.S., you must dial the U.S. country code “001” for landlines and “+1” for mobile before the phone number. Long-distance charges may apply and collect calls cannot be accepted. **This phone line is closed on major holidays.**

The preceding medical and prescription drug benefits are insured under an insurance contract issued by Kaiser Foundation Health Plan, Inc., 711 Kapiolani Boulevard, Honolulu, Hawaii 96813. The services provided by Kaiser Permanente include the payment of claims, when necessary, and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary of coverage. Its contents are subject to the provisions of the Group Agreement, Kaiser Permanente Hawaii’s Guide to Your Health Plan and applicable riders and amendments, which contain all the terms and conditions of membership and benefits. These documents are on file with the Trust Fund Office. Please refer to these documents for specific questions about coverage.

COMPREHENSIVE MEDICAL PLAN
(Self-Funded)

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund has contracted Pacific Southwest Administrators (PSWA) to handle the claims administration for the Comprehensive Medical Plan. This means that if you choose to be covered under the Comprehensive Medical Plan, your physician, hospital, or you will file claims directly with PSWA. If you have any questions about payments made by PSWA, or any other aspect of your coverage, you should contact PSWA. PSWA is only the Claims Administrator for the Comprehensive Medical Plan; it does not guarantee benefits provided by the Plan.

Pacific Southwest Administrators
560 North Nimitz Highway, Suite 217E
Honolulu, Hawaii 96817
Oahu: (808) 275-2520
Toll free: 1 (844) 808-2520

UNDERSTANDING THE PLAN

The Comprehensive Medical Plan has been designed to cover a wide range of medical services while keeping the cost affordable. The Plan does this by paying benefits based on Eligible Charges (see the Eligible Charges section for an explanation) and by the use of some copayments. A copayment is a percentage of the Eligible Charge that you owe when you receive certain medical services covered by the Comprehensive Medical Plan.

Knowing what services the Plan covers and using them only as needed, are ways of getting the best protection from your medical plan. When you need medical services, talk to your physician about different methods and places of treatment and their cost. Together, you and your physician can make the right decisions about your health care.

ANNUAL AND LIFETIME BENEFIT MAXIMUMS

There is no annual or lifetime ***dollar benefit maximum*** for benefits paid or provided under this Plan on your behalf. However, certain benefits may have annual or lifetime maximums. For example, home health care is limited to 150 visits per calendar year and in vitro fertilization is limited to one procedure per qualified beneficiary per lifetime. Please see the Medical Plan Benefits section pages 82 - 104, for a description of these benefit maximums as well as other limitations that may apply to covered services.

ANNUAL COPAYMENT MAXIMUM

There is an Annual Copayment Maximum of $2,800 per individual and $8,400 per family unit of three or more beneficiaries in any calendar year. Once the Annual Copayment Maximum is met, you are no longer responsible for copayment amounts for covered medical services for the rest of that calendar year. Each family member must meet the individual Annual Copayment Maximum until the family Annual Copayment Maximum is met. The following payments do not count toward the Annual Copayment Maximum and you are responsible for these amounts even after you have met the Annual Copayment Maximum:

- When you receive services from a non-participating provider, any difference you pay between the Eligible Charge and the provider's actual charge
- Copayments or additional payments you owe as a result of not obtaining Prior Authorization for services requiring preapproval under the Care Management Program
- Your copayments for Indemnity prescription drug services

CHOICE OF HEALTH CARE PROVIDERS

You are free to go to a licensed physician of your choice and receive coverage under the Comprehensive Medical Plan. For purposes of this Plan, a physician is a properly licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.), doctor of podiatric medicine (D.P.M.), or doctor of optometry (O.D.). Benefits for services rendered by other providers are shown in specific sections of this booklet. The Trust Fund suggests that you choose a physician who can help you obtain the health care you need at a reasonable cost. Your choice of physician or other health care provider can make a difference in how much you will owe after the benefit payments under this Plan have been made.

Participating Providers

The Trust Fund, through its Network Administrator, has contracted with physicians, hospitals, laboratories, and other health care providers throughout Hawaii to provide the medical services covered by this Plan. When you go to one of these Participating Providers, the Claims Administrator (PSWA) sends the provider the benefit payment for the service and you owe only the copayment shown in this booklet and the tax, if any (see example on page 77).

You should ask your physician or call the Claims Administrator to find out if your physician is a Participating Provider. You will receive a Directory of Participating Physicians and Health Care Providers when you enroll in the Comprehensive Medical Plan. Updated directories are available upon request from the Claims Administrator. A Directory is also available on the Trust Fund's website at *www.unitehere5trustbenefits.com*.

Nonparticipating Providers

When you go to a nonparticipating provider, the Trust Fund has no contract with the provider to guarantee limited copayments. The Claims Administrator bases the benefit payment on Eligible Charges (see below) and sends the payment directly to you. You will then owe the provider the total charge and any tax for the service (see example on page 77).

ELIGIBLE CHARGES

Benefit payments and your copayments are based on the Trust Fund's determination of an Eligible Charge for a covered service. The Plan will not pay the portion of any charge that exceeds the Eligible Charge. Here's how the Trust Fund determines the Eligible Charge.

1. For Participating Providers, the Eligible Charge for covered services is part of the contract between the Trust Fund's Network Administrator and each Participating Provider to guarantee you limited out-of-pocket payments.
2. For nonparticipating providers, the Eligible Charge for covered services of physicians and most medical services is the lower of the following two charges:
   - The Eligible Charge approved by the Trust Fund, or
   - The actual charge to you.

The Eligible Charge does not include excise tax or any other tax. You are responsible for paying all taxes associated with medical services you receive.

There may be times when a service is performed for the first time in Hawaii or so infrequently that an Eligible Charge as described above has not been determined. In these cases, the Trust Fund's Network Administrator will recommend the Eligible Charge by comparing the complexity of the infrequent service with similar, frequent services and the Trust Fund will make the final determination on this Eligible Charge.

The following is an example of benefits and copayments for a covered physician's office visit.

If You Go to a Participating Provider	If You Go to a Nonparticipating Provider
Plan Pays Provider – **90%** of the Eligible Charge	Plan Pays You – **80%** of the Eligible Charge
You Owe Provider – Copayment (**10%** of the Eligible Charge) and tax. You do not owe any amount above the Eligible Charge.	You Owe Provider – **Total charge** made up of the Plan payment (**80%** of the Eligible Charge), your Copayment (**20%** of the Eligible Charge), any amount of the Provider's charge above the Eligible Charge, and tax.

The Trust Fund suggests that you discuss charges with your health care provider before receiving services.

CARE MANAGEMENT PROGRAM

The purpose of the Comprehensive Medical Plan is to help you pay your medical expenses. To keep your Plan affordable, each claim is reviewed to make sure that the Plan pays only for services that are covered benefits, follow standard medical practice and medically necessary.

The fact that a physician may prescribe, order, recommend, or approve a service or supply does not in itself mean that it follows standard medical practice or is medically necessary.

Most of the claims received are for services that follow standard medical practice and are medically necessary. However, there are times when the Claims Administrator (PSWA) and your physician may not agree. When this happens, the Claims Administrator's medical consultants will review the services and decide whether the services follow standard medical practice, are medically necessary, and are therefore eligible for benefits. These medical consultants are qualified practicing physicians. They consult with other physicians and specialists in Hawaii and use the findings of Federal agencies.

At times, new services or complex cases require more information than what is provided by your physician. The Claims Administrator's medical consultants will then consult with agencies and specialists outside the State of Hawaii. If more research is required, the Claims Administrator will notify you of any delay in their evaluation.

If you want to know whether a particular service follows standard medical practice or is medically necessary for an illness or injury, please ask your physician to write to the Claims Administrator's Managed Care Department for an evaluation **before** the service is performed. The Claims Administrator's medical consultants will review the service and send their written evaluation to your physician.

STANDARD MEDICAL PRACTICE

To be covered by your Plan, all services must follow standard medical practice. This means that most physicians in the U.S.A. regard the service as safe and effective. If a service is in its trial stages (e.g., "experimental" because it is used in research on animals or "investigative" because it is or has been used on a limited number of people), the service is **not** considered standard medical practice.

MEDICAL NECESSITY

The Comprehensive Medical Plan pays benefits only for services that are medically necessary for the illness or injury being treated. To be medically necessary, a service or the use of a facility must follow standard medical practice. And, in following standard medical practice, the service must be essential, appropriate, and economical for the diagnosis or treatment of an injury or illness. The following examples will help you understand what is meant by medical necessity.

Generally, when there are two different treatments and both are equally safe and effective, benefits for the more economical treatment will be paid.

Example: A minor surgery could have been done safely and effectively in the physician's office at less expense, but instead, was done in the hospital. In this case, the surgery is considered medically necessary and the physician's claim will be paid. Because the surgery could have been done safely in the physician's office, the unnecessary, additional expense for the hospital services will not be covered.

Services or tests that are not generally accepted or appropriate for the diagnosis or treatment of your illness are usually determined to be not medically necessary.

Example: You visit your physician because of the flu and the physician orders a whole series of tests to check on diabetes, kidney disease, heart problems, etc. Only those exams and tests for your flu will be considered medically necessary. The tests for diabetes, kidney disease, and other illnesses that are not necessary in this situation will not be covered.

Example: You are hospitalized and want to stay an extra day after your physician discharges you. This extra day will not be covered because you are well enough to go home and no longer need the continuous skilled medical care provided by the hospital.

PRIOR AUTHORIZATION

Prior authorization is a special pre-approval process to ensure that certain treatments, procedures, or supplies are medically necessary covered services. You (or your physician on your behalf) must call the Claims Administrator's Managed Care Department on Oahu at (808) 275-2520 or (844) 808-2520 (toll free) and obtain prior authorization for certain types of medical services, including surgery, hospitalization, and certain diagnostic tests. **If a required review or authorization is not requested and obtained, your benefit payments will be reduced by 10%.** For emergency or maternity admissions, you must notify the Claims Administrator's Managed Care Department within 48 hours or by the next working day.

The following services require prior authorization. Failure to obtain prior authorization may result in a reduction of benefits. **You or your physician must call the Claims Administrator's Managed Care Department before the services are provided.**

INPATIENT ADMISSIONS	• All inpatient admissions, including acute, skilled and observation stays[1]
SURGICAL SERVICES	• Surgical Review required for certain procedures
OUTPATIENT SERVICES	• Imaging scans (MRI, MRA, or PET scans) • Gamma Knife/X Knife procedures • More than two OB ultrasounds per pregnancy • In vitro fertilization • Plastic and/or reconstructive surgery
OUTPATIENT REHABILITATION SERVICES	• Physical Therapy • Occupational Therapy • Speech Therapy
OTHER MEDICAL SERVICES	• Durable Medical Equipment (DME) • Hospice Care • Home Health Services • Infusion Therapy • Human Growth Hormone Therapy
MENTAL HEALTH AND ALCOHOL OR DRUG DEPENDENCE SERVICES	• All services require a treatment plan • All inpatient services require Preadmission Review
OUT-OF-STATE SERVICES	• All non-emergency inpatient admissions, services or procedures

INTER-ISLAND TRAVEL BENEFIT	• Inter-island travel to obtain non-emergency medically necessary services which are not available on the island where the beneficiary resides
[1]For emergency or maternity admissions, you must notify the Claims Administrator's Managed Care Department on Oahu at (808) 275-2520 or (844) 808-2520 (toll free) within 48 hours or by the next business day, whichever is later.	

If you do not notify the Claims Administrator's Managed Care Department as outlined above, your benefit payments will be reduced by 10%. All services other than emergency or maternity admissions require authorization prior to the services being incurred.

SURGICAL REVIEW

The Plan has identified certain kinds of surgical services that are sometimes performed even though non-surgical treatment may be equally effective. A list of these surgical services has been provided to Participating Providers and is available from the Claims Administrator's Managed Care Department. Before scheduling any of the listed surgical services, you (or your physician on your behalf) must notify the Claims Administrator's Managed Care Department and request a Surgical Review. Based on the results of its Surgical Review, the Claims Administrator may approve or deny payment of benefits for the surgery, or may condition the payment of benefits on obtaining a second opinion on the necessity of surgery.

Second Surgical Opinion

A second surgical opinion may be required for certain surgeries. If your physician advises you that you need any of the surgeries listed below, you (or your physician on your behalf) must contact the Claims Administrator's Managed Care Department:

- Inpatient Cholecystectomy (gall bladder surgery)
- Varicose Vein surgery
- Blepharoplasty (eyelid surgery)
- Septoplasty/Rhinoplasty (nose surgery)
- Scar revision surgery

Upon obtaining necessary information from you and your physician, the Claims Administrator will determine whether or not a second surgical opinion is required. If a second surgical opinion is required and arranged by the Claims Administrator, the Plan will cover 100% of Eligible Charges

for a Participating Provider or 80% of Eligible Charges for a nonparticipating provider for the second surgical opinion visit. If you choose to obtain a second surgical opinion when it is not required by the Claims Administrator, regular office visit benefits will apply.

If, on review, the surgery is determined to be medically necessary, but you were required to have a second surgical opinion and did not obtain one, your benefit payments will be reduced by 10%. If the surgery is determined not to have been medically necessary, no benefits will be paid.

INPATIENT REVIEW

When you are hospitalized, the Claims Administrator will monitor the appropriateness of the inpatient care provided and the appropriateness of continuing hospitalization. This review will occur within 48 hours after admission and at set intervals, until you are discharged from the Hospital. The Claims Administrator will also review discharge plans for the appropriateness of after-Hospital care.

This review is for benefit payment purposes. If the Claims Administrator has a question regarding the appropriateness of continuing hospitalization or after-Hospital care, or determines that benefits are not payable, you and your physician will be notified. If the Claims Administrator determines that the continuation of any service or care is not medically necessary or appropriate, you and your physician may still decide to continue with the service or care, but benefits under this Plan will not be payable for that continued service or care.

BENEFITS MANAGEMENT PROGRAM

The Plan may assist a beneficiary by providing benefits for alternative services that are medically appropriate, but may not otherwise be covered under this Plan. Benefits for any alternative services will be paid in lieu of benefits for regularly covered services and will not exceed the total benefits otherwise payable for regularly covered services.

These alternative services will be paid in the Plan's sole discretion as long as the beneficiary and the beneficiary's physician agree that the recommended alternative services are medically appropriate for the beneficiary's illness or injury. Payment for alternative services in one instance does not obligate the Plan to provide the same or similar benefits for the same or any other beneficiary in any other instance. Payment of these alternative benefits is made as an exception and in no way changes or voids the Plan benefits, or terms and conditions.

MEDICAL PLAN BENEFITS

The following is a summary of the benefits available under this Plan and your payment obligations for the covered services depending on whether you receive them from a Participating or non-participating provider. This summary of benefits is subject to the description of benefits, limitations, and exclusions described in the Special Notes and elsewhere in this Medical Plan Benefits section.

Prior Authorization is required for some services. From time to time it is necessary to change prior authorization requirements so that benefits remain current with the way therapies are delivered. Changes may occur at any time during the calendar year. Please call the Claims Administrator's Managed Care Department to see if a service has been added to or deleted from the list on page 79 of this booklet.

Please remember that in addition to the payment amounts shown in this summary, you are responsible for:

1. Payment of all applicable taxes and non-covered services charged by the provider; and
2. If you see a non-participating provider, any difference between the Eligible Charge and the actual charge made by the provider, in addition to the copayment amount listed.

PHYSICIAN SERVICES

PHYSICIAN SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Physician Visits Home, office, hospital emergency room, or office consultation visit. Office visit benefits will be paid for a second surgical opinion on the necessity of surgery.	10% of Eligible Charges (No copayment for a required second surgical opinion on the necessity of surgery if the second opinion is arranged by the Claims Administrator)	20% of Eligible Charges and any difference between actual and Eligible Charges
Hospital or Skilled Nursing Facility Visit One visit per day to a beneficiary who is a Registered Bed Patient	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges

PHYSICIAN SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Consultation Visit Medical or surgical, one visit per specialty during each confinement to a beneficiary who is a Registered Bed Patient as required by the attending physician	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Well-Baby Care Visits Eight visits during the first two years of a child's life, and one visit each year during ages 2, 3, 4, and 5. Well-baby immunizations are covered under Immunizations below. Well-baby routine laboratory tests are covered under Outpatient Diagnostic Tests, Laboratory and X-ray Services.	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Immunizations Cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus, varicella (chicken pox and shingles), human papilloma virus, meningococcal, rotavirus and streptococcus pneumonia. See Special Notes for coverage limitations.	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Surgery Inpatient or outpatient	No Copayment	20% of Eligible Charges and any difference between actual and Eligible Charges

PHYSICIAN SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Anesthesiology Services of an anesthesiologist (physician) that are required by a physician. Hospital anesthesia services (i.e., nurse anesthetist services) will be paid in accordance with Hospital Inpatient Services.	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges

PHYSICIAN SERVICES SPECIAL NOTES

Well-Baby Care Visits: Covered, eight visits during the first two years of a child's life and one visit each year during ages 2, 3, 4, and 5 years. When a well-baby care visit cannot be scheduled within a designated benefit period, the visit may be covered if rendered within 30 days of the benefit period, as long as the total number of well-baby care visits allowed is not exceeded.

Immunizations: Covered, for well-baby immunizations and immunizations in connection with cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus, varicella (chicken pox and shingles), and streptococcus pneumonia.

Human Papilloma Virus (HPV) quadrivalent vaccine:

- Covered, at 90% of Eligible Charges for the services of a Participating Provider or 80% of Eligible Charges for the services of a non-participating provider when the first dose is administered to an 11-12 year old male or female beneficiary with the second or third dose administered prior to 13 years of age. Should the second or third dose be administered at 13 years of age or later, the second or third dose will be covered at 50% of Eligible Charges for the services of a Participating or non-participating provider.
- Covered, at 50% of Eligible Charges for the services of a Participating or non-participating provider when the first dose is administered to a 13 through 25 year old male or female beneficiary with the second or third dose administered prior to 26 years of age.

Meningococcal vaccine: Covered, for beneficiaries from the age of 11 years. Prior authorization is required for beneficiaries younger than 11 years of age who are at increased risk due to immune compromise or other disorders.

Rotavirus vaccine: Covered, when the first dose is administered to an infant by 12 weeks of age and the remaining two doses of the vaccine are administered by 32 weeks of age.

Surgery

The preoperative and postoperative care that most physicians customarily provide in connection with most major surgery is included in the Eligible Charge for surgery. If the physician charges separately for the preoperative and postoperative care in excess of this single Eligible Charge, the excess will not be paid.

Postoperative care for most minor surgery is not included in the charge for surgery and will be considered a separate physician's visit payable at the applicable physician office visit benefit.

Assistant Surgeon: The Plan will pay benefits for the services of an assistant surgeon only when the assistance is medically necessary based on the complexity of the surgery and the hospital had no resident or training program in effect so that there was no resident or intern on the staff to assist the surgeon.

"Stand By" Time: When the services of another physician may be necessary during a surgery so that the physician must "stand by" at the hospital, the Plan will pay benefits for covered services that the physician actually provides but will not pay for the waiting or "stand by" time.

Reconstructive Surgery: The Plan will pay benefits for reconstructive surgery only when it is required to restore, reconstruct, or correct any bodily function that was lost, impaired, or damaged as a result of an illness or injury.

Reconstructive surgery for congenital anomalies (i.e., defects present from birth) is payable only when the defect severely impairs or impedes normal, essential bodily functions and is medically necessary. (Note: This benefit is available for active employees and their dependents only.)

Following a mastectomy, reconstructive surgery of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedema, are covered as provided for under the Women's Health and Cancer Rights Act of 1998. Such coverage is subject to copayments that are consistent with those established for other benefits under this Plan.

Oral Surgery: Physician benefits are available for certain oral surgical services provided by a physician or a dentist. Services of a dentist are covered only when:

- The dentist is performing emergency services or surgical services and
- These services could also be performed by physicians (M.D. or D.O.).

For the purposes of this Plan, a dentist means a doctor of dentistry (D.M.D.) or dental surgery (D.D.S.) who is appropriately licensed to practice by the proper governmental authority and who renders services within the lawful scope of such license. A dentist is considered a “Physician” under this Plan, but only with respect to surgical services which he or she is legally authorized to perform.

The Plan does not pay for dental services that are generally done only by dentists and not by physicians. Regardless of the symptoms or illness being treated, services such as orthodontia, dental splints and other dental appliances, dental prostheses, osseointegration and all related services, removal of impacted teeth, and any other procedure involving the teeth, structures supporting the teeth, gum tissues, and temporomandibular joint problems or malocclusion are not benefits of the Comprehensive Medical Plan.

Hospital benefits are available if you are hospitalized because you have a medical problem as certified by your physician, such as hemophilia, that makes hospitalization necessary in order for you to safely receive dental services or when the oral surgery itself requires hospitalization.

Transplants

The following transplants are eligible for benefits:

- Kidney
- Cornea
- Bone marrow (excluding high dose chemotherapy with bone marrow transplants or peripheral stem cell infusion for epithelial ovarian cancer, multiple myeloma, or primary intrinsic tumors of the brain)
- Liver (excluding liver transplants for metastatic malignancies to the liver, or where Hepatitis B e antigen or core antibody positive are present)
- Heart
- Heart-lung
- Lung
- Simultaneous kidney-pancreas transplants

All other transplants, including artificial or animal organ transplants, are not eligible for benefits under this Plan.

Benefits for transplants and transplant evaluation services must be pre-approved by the Claims Administrator. **If you or your physician do not receive approval and certification by the Claims Administrator prior to receiving transplant services, including evaluation services, no benefits will be payable.**

OUTPATIENT SURGICAL CENTER SERVICES

OUTPATIENT SURGICAL CENTER SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Operating room, surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics, blood transfusion services. Covered services include routine laboratory and X-ray services normally associated with the surgery.	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
Other Laboratory and X-ray Services	See Outpatient Diagnostic Tests, Laboratory and X-ray Services for benefits	See Outpatient Diagnostic Tests, Laboratory and X-ray Services for benefits

OUTPATIENT SURGICAL CENTER SPECIAL NOTES

An outpatient surgical center is a facility that provides surgical services without an overnight stay. This facility may be in a hospital or it may be a separate, independent facility. To be eligible for benefits, the facility must be equipped and operated according to generally recognized standards that meet State of Hawaii licensing requirements and be approved by the Trust Fund’s Network Administrator.

HOSPITAL INPATIENT SERVICES

HOSPITAL INPATIENT SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Up to 365 days per calendar year of hospital inpatient services		
Room & Care Based on semi-private room rate	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
Special Care Units Intensive Care, Coronary Care, Intermediate Care or Isolation	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
Ancillary Inpatient Services Operating room, surgical supplies, drugs, dressings, hospital anesthesia services and supplies, oxygen, antibiotics, hospital blood transfusion services	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
Laboratory and X-ray Services Laboratory services, diagnostic tests, X-ray films	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
Radiotherapy Services		
· For treatment of malignancies	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
· For treatment of non-malignancies	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges

HOSPITAL INPATIENT SERVICES SPECIAL NOTES

Room and Care: Coverage is based on the semi-private room rate. If you choose to receive inpatient services in a private room, you may be responsible for additional room charges not covered by the Plan.

Use of Single All In-Inclusive Daily Charge: If a hospital uses a single, all-inclusive daily charge instead of itemized charges for laboratory, X-ray, radiotherapy, and all other allowable hospital inpatient services and supplies, you owe a copayment of 10% of Eligible Charges for the services of a Participating Provider or 20% of Eligible Charges for the services of a nonparticipating provider. In no event will the Plan pay more than if the hospital charged separately for these services.

Mental Illness Services: Inpatient hospital services for a member being treated for mental illness are covered under Mental Illness and Alcohol or Drug Dependence Services and are subject to the limitations specified in that section.

SKILLED NURSING FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Up to 120 days per calendar year of skilled nursing facility services		
Room and Care Based on semi-private room rate	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Inpatient Services Routine surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics, and blood transfusion services	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Laboratory and X-ray Services	For Participating Providers whose laboratory and X-ray services are not included in a single all-inclusive amount per day, this Plan will pay benefits in accordance with Outpatient Diagnostic Tests, Laboratory & X-ray Services	See Outpatient Diagnostic Tests, Laboratory & X-ray Services for benefits

SKILLED NURSING FACILITY SERVICES SPECIAL NOTES

Eligibility for skilled nursing facility services benefits requires that all of the following be true:

- The facility must meet Medicare standards and be approved by the Trust Fund's Network Administrator.
- A physician must admit you to the facility. You must need skilled nursing services and must be under the care of an attending physician while in the facility. No payment will be made for services furnished primarily for comfort, convenience, rest cure, or domiciliary care.
- If you remain in the facility more than 30 days, the attending physician must submit a report to the Claims Administrator showing the need for skilled nursing care at the end of each 30-day period of confinement.
- The confinement is not for custodial care.
- Services do not exceed 120 days per calendar year.

HOME HEALTH CARE SERVICES

HOME HEALTH CARE SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Up to 150 visits per calendar year for part-time skilled medical services	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges

HOME HEALTH CARE SERVICES SPECIAL NOTES

Eligibility for home health care services benefits requires that all of the following be true:

- Services must be provided by a qualified home health agency that meets Medicare standards and is approved by the Trust Fund's Network Administrator.
- Your physician must certify that: (i) you need skilled medical services because you are homebound due to an injury or illness, (ii) require part-time skilled health services, and (iii) would require inpatient Hospital or Skilled Nursing Facility care if there were no home health care visits.
- Being homebound means that you are unable to leave home, unless you use supportive devices or have assistance from another person, because of an illness or injury. Homebound standards defined by the Federal Medicare program apply.

- If you need home health care services for more than 30 days, a physician must recertify that there is further need for the services and provide a continuing plan of treatment at the end of each 30-day period of care.
- Services do not exceed 150 visits per calendar year.

No payment will be made for home care services furnished primarily to assist in meeting personal, family, and domestic needs such as general household services, meal preparation, shopping, bathing, or dressing.

HOSPICE CARE SERVICES

HOSPICE CARE SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Up to 150 days of care for a terminal illness, based on an-all-inclusive daily rate (in lieu of other covered services for such illness)	No copayment	Not a benefit

HOSPICE CARE SERVICES SPECIAL NOTES

Eligibility for hospice care services benefits requires that all of the following be true:

- Services must be received from a hospice agency which is under contract with the Trust Fund's Network Administrator to provide such services, and is operating under generally accepted standards for hospices.
- The hospice agency and attending physician must certify in writing that you are terminally ill and have a life expectancy of six months or less.
- Services do not exceed 150 days.

If you elect hospice benefits, you will not be eligible for any other benefits for the treatment of the terminal illness, except for physician services. You may continue to receive benefits for all other illnesses or injuries.

You may decide to discontinue hospice care and receive other covered services at any time before the end of the 150-day hospice benefit period. However, if you do so, any remaining days of the 150 days of hospice benefits will be lost and will not be available for future use.

OUTPATIENT DIAGNOSTIC TESTS, LABORATORY & X-RAY SERVICES

OUTPATIENT DIAGNOSTIC TESTS, LABORATORY & X-RAY SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Services ordered by a physician for the diagnosis or treatment of an injury or illness		
Diagnostic Tests	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
Laboratory Services	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
X-ray Films	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
Radiotherapy Services		
· For treatment of malignancies	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
· For treatment of non-malignancies	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges

OUTPATIENT DIAGNOSTIC TESTS, LABORATORY & X-RAY SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Screening Services · Breast cancer screening by low-dose mammography · Colorectal cancer screening · Routine Pap Smear - one per calendar year · Prostate Specific Antigen Test - one per calendar year for men age 50 and above · Tuberculin Tine Test - one per calendar year · Well-baby care laboratory tests	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges

OUTPATIENT DIAGNOSTIC TESTS, LABORATORY & X-RAY SERVICES SPECIAL NOTES

Breast cancer screening by low-dose mammography: Coverage is limited to one baseline mammogram for women during ages 35 through 39 and one mammogram every 12 months for women age 40 and above. Women of any age with a history of breast cancer or whose mother or sister has had a history of breast cancer, or women with an increased risk of breast cancer or who have had an abnormal mammogram requiring breast biopsy, are eligible for a mammogram upon the recommendation of a physician. When a mammogram cannot be scheduled within the above designated benefit periods, the mammogram may be covered if rendered within 10 days of the benefit period, as long as the total number of mammograms allowed by the Plan is not exceeded.

Colorectal cancer screening is **c**overed beginning at age 50 through age 75 as follows:

- Fecal occult blood testing every calendar year; or
- Flexible sigmoidoscopy every five years; or
- Colonoscopy every ten years

Well-baby care laboratory tests are limited to the following tests through age 5:

- Two tuberculin tests (tine or skin sensitivity);
- Two blood tests (hemoglobin or hematocrit); and
- One urinalysis

MATERNITY SERVICES

MATERNITY SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Physician Services For pregnancy, childbirth, or other termination of pregnancy and related medical conditions; caesarean section and surgery; and routine nursery visits to newborn child	See Physician Services for benefits	See Physician Services for benefits
Surgery for Complications of Pregnancy Including ectopic pregnancy	See Physician Services for benefits	See Physician Services for benefits
Nurse-Midwife Services	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
Hospital Services Hospital services shall count against the 365-day maximum for hospital benefits	See Hospital Inpatient Services for benefits	See Hospital Inpatient Services for benefits
Birthing Center Services	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
In Vitro Fertilization One procedure per lifetime, whether successful or not, subject to limitations and exclusions		
Physician Services	See Physician Services for benefits	See Physician Services for benefits

MATERNITY SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Laboratory and X-ray Services	See Outpatient Diagnostic Tests, Laboratory and X-ray Services for benefits	See Outpatient Diagnostic Tests, Laboratory and X-ray Services for benefits
Prescription Drugs	See Indemnity Prescription Drug section for benefits	See Indemnity Prescription Drug section for benefits

MATERNITY SERVICES SPECIAL NOTES

Maternity Length of Stay: Covered in compliance with the Federal Newborns' and Mothers' Health Protection Act for up to 48 hours after a normal delivery or 96 hours following a caesarean delivery. Your physician does not need to obtain authorization to prescribe a length of stay within these limits.

The Eligible Charge for delivery includes prenatal and postnatal care.

Nurse-Midwife Services: For normal pregnancy and childbirth, payment may be made in lieu of physician services for services of a certified nurse-midwife who is properly licensed, certified by the American College of Nurse-Midwives, and is formally associated with a physician for purposes of supervision and consultation.

Birthing Center Services: When a properly licensed birthing center is used instead of regular hospital facilities, payment will be made under Hospital Inpatient Services for birthing center services. The birthing center must be approved by the Trust Fund's Network Administrator. Benefits for birthing center services are in lieu of payment for hospital inpatient services.

Newborn Child: Hospital and physician benefits are available for in-Hospital, routine nursery care of a newborn.

In order for a newborn child to be eligible for Plan benefits from the date of birth for illness, injury, circumcision, premature birth care, or birth defect, you must enroll the child as a dependent within 30 days of birth. **NOTE**: Enrollment of your newborn child must be made through the Trust Fund Office and not through the Claims Administrator.

Diagnostic tests for an unborn child will be paid only when medically necessary.

In Vitro Fertilization

Coverage is subject to the following criteria and limitations:

- Coverage is limited to one procedure per lifetime whether successful or not.
- Beneficiary's oocytes are to be fertilized with the beneficiary's Spouse's sperm, except a same sex married couple's use of donor sperm is covered.
- Beneficiary and beneficiary's Spouse have a history of infertility of at least five years duration or infertility associated with one or more of the following: a) endometriosis, b) exposure in utero to diethylstilbestrol commonly known as DES, c) blockage or surgical removal of one or both fallopian tubes, or d) abnormal male factors.
- Beneficiary has been unable to attain successful pregnancy through other applicable infertility treatments for which coverage is available under this Plan.
- In vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.
- "Spouse" means the person lawfully married to the beneficiary.

The following are excluded from coverage:

- Cost of equipment and of collection, storage, and processing of sperm.
- In vitro fertilization requiring the use of either donor sperm, donor eggs or a surrogate; except a same sex married couple's use of donor sperm is covered.
- Services related to conception by artificial means, other than in vitro fertilization as specified above.

MENTAL ILLNESS & ALCOHOL OR DRUG DEPENDENCE SERVICES

MENTAL ILLNESS AND ALCOHOL OR DRUG DEPENDENCE SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
INPATIENT		
Hospital and Facility Services Services received by a beneficiary confined as a Registered Bed Patient in a Hospital or Qualified Treatment Facility shall count against the 365-day maximum for inpatient hospital benefits	See Hospital Inpatient Services for benefits	See Hospital Inpatient Services for benefits
Professional Services (Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist) One visit per day to a beneficiary who is a Registered Bed Patient	See Physician Services for benefits	See Physician Services for benefits
OUTPATIENT		
Outpatient Facility Services	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Professional Services (Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist)	See Physician Services for benefits	See Physician Services for benefits
Psychological Testing	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges

MENTAL ILLNESS & ALCOHOL OR DRUG DEPENDENCE SERVICES SPECIAL NOTES

Hospital and Facility Services

A Qualified Treatment Facility is a facility that has been specifically accredited and licensed to render mental illness or alcohol or drug dependence services by the proper authorities.

For inpatient hospital or facility services, you or your physician must notify the Claims Administrator and obtain a Preadmission Review.

Mental Illness Services

Mental health services must be for a nervous or mental disorder classified as such in the current version of the Diagnostic and Statistical Manual of the American Psychiatric Association and must be provided under an individualized treatment plan approved by a psychiatrist, psychologist, clinical social worker, licensed mental health counselor, or marriage and family therapist.

Alcohol or Drug Dependence Services

Benefits for Mental Illness Services are available for alcohol or drug dependence treatment services, including detoxification. Benefits paid for alcohol or drug dependence services will count against the Plan maximums for mental illness and will be subject to the clarifications and limitations listed below:

- Outpatient alcohol or drug dependence treatment services must be provided under an individualized treatment plan approved by a psychiatrist, psychologist, clinical social worker, licensed mental health counselor, or marriage and family therapist who is a certified substance abuse counselor.
- In the case of alcohol or drug dependence treatment episodes, if a hospital or Qualified Treatment Facility charges on an all-inclusive basis, this Plan will pay benefits in accordance with the Hospital Inpatient Services benefits.
- The cost of educational programs to which drinking or drugged drivers are referred by the judicial system and any and all services performed by mutual self-help groups are not eligible for benefits.

EMERGENCY SERVICES

EMERGENCY SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Emergency Room Facility	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
Physician Services	See Physician Services for benefits	See Physician Services for benefits
Automobile Ambulance	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges

EMERGENCY SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Air Ambulance	20% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges

EMERGENCY SERVICES SPECIAL NOTES

Emergency services are services received in connection with a medical condition that exhibits acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect in the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual, including the health of a pregnant woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency room physician services are covered under physician visits or surgical services.

No payment will be made for take-home drugs or supplies such as crutches or braces.

Automobile and Air Ambulance

Covered, when all of the following apply:

- Services are received from a properly licensed or certified automobile or air ambulance service.
- Transportation is for the purpose of emergency treatment.
- Transportation begins at the place where an injury or illness occurred or first required emergency care, or at the hospital or nursing facility at which the beneficiary is an inpatient and services to treat the injury or illness are not available.
- Transportation ends at the nearest facility equipped to furnish emergency treatment.
- The injury or illness must require emergency medical treatment, surgical treatment, or hospitalization.

Air ambulance benefits shall be for transportation within the State of Hawaii and transportation within the United States when facilities within the State of Hawaii are not equipped to furnish medically necessary treatment of an illness or injury. Services performed by medical transport personnel required during air ambulance transportation are also covered under the Plan.

OTHER MEDICAL SERVICES

OTHER MEDICAL SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Allergy Testing One testing series per calendar year	No copayment	20% of Eligible Charges and any difference between actual and Eligible Charges
Allergy Treatment Materials	20% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Appliances and Durable Medical Equipment	20% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Blood, Blood Products, and Blood Bank Service Charges Cost of blood and blood products except when donated, and blood bank service charges. Any additional charges for autologous blood (reserved for the person who donated the blood) are excluded as a benefit	20% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Chemotherapy Chemical agents and their administration (other than oral) for treatment of malignancy	20% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Diabetes Self-Management Training and Nutrition Education Classes Covered when prescribed for diabetic patients and pregnant women with gestational diabetes	10% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges

OTHER MEDICAL SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Dialysis and Supplies Acute or maintenance dialysis for kidney disorders	20% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Evaluations for the Use of Hearing Aids	20% of Eligible Charges	20%of Eligible Charges and any difference between actual and Eligible Charges
Human Growth Hormone Therapy	10% of Eligible Charges	10% of Eligible Charges and any difference between actual and Eligible Charges
Intrauterine Device (IUD) Implant for Contraceptive purposes One IUD implant every 5 years	50% of Eligible Charges	50% of Eligible Charges and any difference between actual and Eligible Charges
Nutrient Solutions required for Primary Diet Covered when prescribed by a physician for hereditary metabolic disorders	20% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Outpatient Injections Services and supplies for the injection or intravenous administration of medication or nutrient solutions required for primary diet	20% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Routine Physical Examination One physical examination and recommended screening tests per calendar year for children ages 6 through 18 years	No copayment	No copayment (You pay any difference between actual and Eligible Charges)
Physical Therapy Physical therapy from a registered physical therapist (R.P.T.) or a Registered Occupational Therapist (O.T.R.)	20% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges

OTHER MEDICAL SERVICES	Participating Provider YOU PAY	Nonparticipating Provider YOU PAY
Speech Therapy Speech therapy from a certified speech therapist	20% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges
Transplant Donor Services Services related to the donor or organ bank	20% of Eligible Charges	20% of Eligible Charges and any difference between actual and Eligible Charges

OTHER MEDICAL SERVICES SPECIAL NOTES

Appliances and Durable Medical Equipment

Covered, for the initial provision and replacement of appliances and durable medical equipment listed below:

- Hearing aids (one device per ear every five years)
- Cardiac pacemakers
- Artificial limbs, eyes, and hips, and similar nonexperimental appliances
- Casts, splints, trusses, braces, and crutches
- Oxygen and rental of equipment for its administration
- Rental or purchase of wheelchair and hospital-type bed
- Charges for use of an iron lung, artificial kidney machine, pulmonary resuscitator and similar special mechanical equipment

All appliances and durable medical equipment must be for services covered under this Plan and must be ordered by the attending physician. However, the Trust Fund must agree that the ordered item is medically necessary for the treatment of your illness or injury before the item will be considered a covered benefit. The Plan will not pay for any convenience items.

Human Growth Hormone Therapy

Coverage is limited to replacement therapy services to treat:

- Hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy
- Short stature due to endogenous growth hormone deficiency.

Benefits for human growth hormone therapy must be pre-approved by the Claims Administrator. If prior approval from the Trust Fund's Claims Administrator is not received, no benefit will be paid.

Physical and Speech Therapy

Coverage is subject to the following criteria and limitations:

- Physical therapy services must be rendered by a registered physical therapist (R.P.T.) or registered occupational therapist (O.T.R).
- Services must be ordered by a physician under an individual treatment plan and medically necessary to restore musculoskeletal function that was lost or impaired by injury or illness.
- The outpatient therapy treatment plan prescribed by the physician must be submitted to the Claims Administrator's Managed Care Department for preauthorization.
- Services must be medically necessary for restoration of a function which was lost or impaired by injury or illness.
- Services must be reasonably expected to improve the beneficiary's condition through short-term care. (Long-term maintenance therapy is not covered.)
- Group exercise programs are not covered.

Speech Therapy

Coverage is subject to the following criteria and limitations:

- Speech therapy services must be rendered by a certified speech therapist holding a Certificate of Clinical Competence from the American Speech and Hearing Association.
- Services must be ordered by a physician under an individual treatment plan and medically necessary to restore speech or hearing function that was lost or impaired by injury or illness.
- The outpatient therapy treatment plan prescribed by the physician must be submitted to the Claims Administrator's Managed Care Department for preauthorization.
- Services must be reasonably expected to improve the beneficiary's condition through short-term care. (Long-term maintenance therapy is not covered.)
- Speech therapy for children with developmental learning disabilities (developmental delay) is not covered.

Transplant Donor Services

Coverage is subject to the following limitations:

- Services related to the donor or organ bank (for bones, corneas, etc.) are covered only if a beneficiary is the recipient.
- Covered expenses for screening of donors shall be limited to expenses associated with the actual donor.
- If the donor is covered under another medical plan, that plan will be the primary plan and its benefits will be applied first before benefits under this Plan apply.

NON-EMERGENCY INTER-ISLAND TRAVEL BENEFITS

A beneficiary who resides in the State of Hawaii but does not reside on the island of Oahu may seek reimbursement for qualified travel expenses to the island of Oahu related to obtaining non-emergency medically necessary services for the diagnosis or treatment of an illness or injury when the required medical services are not available on the island where the beneficiary resides. The following benefit will be provided subject to prior review for medical necessity and authorization by the Claims Administrator under the Care Management Program:

- Reimbursement for roundtrip airfare, not to exceed $200.00.
- Reimbursement for taxi fare to and from the airport on the island of Oahu, not to exceed $50.00.
    - When the beneficiary seeking the inter-island travel benefits is a minor child under 18 years of age, the Plan will also reimburse qualified travel expenses for one accompanying parent or guardian up to the benefit limitation.

EXCLUSIONS AND LIMITATIONS OF COVERAGE

SERVICES NOT COVERED

No benefits will be paid under the Comprehensive Medical Plan in connection with:

- **Autism**.
- **Cosmetic services** (services, supplies or drugs that may improve the physical appearance but do not restore or materially improve a bodily function including related services such as laboratory tests, anesthesia, and hospitalization).
- Treatment of **baldness**, including hair transplants and topical medications.
- Treatment with **non-ionizing radiation**.
- **Eye refractions or examinations**, except if done by a physician for the diagnosis and management of diseases and disorders of the visual system as well as diagnosis of related systemic conditions.
- **Eye eyeglasses or contact lenses.**
- **Refractive eye surgery** to correct visual problems.
- **Dental services** generally done only by dentists including orthodontia, dental splints and other dental appliances, dental prostheses, osseointegration and all related services, removal of impacted teeth, any other procedures involving the teeth, structures supporting the teeth and gum tissues. In addition, any services in connection with the diagnosis or treatment of temporomandibular joint problems or malocclusion (misalignment of the teeth or jaws), regardless of the symptoms or illnesses being treated, are not eligible for benefits under this Plan.
- **Rest cures**.
- **Routine physical examinations** or health appraisals and related services, except as described in the Medical Plan Benefits section.
- Services for **work-related injuries or illnesses**.
- Services furnished by **government agencies** and available at no cost to you.
- Services or expenses for which you have no obligation to pay or no charge would be made if you had no health plan coverage.
- Services provided by a member of your **immediate family or household**.

- Services or expenses connected with confinement which is primarily for **custodial or domiciliary care**.
- Services for the treatment of an injury or illness resulting from an **act of war** or armed aggression (whether or not a state of war legally exists) or that occurs during a period of **active duty** exceeding 30 days in the service of any armed force of any state or nation.
- **Fertilization by artificial means** and all services or drugs related to the **diagnosis or treatment of infertility**, except for one in vitro fertilization program per qualified married couple per lifetime.
- **Reversal of sterilization**.
- Services and prosthetic devices related to treatment of **sexual dysfunction** or inadequacies.
- **Biofeedback** and other forms of self-care or self-help training and any related diagnostic testing.
- **Human growth hormone therapy**, except replacement therapy services as described in the Medical Plan Benefits section.
- **Weight loss or weight control** programs.
- **A physician's waiting or stand-by time**.
- **Outpatient prescription drugs**, except as described in the Medical Plan Benefits section.
- **Private duty nursing**.
- **Foot orthotics**, except for specific diabetic conditions.
- **Services not medically necessary** and **charges which exceed the Eligible Charges**.
- **Services that do not follow or are not standard medical practice**.
- **Experimental or investigative services.**
- **Services for which coverage has been exhausted, services not described as covered in this booklet or in the Comprehensive Medical Plan Document, or excluded services**.
- Treatment of any **complications of a non-covered service** regardless of how long ago such services were performed.
- **General excise or other tax**.

IF HOSPITALIZED ON YOUR EFFECTIVE DATE

If you are confined in a hospital or other inpatient facility on your effective date (i.e., the day on which your coverage under this Plan begins) and you had no other insurance or coverage prior to this coverage, the Plan will cover the confinement from your effective date. However, if you had other insurance or coverage immediately prior to your effective date under this Plan, which extends coverage for any services related to the hospitalization or other inpatient facility, the Plan will provide coordination of benefits with your existing coverage until the termination of your existing coverage. Thereafter, the Plan will provide coverage in accordance with the Plan document and plan of benefits.

INCORRECT OR FALSE INFORMATION

The Plan will not pay any benefits to the extent that such benefits are payable by reason of any false statement or other misrepresentation made on the enrollment form or in any claim for benefits. If the Plan pays such benefits before learning of any false statement, you agree to reimburse the Plan for 100% of such payment, without any deduction for legal fees or costs which you incurred or paid. In addition, you agree to reimburse the Plan for any legal fees and costs incurred or paid by the Plan to secure reimbursement. If reimbursement is not made as specified, the Plan, at its sole option, may:

1. Take legal action to collect 100% of any payments made, plus any legal fees and costs incurred or paid by the Plan to secure reimbursement, or
2. Offset future benefit payments by the amount of such reimbursement, plus any legal fees and costs incurred or paid by the Plan to secure reimbursement.

COORDINATION OF BENEFITS

If you are covered under this Plan and another group medical plan, Medicare, or motor vehicle insurance, the benefits of this Plan and those of the other plan will be coordinated and adjusted so that the total payments by all programs or policies will not be greater than the Eligible Charge under this Plan for the covered service. However, in no event will the payment from this Plan exceed what the Plan would have paid had there been no other program or policy creating dual coverage.

In order to coordinate benefits, it is necessary to determine which plan is primary (pays first) and which plan is secondary (pays second) for each family member. The Plan's determination of which health plan is primary is modeled according to the guidelines provided by the National Association of Insurance Commissioners (NAIC). The following is a chart to assist in determining which plan is primary for different family members:

Patient	Employee’s Plan	Spouse’s Plan
Employee	Primary	Secondary
Employee’s Spouse	Secondary	Primary
Dependent Children*		
• Employee’s birthday is earlier in the calendar year	Primary	Secondary
• Spouse’s birthday is earlier in the calendar year	Secondary	Primary

*For dependent children, the Trust Fund uses the “birthday rule” to determine which plan pays first. The birthday rule provides that the plan of the parent whose birthday is earlier in the calendar year is primary. For example, if the employee’s birthday is in January and the spouse’s birthday is in March, the employee’s plan is the primary plan.

For motor vehicle insurance cases, motor vehicle insurance coverage will be considered primary for payment, and those benefits will be applied first before any benefits of this Plan apply. You must provide the Trust Fund with a list of the medical expenses that the motor vehicle insurance covered. The list of expenses will be reviewed and upon verification that benefit maximums were met, this Plan will begin paying benefits. If another person caused the motor vehicle accident, refer to the THIRD PARTY LIABILITY section on page 111.

Once primary and secondary plans are determined, a claim may be filed (see FILING CLAIMS on page 113). Claims for services must be paid by the primary plan first. Once payment is made, a copy of the Explanation of Benefits (EOB) must be sent to the secondary plan along with a claim for payment by the provider or employee. THE SECONDARY PLAN CANNOT PROCESS YOUR CLAIM WITHOUT AN EOB FROM THE PRIMARY PLAN.

This is a general explanation of this Plan’s coordination-of-benefits provisions. The Trust Fund’s Comprehensive Medical Plan document contains the full provisions and is the controlling document for administration of the benefits under this Plan.

SPECIAL PROVISIONS RELATING TO MEDICAID

In determining or making any payment for you under this Plan, eligibility for state-provided medical assistance shall not be taken into consideration.

SPECIAL PROVISIONS RELATING TO MEDICARE

The Federal Medicare Program will be considered the primary plan unless the beneficiary is an active employee covered under an employer or group health plan. Where an employee or dependent is covered by both Medicare and this Plan, applicable Federal laws or regulations will determine which plan is primary. These rules apply to the working aged, the disabled, or patients with end stage renal disease (ESRD). For the working aged and disabled, these rules take into consideration the employment status of the employee covered by the group health plan.

If the beneficiary is 65 or older and eligible for Medicare only because of his or her age, this Plan will pay first before Medicare, as long as coverage is based on the beneficiary's status as a current active employee or the status of the beneficiary's spouse as a current active employee.

If the beneficiary is under age 65 and eligible for Medicare only because of end stage renal disease (ESRD), this Plan will pay first before Medicare, but only for the first 30 months of ESRD coverage. After 30 months, Medicare shall be the primary coverage.

If the beneficiary is under age 65 and eligible for Medicare only because of a disability (and not ESRD), this Plan will pay first before Medicare as long as coverage is based on the beneficiary's status as a current active employee, or the status of the beneficiary's spouse as a current active employee, or the current active employee status of the person for whom the beneficiary is a dependent.

If, under the Federal rules on Medicare for the working aged, the disabled, or patients with ESRD this Plan would not be required to pay as the primary payer, this Plan shall pay as the secondary payer as allowed by law.

WORKERS' COMPENSATION

If you are entitled to receive disability benefits or compensation under any Workers' Compensation or Employer's Liability Law for an injury or illness, the Plan will not pay benefits for any services related to that injury or illness. If you formally appeal the denial of a Workers' Compensation claim, you must notify the Trust Fund of such appeal. Upon the execution and delivery to the Trust Fund of all documents it requires to secure its rights for reimbursement, the Plan may pay such benefits. However, such payments shall be considered only as an advance or loan to you.

If your claim is declared eligible for benefits under Workers' Compensation or Employer's Liability Law or if you reach a compromise settlement of the Workers' Compensation claim, you agree to repay 100% of the advance or loan, without any deduction for legal fees or costs which you incurred or paid, within ten (10) calendar days of receiving payment. If reimbursement is not made as specified, the Plan, at its sole option, may:

1. Take legal action to collect 100% of any payments made, plus any legal fees and costs incurred or paid by the Plan to secure reimbursement, or

2. Offset future benefit payments by the amount of such reimbursement, plus any legal fees and costs incurred or paid by the Plan to secure reimbursement.

THIRD PARTY LIABILITY

If an injury or illness is or may have been caused by a third party and you have a right or assert a right to recover damages from that third party or your own insurance company, the Plan is not liable for benefits in connection with services rendered for such injury or illness. However, upon the execution and delivery to the Trust Fund of all documents it requires to secure its rights for reimbursement, within 180 days from the date the documents are sent to you, the Plan may pay such benefits. **Time is of the essence as to your timely delivery of these documents to the Plan. If the fully executed papers are not received within the 180 days, this loan provision will expire and will not be available and no payments will be made.** Such payments shall be considered only as an advance or a loan to you and you agree to repay 100% of this advance or loan, without any deduction for legal fees and costs which you incurred or paid, from any recovery received, however classified or allocated, and you promise not to waive or impair any of the Trust Fund's rights without its written consent. If and when there is a recovery on or settlement of the third party claim, all Plan payments cease and 100% reimbursement of all amounts advanced by the Plan is required without any offset for attorneys' fees.

The assets so recovered shall be considered Plan assets and you shall be under a fiduciary duty to pay them over to the Plan. In addition to any other remedy provided hereunder, the Plan shall be entitled to enforce this requirement by way of restitution or constructive trust. You agree to waive any defense based upon an inability of the Plan to trace the amounts recovered and agree that the lien may be satisfied by any of your assets. The "common Fund doctrine" and the "make whole rule" shall have no application to the Plan's reimbursement rights.

If the Plan makes payments for such injury or illness, the Trust Fund shall have reimbursement rights and shall have a lien on that portion of any recovery you obtain from the third party or your insurance company which is due for said benefits paid by the Plan without any deduction for legal fees and costs which you incurred or paid, even if the recovery does not make you whole or does not include medical payments. Such lien may be filed with you, the third party, his or her agent or insurance company, your insurance company, any other person or party holding such recovery for you, or the court. If you do not repay the loan from the recovery, the Trust Fund has the right to either:

1. Take legal and/or equitable action to collect 100% of any payments made, plus any legal fees and costs incurred or paid by the Plan to secure reimbursement, or

2. Offset future benefit payments by the amount of such reimbursement, plus any legal fees and costs incurred or paid by the Plan to secure reimbursement.

In addition, there continues to be no coverage under the Plan for third party liability claims. The Plan will not be liable for the provision of any benefits where an injury or illness is or may have been caused by a third party and you have a right, or have asserted a right, to recover damages from that third party or your insurance company.

CLAIMS FILING AND PAYMENT

FILING CLAIMS

When you obtain services from any provider:

- Present your AFL Medical ID card. This card is for identification purposes only and does not guarantee eligibility for benefits.
- Be sure that the provider and the Claims Administrator (PSWA) have your correct mailing address.
- Ask the provider to file a claim directly on your behalf.

All claims must be filed within one year after the date of service. Any claim received by the Claims Administrator after the one-year period will be denied.

If any additional information, such as medical records or reports, is required to process your claim, the Claims Administrator will request the information from the provider. The Claims Administrator will not pay the claim unless all necessary information is received. All required information must be received within one year after the date of service, otherwise the claim will be denied.

PAYMENT OF MEDICAL BENEFITS

- When you go to a **Participating Provider**, payment will be made directly to the provider.
- When you go to a **nonparticipating provider**, payment will be made directly to you. **You are responsible for paying the entire amount charged to the provider.**
- The Claims Administrator will mail you an Explanation of Benefits (EOB) after your claim has been processed showing the services performed, the amount charged, the amount allowed, the amount paid by the Plan and the amount, if any, that you owe.
- Retain your EOBs and receipts for tax purposes. The Claims Administrator will not be able to supply duplicate reports.

All provisions of the Comprehensive Medical Plan concerning determination of Eligible Charges and medical necessity of services apply to the claim and payment of all benefits.

OUT-OF-STATE MEDICAL SERVICES

If you need covered services outside the State of Hawaii:

- Contact the Claims Administrator for assistance in locating a Participating Provider who will perform the required services. However, there is no guarantee that the Claims Administrator will be able to find an out-of-state Participating Provider.
- **If you receive services from a nonparticipating provider**, send the Claims Administrator a claim form signed by the provider and attach a copy of the itemized bill or receipt. You can obtain claim forms from the Claims Administrator to take with you on your trip.
- **Prior authorization is required for all non-emergency out-of-state services**. You or your physician must call the Claims Administrator's Managed Care Department for out-of-state hospital admissions, services, or procedures before the services are received. For emergency or maternity admissions, you must notify the Claims Administrator within 48 hours or by the next working day (see CARE MANAGEMENT PROGRAM, page 77).
- For covered services received outside the State of Hawaii, reimbursement will be made as though such services had been rendered in Hawaii and the Eligible Charge for out-of-state services shall not exceed 150% of the Hawaii Eligible Charge for the same service. This limitation applies to both participating and nonparticipating providers.

REIMBURSEMENT FOR PAYMENTS MADE IN ERROR

The Plan reserves the right to seek reimbursement for payments made in error. If reimbursement is not made, the Plan, at its sole option, may offset future benefit payments for you and/or your dependents by the amount paid in error.

CLAIMS AND APPEALS PROCEDURES

Specific information about the Plan's claims and appeals procedures are contained in the CLAIMS AND APPEALS PROCEDURES section of this booklet (see SELF-FUNDED MEDICAL, DRUG AND VISION CLAIMS beginning on page 144).

If you have any questions regarding a benefit determination, please call the Claims Administrator on Oahu at (808) 275-2520 or (844) 808-2520 (toll free). If you are not satisfied with the response you receive and wish to pursue a claim for coverage, you may file an appeal with the Trust Fund.

The Board of Trustees has appointed the Benefits and Appeals Committee to hear all requests for review of denied claims. Please refer to the APPEALS section beginning on page 147 of this booklet for further details on appealing a denied claim to the Board of Trustees.

Comprehensive Medical Plan benefits are self-funded by the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund.

The preceding is for informational purposes only and is only a summary of coverage. Its contents are subject to the provisions of the Comprehensive Medical Plan Document and all amendments thereto. These documents are on file with the Trust Fund Office. Please refer to these documents for specific questions about coverage.

INDEMNITY PRESCRIPTION DRUG PLAN
(Self-Funded)

If you and/or your dependents are covered under the Trust Fund's Comprehensive Medical Plan, you will also have coverage under the Trust Fund's Indemnity Prescription Drug Plan.

The Trust Fund has contracted OptumRx as the Pharmacy Benefits Manager to administer and process Indemnity Prescription Drug claims. If you have any questions regarding your prescription drug benefits, please contact OptumRx at:

OptumRx

National Help Desk

Toll Free: 1(888) 869-4600

(Help is available 24 hours daily, 7 days a week)

UNDERSTANDING THE PLAN

COVERED DRUGS

The Indemnity Prescription Drug Plan covers medically necessary prescription drugs which are federally controlled and prescribed by a physician. However, although a physician may prescribe a particular prescription drug, this will not guarantee coverage under the Plan.

You may seek prior approval for a particular drug by asking your physician to write to the Pharmacy Benefits Manager prior to dispensing the drug. The Pharmacy Benefits Manager will determine if a particular drug is medically necessary, and thus, covered under this Plan.

The drug may be considered medically necessary if it meets the following requirements:

1. Is essential and appropriate for the diagnosis or treatment of an illness or injury
2. Is regarded as safe and effective by most of the Physicians in the United States
3. Is the most appropriate and economical prescription drug available

Over-the-Counter Drugs

The following drugs, although obtainable without a prescription, are covered only if your physician has issued a prescription for such items and the Pharmacy Benefits Manager has received acceptable evidence through clinical Prior Authorization review that such items are necessary for the treatment of an illness or injury.

- Ointments and lotions for the skin which are prepared by a pharmacist
- Special vitamins which are prescribed by a physician for treatment of a severe vitamin deficiency
- Insulin and diabetic supplies prescribed for the treatment of diabetes (diabetic supplies are limited to syringes, needles, lancets, sugar test tablets and tapes, and acetone test tablets)
- Cough mixtures
- Antacids: Aluminum Hydroxide with Magnesium Trisilicate (Gaviscon), Aluminum and Magnesium Hydroxide Gel, Calcium Carbonate, Magnesium Carbonate
- Eye and ear medications
- Miscellaneous: Gamma Globulin, Epinephrine, USP, Ephedrine Sulfate – 25 mg. (3/8 gr.), Ferrous Sulfate, USP

COVERAGE LIMITATIONS

Prior Authorization

Certain medications require **Prior Authorization** through the Pharmacy Benefits Manager. To initiate a Prior Authorization, you should work in partnership with your prescribing physician and contact the Pharmacy Benefits Manager to request a Prior Authorization. Your physician will be faxed a form to complete and return to the Pharmacy Benefits Manager. You and your physician will receive written notification from the Pharmacy Benefits Manager after the physician’s documentation has been reviewed.

Brand Name Medication with a Generic Equivalent

A generic equivalent will be substituted for a brand name drug, except when a physician directs that substitution is not permissible. Plan beneficiaries who request a brand name medication when a generic equivalent is available will pay the applicable copayment plus the cost difference between the brand name and the generic equivalent medication. If you require the brand name medication in place of the generic equivalent, your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager.

Oral Contraceptives

Coverage of oral contraceptives is limited to generic medications. Brand name medications with a generic equivalent require Prior Authorization from the Pharmacy Benefits Manager. **Without Prior Authorization, the brand name medication will not be a covered benefit and you are responsible for 100% of the cost of the medication with no reimbursement by the Plan.**

Step Therapy Program

Step therapy, also known as “fail first”, is a process that requires patients to try one or more medications in a therapeutic drug class to treat a health condition. Patients must “fail” on the medication(s) before “stepping up” to another medication to treat the condition.

If you are prescribed a medication in one of these targeted drug categories, you will be required to try a preferred medication. Non-preferred medications will be covered only with Prior Authorization. **Without Prior Authorization, the non-preferred medication will not be a covered benefit and you are responsible for 100% of the cost of the medication with no reimbursement from the Plan.**

Plan beneficiaries who have already tried the suggested therapy and have moved on to a non-preferred medication should ask their physician to submit a Prior Authorization request to the Pharmacy Benefits Manager.

Drug Quantity Management Program

Drug Quantity Management is a program that places quantity limits on certain medications as indicated by Food and Drug Administration (FDA) recommended guidelines. If you are prescribed one of these medications and require more than the recommended quantity per prescription, your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager.

Specialty Medications

Specialty medications are high-cost drugs that generally require special storage or handling and close monitoring of the patient’s drug therapy. Your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager for coverage approval when you are prescribed a new or different specialty medication. Coverage is limited to a 30-day supply per fill and oral medications only. Specialty injectable medications may be obtained under the Comprehensive Medical Plan.

New FDA Approved Drugs

New FDA approved drugs released to the market within the most recent six-month period may be excluded from coverage until the Pharmacy Benefits Manager can properly evaluate and provide clinical and coverage criteria for these new medications. If you require one of these drugs, you or your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager.

DRUGS NOT COVERED

No benefit shall be payable under the Indemnity Prescription Drug Plan for:

- Drugs not approved by the Food and Drug Administration (FDA)
- Injectable drugs, including injectable drugs administered by a physician or physician's nurse, *other than* insulin and medications related to diabetes (Prior Authorization is required for non-insulin injectable medications used to treat diabetes)
- Agents used in skin tests for determining allergic sensitivity
- Fertility agents, *other than* oral in vitro fertilization prescription drugs (Prior Authorization is required)
- Medical equipment, appliances and other non-drug items
- Drugs furnished to beneficiaries confined as a registered bed patient in a hospital or skilled nursing facility
- Drugs for treatment of sexual dysfunction or inadequacies
- Drugs which may be purchased without a prescription, except as specified above
- Compounded medications costing more than $150

CLAIMS AND APPEALS PROCEDURES

Specific information about the Plan's claims and appeals procedures are contained in the CLAIMS AND APPEALS PROCEDURES section of this booklet (see SELF-FUNDED MEDICAL, DRUG AND VISION CLAIMS beginning on page 144).

If you have any questions regarding a benefit determination, please call the Pharmacy Benefits Manager toll free at 1 888-869-4600. If you are not satisfied with the response you receive and wish to pursue a claim for coverage, you may file an appeal with the Trust Fund.

The Board of Trustees has appointed the Benefits and Appeals Committee to hear all requests for review of denied claims. Please refer to the APPEALS section beginning on page 147 of this booklet for further details on appealing a denied claim to the Board of Trustees.

INDEMNITY PRESCRIPTION DRUG BENEFIT PROGRAMS

You have the following options for obtaining covered prescription drugs:

1. Point of Service program
2. Central Fill program
3. Mail Order program
4. Direct Member Reimbursement program

To obtain services through the Point of Service or Central Fill programs, you must use participating or designated pharmacies and present your OptumRx identification card.

To obtain prescriptions through the Mail Order program, you must register with one of the Mail Order providers.

For the Direct Member Reimbursement program, you must file claims directly with the Pharmacy Benefits Manager.

If you have any questions about how to use these programs, please contact the Pharmacy Benefits Manager at 1 (888) 869-4600. A brief description of each program is outlined below.

POINT OF SERVICE (POS) PROGRAM (through any Participating Pharmacy)

The Point of Service prescription drug program is intended for short-term prescription drugs that you need for an acute or limited illness or injury. Under the Point of Service program, you pay the copayments listed below if you obtain your prescription drug from a Point of Service participating pharmacy. For a current list of participating pharmacies in your area, contact the Pharmacy Benefits Manager at 1 (888) 869-4600.

	Participating Pharmacy
Generic Drugs, Insulin, Diabetic Supplies	$6.00 copayment
Brand Name Drugs	$18.00 copayment*
Days Supply Limit	Up to 15 days**

* If you request brand name only and a generic equivalent is available, you will be responsible for the brand name copayment plus the difference between the cost of the brand name drug and its generic equivalent.

** For prescription drugs that can only be dispensed in "unbreakable" packages (e.g., creams, ointments, certain inhalers), the days supply limit shall be equivalent to the package size days supply, not to exceed a 30-day supply, with a single copayment charged to the member.

** For oral contraceptives, a single copayment will apply for up to a 30-day supply.

Prescriptions obtained from a nonparticipating pharmacy are NOT covered under the Point of Service program. You are responsible for paying the entire cost of the prescription at the nonparticipating pharmacy and filing a claim under the Direct Member Reimbursement program.

NOTE: If you were charged the full price for your medication at a Point of Service participating pharmacy, please call the Pharmacy Benefits Manager at 1 (888) 869-4600 for assistance.

CENTRAL FILL PROGRAM (through designated Central Fill Pharmacies)

If you need to obtain a long-term or maintenance prescription drug that you take daily or regularly, you may fill your prescription through the Central Fill program.

Under the Central Fill program, you fill your long-term prescriptions at any designated Central Fill pharmacy by following the steps below. For a current list of participating Central Fill pharmacies, contact the Pharmacy Benefits Manager at 1 (888) 869-4600.

To use the Central Fill Program:

Step 1: Obtain a prescription from your doctor.

Step 2: Go to the nearest Central Fill pharmacy and present your prescription and Optum Rx identification card.

Step 3: If this is the first time you are taking this drug or dosage of this drug, the pharmacist will fill your prescription for 15 days and you pay the following copayment:

	(Initial Fill) **15-day Supply Limit**
Generic Drugs, Insulin, Diabetic Supplies	$6.00 copayment
Brand Name Drugs	$18.00 copayment*

Step 4: If you and your doctor decide to continue to use this drug and dosage, you may obtain a refill for up to a 60-day supply. Call the Central Fill pharmacy refill phone number listed on your prescription at least three days before your prescription supply runs out and request a refill.

Step 5: Go to the Central Fill pharmacy and pick up your prescription refill for up to a 60-day supply at the following copayment:

	Refills **60-day Supply Limit**
Generic Drugs, Insulin, Diabetic Supplies	$9.00 copayment
Brand Name Drugs	$28.00 copayment*

* If you request brand name only and a generic equivalent is available, you will be responsible for the brand name copayment plus the difference between the cost of the

brand name drug and its generic equivalent.

MAIL ORDER PROGRAM (through designated Mail Order Providers)

If you prefer to have your long-term prescription drugs delivered to your home or mailing address, you may use the Mail Order program. To use this program, contact the Pharmacy Benefits Manager at 1 (888) 869-4600 for a Mail Order Registry and/or Brochure and mailing instructions.

Under the Mail Order program, you may obtain up to a 60-day supply at the copayments listed below.

	60-day Supply Limit (15-day initial fill required)
Generic Drugs, Insulin, Diabetic Supplies	$9.00 copayment
Brand Name Drugs	$28.00 copayment*

* If you request brand name only and a generic equivalent is available, you will be responsible for the brand name copayment plus the difference between the cost of the brand name drug and its generic equivalent.

DIRECT MEMBER REIMBURSEMENT PROGRAM

Under the Direct Member Reimbursement program, you may obtain prescription drugs from any legally licensed pharmacy of your choice. You are responsible for paying the entire cost of the prescription at the time services are received and filing a claim for reimbursement with the Pharmacy Benefits Manager. The Trust Fund will pay as follows:

	15-day Supply Limit*
Generic Drugs, Insulin, Diabetic Supplies	The Plan reimburses you the remaining Eligible Charge after a $4.00 copayment.
Brand Name Drugs	The Plan reimburses you the remaining Eligible Charge after a $10.00 copayment.

* For prescription drugs that can only be dispensed in “unbreakable” packages (e.g., creams, ointments, certain inhalers), the days’ supply limit shall be equivalent to the package size days’ supply, not to exceed a 30-day supply, with a single copayment charged to the member.

How to File a Direct Member Reimbursement Claim

Claim forms are available from providers and the Pharmacy Benefits Manager or online at www.optumrx.com.

Step 1: Present your OptumRx membership ID card to the provider of services.

Step 2: You should complete Part A of the claim form.

Step 3: The provider who dispenses the drug should complete Part B of the claim form.

Step 4: Mail the completed claim form together with your receipts to OptumRx within 90 days from the date of purchase. Payment will be made directly to you.

Claim forms submitted for prescription drugs purchased from a Point of Service participating pharmacy will NOT be accepted or paid under the Direct Member Reimbursement program.

All claims must be filed within 90 days from the date the drug was purchased. Any claim received by the Pharmacy Benefits Manager after the 90-day period will be denied.

Indemnity Prescription Drug benefits are self-funded by the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund.

The preceding is for informational purposes only and is only a summary of coverage. Its contents are subject to the provisions of the Indemnity Prescription Drug Plan document and all amendments thereto. These documents are on file with the Trust Fund Office. Please refer to these documents for specific questions about coverage.

INDEMNITY VISION CARE PLAN
(Self-Funded)

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund has contracted Pacific Southwest Administrators (PSWA) to handle the claims administration for the Trust Fund's Indemnity Vision Care benefits. If you have any questions about any aspect of your coverage or payments made by PSWA, you should contact PSWA. PSWA is only the Claims Administrator and does not guarantee benefits provided by the Plan.

Pacific Southwest Administrators
560 North Nimitz Highway, Suite 217E
Honolulu, Hawaii 96817
Oahu: (808) 275-2520
Toll free: 1 (844) 808-2520

WHO IS ELIGIBLE?

All Active employees and their eligible dependents are eligible for Indemnity Vision Care benefits. However, if you are enrolled in the Kaiser Permanente Plan, you and your dependents are eligible for the Indemnity Plan vision care benefits **for appliances only**. Your eye examinations are covered under the Kaiser Permanente Plan.

WHAT ARE THE VISION CARE BENEFITS?

You and your eligible dependents are entitled to one eye examination every 12 months and one pair of lenses and one frame, or one pair of contact lenses every 24 months. However, if there is a change in vision of more than plus (+) or minus (-) .50 diopter or a spherocylinder change of more than plus (+) or minus (-) .50 diopter, lenses only will be provided every 12 months. Copies of both the prior and new prescription must be submitted with your claim to substantiate the change in vision.

The Plan will pay up to the following amounts:

Allowances

Eye Examination*

Ophthalmologist (M.D.)	$60.00
Optometrist (O.D.)	$50.00

Appliances

Single vision lenses and frame	$175.00
Multifocal lenses and frame	$225.00
Contact lenses	$175.00
Frame only	$115.00

* **SPECIAL NOTE**: Members covered under the Kaiser Permanente Plan must obtain their eye examination for prescription eyeglasses through a Kaiser Permanente facility since this benefit is provided under the Kaiser Permanente Plan. The Kaiser Permanente Plan does not cover eye examinations for contact lenses.

If lenses are replaced without furnishing a new frame, the total allowance for both lenses and frame may be used for the cost of the lenses, if required.

If contact lenses are furnished, no benefits are payable for frames in the same 24-month period. If benefits for a frame have already been paid in a 24-month period, these benefits will be deducted from the benefits payable for any contact lenses furnished in the same 24-month period.

EXCLUSIONS FROM COVERAGE

- Repair or replacement of frame parts and accessories
- Sunglasses
- Prescription inserts for diving masks
- Non-prescription industrial safety goggles or glasses
- Non-standard items for lenses

HOW ARE VISION CARE SERVICES PROVIDED?

You may go to any licensed ophthalmologist (M.D.), optometrist (O.D.), or other vision care provider of your choice. You should choose a provider who can help you obtain the vision care you need at a reasonable cost. Your choice of vision care provider can make a difference in how much you will owe after vision care benefit payments have been made.

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund contracts with certain vision care providers in the State of Hawaii. A list of these participating providers is available at the Trust Fund Office and will be provided to you at no charge. When you go to one of the participating providers, payment for the services and/or appliances is sent directly to the provider. The only copayments you will be required to pay will be for trifocal and progressive multifocal lenses, the balance of charges for frames not within a selected group of frames available at no charge, contact lenses, and non-covered items.

If you go to a nonparticipating provider, payment for the services and/or appliances is made directly to you. You will then owe the provider the total charge for the services and/or appliances.

HOW TO FILE A CLAIM

If you go to a participating provider

- Present your AFL Medical ID card to the provider of services.
- The provider will complete and file a claim on your behalf.
- Payment will be made directly to the provider. However, you must arrange to pay the provider for any copayments that may be required.

If you go to a nonparticipating provider

- Present your AFL Medical ID card to the provider of services.
- Send your receipt for payment of services and/or appliances to the Claims Administrator for reimbursement. (Make a copy of the payment receipt for your records.)
- Payment will be made directly to you

All claims must be filed within 90 days from the date of service. Any claim received by the Claims Administrator after the 90-day period will be denied.

If you or any of your eligible dependents also have coverage under another group plan, Medicare, or any motor vehicle insurance policy or contract that provides benefits similar to those of this Plan, any benefit payable by that other plan will be taken into consideration in determining the benefits payable by the Indemnity Vision Care Plan.

CLAIMS AND APPEALS PROCEDURES

Specific information about the Plan's claims and appeals procedures are contained in the CLAIMS AND APPEALS PROCEDURES section of this booklet (see SELF-FUNDED MEDICAL, DRUG AND VISION CLAIMS beginning on page 144).

If you have any questions regarding a benefit determination, please call the Claims Administrator on Oahu at (808) 275-2520 or (844) 808-2520 (toll free). If you are not satisfied with the response you receive and wish to pursue a claim for coverage, you may file an appeal with the Trust Fund.

The Board of Trustees has appointed the Benefits and Appeals Committee to hear all requests for review of denied claims. Please refer to the APPEALS section beginning on page 147 of this booklet for further details on appealing a denied claim to the Board of Trustees.

Indemnity Vision Care benefits are self-funded by the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund.

The preceding is for informational purposes only and is only a summary of coverage. Its contents are subject to the provisions of the Indemnity Vision Care Plan document and all amendments thereto. This document is on file with the Trust Fund Office. Please refer to this document for specific questions about coverage.

DENTAL CARE BENEFITS

All Active employees and eligible dependents are eligible for dental care benefits.

CHOICE OF PLANS

Employees may choose either the fee for service dental plan provided through Hawaii Dental Service (HDS), or the prepaid dental plan offered by Dental Care Centers of Hawaii (DCCH) which is available only on Oahu and in Kailua Kona on the island of Hawaii. The main benefit provisions of each plan are summarized on the following pages. The principal difference between the two plans is that under the HDS Plan, you may select any dentist; however, only a percentage of your expenses may be covered. If you select the DCCH Plan, you must use one of the DCCH dental providers; however, your out-of-pocket expenses are limited to a $12.00 office visit charge and laboratory fees, if necessary.

OPEN ENROLLMENT PERIOD

You may change dental plans during the annual open enrollment period. If you wish to change plans, contact the Trust Fund Office during the month of November of any year. The change will become effective January 1st. No change between dental plans may be made at any other time unless you meet one of the requirements specified in the Special Enrollment Periods section beginning on page 34 of this Summary Plan Description.

<u>GETTING STARTED</u>

REGISTER FOR ONLINE MEMBER INFORMATION

The HDS website provides valuable information on your dental plan. You will be able to review your dental plan benefits, search for a participating dentist, view your Explanation of Benefits reports, print your membership card, and more!

To register:

1. Log on at <u>HawaiiDentalService.com</u>
2. Follow the on-screen directions to create a new account
3. Complete the “Member Registration” form
4. Select “Yes” to “Request electronic Explanation of Benefits”

HDS will then send you an e-mail to activate your account. Please be sure to click on the link.

Please note that HDS members 18 years and older must register for their own account.

EFFECTIVE DATE OF ELIGIBILITY

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund will let you know the start date (effective date) of your dental coverage and an HDS membership card will be mailed directly to you.

- At your first appointment, let your dental office know that you are covered by HDS and present your HDS membership card.
- If you need dental services immediately after your effective date of dental coverage but have not received your HDS membership card, you may print or request a card through the HDS website at HawaiiDentalService.com or you may ask your dentist to confirm your eligibility with HDS prior to receiving services.
-

ELIGIBLE PERSONS

Check with your Trust Fund Office to determine who is eligible to be covered as your dependent(s) under your plan.

Disabled dependent children, over your plan's age limit, may be eligible for coverage. They must live with you and meet all of the following criteria:

- Unmarried, and
- Incapable of supporting themselves because of physical or mental incapacity that began before your plan's cutoff age for dependent coverage.

UPDATING INFORMATION

To ensure that you and your family receive the full benefits of your plan and to assist HDS in processing your dental claims accurately, please notify the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund Office **immediately** of any of the following:

- Name change
- Address change
- Add/remove a spouse
- Add/remove a dependent

COMPLETION OF PROCEDURES WHEN ELIGIBILITY ENDS

If a dental procedure is in progress when your eligibility ends, coverage for services in progress may continue for a maximum of 30 days following the date your eligibility ends. HDS will determine the applicable plan benefit for dental work within 30 days of the termination of eligibility as long as the specific dental procedure has been started before the date of ineligibility. Any dental work remaining on your treatment plan that did not begin before your eligibility ends, will not be covered by the plan.

SELECTING A DENTIST

IN HAWAII, GUAM, AND SAIPAN – CHOOSE AN HDS PARTICIPATING DENTIST

You may select any dentist; however, you save on your out-of-pocket costs when you visit an HDS participating dentist for services received in Hawaii, Guam, and Saipan. HDS participating dentists partner with HDS by limiting their fees for services that are covered.

About 95% of all licensed, practicing dentists in Hawaii participate with HDS, so it is more than likely your dentist is an HDS participating dentist. For a current listing of HDS participating dentists, visit the HDS website at HawaiiDentalService.com or call the HDS Customer Service Department.

ON THE MAINLAND – CHOOSE A DELTA DENTAL PARTICIPATING DENTIST

HDS is a member of the Delta Dental Plans Association (DDPA), the nation's largest and most experienced dental benefits carrier with a network of more than 348,000 dentist locations.

If your job takes you out of state or your child attends school on the Mainland, HDS recommends that you and/or your dependents visit a Delta Dental participating dentist to receive the maximum benefit from your plan.

For a list of Delta Dental participating dentists, visit the HDS website at HawaiiDentalService.com and click on "Members/Find a Participating Dentist." Click on the "US Mainland & Puerto Rico" button to search for a dentist. Select the Specialty from the drop-down box then select "Delta Dental Premier" as your plan type. Click "No" for current location then enter the zip code of the location you are searching for. Click on the "Find dentists" button and a list of participating dentists will be displayed. Or you may call the HDS Customer Service Department.

VISITING A DELTA DENTAL PARTICIPATING DENTIST

When visiting a dentist on the Mainland, let the dentist know that you have an HDS plan and present your HDS membership card.

- If the dentist is a Delta Dental participating dentist, the claim will be submitted directly to HDS for you.
- Provide the dentist with the HDS mailing address and toll free number located on the back of your membership card.
- HDS's payment will be based upon HDS's participating dentist's Allowed Amount.
- Your Patient Share will be the difference between the Delta Dental dentist's Approved Amount and HDS's payment amount.

VISITING A NON-PARTICIPATING DENTIST

If you choose to have services performed by a dentist who is not an HDS or Delta Dental participating dentist, you are responsible for the difference between the amount that the non-participating dentist actually charges and the amount paid by HDS in accordance with your plan.

- The non-participating dentist will render services and may submit a completed claims form to HDS on your behalf or provide you with a completed claims form to submit to HDS. If the non-participating dentist provides you with a completed claims form, mail the completed claims form to:

  HDS – Dental Claims
  700 Bishop Street, Suite 700
  Honolulu, HI 96813-4196

- HDS payment will be based on the HDS non-participating dentist fee schedule and a reimbursement check will be sent to you along with your Remittance Advice.

Whether you visit a participating or non-participating dentist, please be sure to discuss your financial obligations with your dentist before you receive treatment. All dental claims must be filed within 12 months of the date of service for HDS claims payment.

HELPING YOU MANAGE YOUR COSTS

HDS participating dentists agree to limit their fees and charge you at the agreed upon fee even after you reach your annual plan maximum.

Your participating dentist may submit a preauthorization request to HDS **before** providing services. With HDS's response, your dentist should explain to you the treatment plan, the dollar amount your plan will cover, and the amount you will pay.

This preauthorization will reserve funds for the specified services against your Plan Maximum. It will also help you to plan your dental services accordingly should you reach your Plan Maximum.

HDS REPORTS AND PAYMENTS

EXPLANATION OF BENEFITS (EOB) REPORT

HDS provides its members with Explanation of Benefits (EOB) statements which summarize the services you received from your dentist and lists payment information.

EOBs are available electronically and are accessible through your HDS website account. If you choose to receive EOBs through the mail, you will not receive an EOB for services with no patient share or when only tax is due.

It is important to note that the EOB statement is not a bill. Depending on your dentist's practice, your dentist may bill you directly or collect any portion not covered by your plan at the time of service.

CALCULATING YOUR BENEFIT PAYMENTS

Determining the amount you should pay your HDS participating dentist is based on a simple formula (see box to the right). HDS will pay the "% Plan Covers" amount.

You are responsible for the balance owed to your dentist, which includes the Approved Amount (the maximum amount that the member is responsible for), any applicable deductible amounts, and taxes, less the HDS payment. Participating dentists are paid based upon their Allowed Amount (the amount which the benefit percentage is applied against to calculate the HDS payment).

Dentist's Allowed Amount
X % plan covers
HDS Payment

Dentist's Approved Amount
<minus HDS Payment>
Patient Share

QUESTIONS ON YOUR CLAIMS

If you have any questions or concerns about your dental claims, please call HDS's Customer Service Department at 529-9248 on Oahu or toll-free at 1-844-379-4325.

CLAIMS APPEAL PROCESS

If a service is not covered, a copy of the specific rule, guideline, or protocol relied upon in making the benefit determination will be provided free of charge upon request by you or your authorized representative. A copy of HDS's claims appeal process may be obtained from Customer Service.

If you are not satisfied with the explanation of why a service was not covered, you have the right to appeal the decision and request reconsideration.

You or your authorized representative should submit a request, in writing, within one year of the date of the service to:

HDS
Attn: Appeals Manager
700 Bishop Street, Suite 700
Honolulu, Hawaii 96813

Your request should include:

- HDS Subscriber ID
- Patient name
- Contact phone number and mailing address
- Treating dentist's name
- Claim number
- Service being appealed
- Reason for appeal

HDS will review your request and provide you with a written response within 30 days. If you do not agree with the response, you have the right to file a civil action under section 502(a) of ERISA.

DUAL COVERAGE/COORDINATION OF BENEFITS

Please be sure to let your dentist know if you are covered by any other dental benefits plan(s).

- When you are covered by more than one dental benefits plan, the amount paid will be coordinated with the other insurance carrier(s) in accordance with guidelines and rules of the National Association

of Insurance Commissioners. Total payments or reimbursements will not exceed the participating dentist's Allowed Amount when HDS serves as the second plan.

- There is a limit on the number of times certain covered procedures will be paid and payment will not be made beyond these plan limits.
- Coverage of identical procedures will not be combined in cases where there are multiple plans. For example, if you have two plans and each includes two cleanings during each calendar year, your benefits will cover two cleanings (not four) in each calendar year.

FRAUD AND ABUSE PROGRAM

Fraud and abuse is taken seriously at HDS. HDS periodically conducts reviews at HDS participating dentists' offices to ensure that you are being charged in accordance with HDS's contract agreements.

CONFIDENTIAL FRAUD HOTLINE

From Oahu: (808) 529-9277
Toll free: 1(866) 505-9227
E-mail: HDSCompliance@HawaiiDentalService.com

PLAN EXCLUSIONS

The following are general exclusions not covered by the plan:

- Services for injuries and conditions that are covered under Workers' Compensation or Employer's Liability Laws; services provided by any federal or state government agency or those provided without cost to the eligible person by the government or any agency or instrumentality of the government.
- Congenital malformations, medically related problems, cosmetic surgery or dentistry for cosmetic reasons.
- Procedures, appliances or restorations other than those for replacement of structure loss from cavities that are necessary to alter, restore, or maintain occlusion.
- Treatment of disturbances of the temporomandibular joint (TMJ).
- Orthodontic services.

- Implants.
- All prescription medication.
- Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to a patient by a dentist.
- All transportation costs such as airline, taxi cab, rental car and public transportation.
- Other exclusions are listed in HDS's Procedure Code Guidelines.

SUMMARY OF DENTAL BENEFITS

BENEFIT	PLAN COVERS
DIAGNOSTIC	
Examinations – once per calendar year	100%
Bitewing X-rays – twice per calendar year	100%
Full mouth X-rays – once every three years	80%
Other X-rays	80%
PREVENTIVE	
Cleanings – twice per calendar year	100%
• Expectant mothers – cleanings or periodontal maintenance* three times per calendar year	
• Diabetic patients – cleanings or periodontal maintenance* four times per calendar year	
** Periodontal maintenance benefit level*	**80%*
Fluoride (through age 17) – once per calendar year	80%
Space maintainers (through age 17)	80%
RESTORATIVE	80%

- Amalgam (silver-colored) fillings
- Composite (white-colored) fillings – limited to the anterior (front) teeth
- Crowns and gold restorations (once every five years when teeth cannot be restored with amalgam or composite fillings)

  NOTE: Composite (white) and Porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.

ENDODONTICS 80%

- Pulpal therapy
- Root canal treatment, retreatment, apexification, apicoectomy

PERIODONTICS 80%

- Periodontal scaling and root planing – once every two years
- Gingivectomy, flap curettage, and osseous surgery – once every three years
- Periodontal maintenance – twice per calendar year after qualifying periodontal treatment

PROSTHODONTICS 80%

- Fixed bridges (ages 16 and older) – once every five years
- Dentures (complete and partial; ages 16 and older) – once every five years

ORAL SURGERY 80%

ADJUNCTIVE GENERAL SERVICES 80%

- Adjunctive services
- Palliative treatment (for relief of pain but not to cure)

HOW TO ACCESS INFORMATION AND CONTACT HDS

HDS WEBSITE (HawaiiDentalService.com)

You can visit HDS online to:

- Check whether you and/or your dependents are eligible for HDS benefits
- Check what services are covered by your plan
- Check what the limits are of each type of covered service and how much you have used
- Search for an HDS participating dentist in Hawaii, Guam or Saipan by specialty, location, handicap accessibility, weekend hours, and more
- Search for a Delta Dental Premier participating dentist on the U.S.

Mainland or Puerto Rico by specialty, location, weekend hours and more

- Download and print a summary of your benefits for tax purposes
- Download and print blank claims forms
- Print your HDS membership card
- Print your Explanation of Benefits
- Print HDS Notice of Privacy Practices

CUSTOMER SERVICE REPRESENTATIVES

From Oahu:	**529-9248**
Toll free:	**1-844-379-4325**
Fax:	529-9366
Toll free fax:	1-866-590-7988

Monday through Friday
7:30 a.m. – 4:30 p.m. (Hawaii Standard Time)

SEND WRITTEN CORRESPONDENCE TO:

Hawaii Dental Service
Attn: Customer Service
700 Bishop Street, Suite 700
Honolulu, Hawaii 96813-4196

E-mail: CS@HawaiiDentalService.com

The preceding dental benefits are fully insured under a contract issued by Hawaii Dental Service (HDS), 700 Bishop Street, Suite 700, Honolulu, Hawaii 96813-4196. The services provided by HDS include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary of coverage. Its contents are subject to the provisions of the Contract for Dental Services which contains all the terms and conditions of membership and benefits. This document is on file with the Trust Fund Office. Please refer to this document for specific questions about coverage.

DENTAL CARE CENTERS OF HAWAII (DCCH)
(formerly GENTLE DENTAL)

UNDERSTANDING THE PLAN

The Dental Care Centers of Hawaii Plan is a prepaid dental coverage plan designed and provided by the same health care professionals delivering your dental care. Who else is better qualified to understand your needs more than your dentist? The only charges are $12.00 per office visit (administrative fee) and laboratory costs, if necessary.

HOW DOES THE PLAN WORK?

When you fill out the enrollment form provided by the Trust Fund Office, that's all the paperwork you have to do. Quality dental care, without cost to you, is waiting for your whole family whenever you're ready to use it. Just call and make an appointment with any DCCH dental provider.

CHOOSING YOUR OWN PERSONAL DENTIST

Each dental provider has a staff of dentists from which you may choose. The dentist you choose coordinates the entire dental treatment plan for your family. All dentists are members of both the Hawaii Dental Association and the American Dental Association.

IS THERE A PREAUTHORIZATION WAITING PERIOD?

No. Unlike other dental plans that often require a waiting period for permission to do your dental work, there are no claim forms to fill out or send in.

WHAT IF I HAVE OTHER DENTAL COVERAGE?

Some families have coverage with two or more dental plans. The DCCH Plan considers the other plan the primary carrier, responsible for dental charges incurred by those members with dual coverage.

MAJOR BENEFITS AND COVERED SERVICES

BENEFIT	MEMBER COPAYMENT
Diagnostic	
Office visits	$12.00
Oral examinations	No charge
Full mouth x-ray	No charge
Panographic x-ray	No charge
Each additional film	No charge

Emergency treatment ....No charge

Prophylaxis (teeth cleaning)
Regular cleaning (semi-annual)...No charge
Topical fluoride..No charge
Scaling and polishing..No charge

Restorative Dentistry (amalgam fillings)
Cavities involving one surface .... No charge
Cavities involving two surfaces...No charge
Cavities involving three surfaces ....No charge

Endodontics
Root canals...No charge
Pulp capping ....No charge
Pulpotomy...No charge

Oral Surgery
Simple extractions ....No charge
Surgical...No charge
Third molars/wisdom teeth ....No charge

Periodontics (gum treatment)
Emergency treatment ....No charge
Scaling and Curettage ....No charge
Periodontal surgery ....No charge

Crown and Bridge[1]
3/4 or full metal cast crown...No charge
Porcelain fused to metal crown (molars not included)...................No charge
Stainless steel crown...No charge
Space maintainers...No charge

Removable Prosthodontics (Partials and dentures) [1]
Complete upper denture..No charge
Complete lower denture ....No charge
Partial denture ....No charge
Relines..No charge
Denture adjustments after six months of delivery..........................No charge
Denture repairs..No charge

[1] Dental laboratory charges will apply if you have not met the eligibility requirement. After 12 months of continuous enrollment in the DCCH Plan, you will not be required to pay the laboratory charges. For a copy of the current Laboratory Fee schedule, contact the Trust Fund Office.

PLAN EXCLUSIONS

The following are general exclusions not covered by the plan:

- Orthodontic services.
- Cosmetic dentistry performed solely to improve appearance.
- Dispensing of drugs.
- Hospitalization when desired by the patient for any dental procedure.
- Services reimbursable under any other insurance or health care plan.
- Services for injuries or conditions covered by Workers' Compensation or employer's liability law.
- Services which DCCH providers do not feel are necessary for dental health.
- Services that cannot be performed because of the general health of the patient.
- Treatment required for conditions resulting from a major disaster or epidemic.

OFFICE FACILITIES

The office facilities are ready to accommodate patients easily and efficiently. The facilities feature thoroughly computerized appointment control, scheduling, and record keeping.

DCCH PROVIDER LOCATIONS

Kaizen Dental Center (Honolulu)
1136 Union Plaza, Suite 502
Honolulu, Hawaii 96813
Phone: (808) 536-3405

Aloha Smiles Dental (Honolulu)
1441 Kapiolani Boulevard, Suite 1405
Honolulu, Hawaii 96814
Phone: (808) 888-9331

Elite Smile Center (Kailua Kona)
75-1028 Henry Street, Suite 203
Kailua Kona, Hawaii 96740
Phone: (808) 329-4425

Healthy Smiles Family Dental (Kapolei)
579 Farrington Highway, Suite 201
Kapolei, Hawaii 96707
Phone: (808) 674-1400

Town Center Dental & Orthodontics (Mililani)
95-720 Lanikuhana Avenue, Suite 210
Mililani, Hawaii 96789
Phone: (808) 625-8899

QUESTIONS ABOUT YOUR COVERAGE

If you have any questions about your dental coverage, please call the DCCH Membership Services Department at (808) 284-6545. The Membership Services Department is responsible for resolving any complaints or disputes relating to services provided by DCCH and any of its providers, including claims regarding the scope of coverage for dental services and denials.

If you have a grievance, you may call the Membership Services Department or fill out a complaint form which is available from your dental provider. Mail the completed form to:

Dental Care Centers of Hawaii, Inc.
Attn: Membership Services Department
92-230 Opuakii Place
Kapolei, Hawaii 96707

DCCH will review your grievance and provide a written response within 30 days. A copy of DCCH's grievance policy may be obtained by calling the DCCH Membership Services Department.

The preceding dental care benefits are fully insured under a contract issued by Dental Care Centers of Hawaii, Inc., P. O. Box 893896, Mililani, Hawaii 96789. The services provided by DCCH include the payment of claims, when necessary, and the handling of claims appeals.

The preceding is for informational purposes only and is only a summary of coverage. Its contents are subject to the provisions of the Agreement for Dental Services which contains all the terms and conditions of membership and benefits. This document is on file with the Trust Fund Office. Please refer to this document for specific questions about coverage.

DEATH BENEFITS FOR ACTIVE EMPLOYEES
(Self-Funded)

COVERAGE

If you are an Active employee and eligible for benefits under the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund, you and your spouse will be covered for a death benefit as follows:

	Benefit Amount
Active Employee	$7,500
Spouse (of Active Employee)	$2,500

BENEFICIARY

On your Trust enrollment form, you may name anyone you choose as your beneficiary to receive your death benefit. You may change your beneficiary designation at any time by submitting a new Trust enrollment form to the Trust Fund Office. The change is effective on the date you signed the form when it is received by the Trust Fund Office.

When the Trust Fund receives due proof of your death, the death benefit proceeds will be paid to your beneficiary.

Unless you request otherwise in your filed beneficiary designation, payment will be made as follows:

1. If more than one beneficiary is named, each will be paid an equal share of the proceeds.
2. If any named beneficiary dies before you, his/her share will be paid equally to the named beneficiaries who survive you.
3. If no beneficiary is named, or if no named beneficiary survives you, or if your beneficiary is a minor, or if your beneficiary is not legally competent to give a valid release, the Trust Fund will pay the executors or administrators of your estate, or at its option, the first of the following classes of successive preference beneficiaries who survive you:
   a. All to your surviving spouse; or
   b. If there is no surviving spouse, in equal shares to your surviving children; or

c. If there is no surviving spouse or child, in equal shares to your surviving parents; or

d. If there is no surviving spouse, child, or parent, to any of your relatives by blood or legal adoption or connection by marriage; or

e. If no such relatives can be identified, to any person appearing to the Trust Fund to be equitably entitled thereto by reason of having incurred expenses for your maintenance, medical attention, or burial.

Any payment made in accordance with the preceding provisions shall release the Trust Fund from further liability for the amount paid.

HOW TO FILE A CLAIM

The Trust Fund Office must be notified when a covered member dies. Claim forms and instructions for filing a claim are available from the Trust Fund Office. Completed claim forms and all required documentation must be submitted to the Trust Fund Office. Upon notification and receipt of the required documentation, the Administrator of the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund will determine whether benefits are payable.

If a claim for benefits is denied, the Administrator will provide a written Notice of Denial to the claimant containing the specific reasons for the denial, reference to the Plan provisions upon which the denial was based, and a description of the Plan's review procedures.

The claimant may appeal to the Board of Trustees for a full and fair review of any denied claim by submitting a written Application for Review within 60 days following receipt of the Notice of Denial. The Board of Trustees (or a subcommittee thereof) will review the claim and notify the claimant of its decision.

For further information on filing claims and appeals, please refer to the SELF-FUNDED DEATH BENEFIT CLAIMS section on page 156.

The death benefit is self-funded by the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund. The preceding is for informational purposes only and is only a summary of coverage. Its contents are subject to the provisions of the Restated Plan of Benefits. This document is on file with the Trust Fund Office. Please refer to this document for specific questions about coverage.

CLAIMS AND APPEALS PROCEDURES

SELF-FUNDED MEDICAL, DRUG AND VISION CLAIMS

(Comprehensive Medical Plan, Indemnity Prescription Drug Plan and Indemnity Vision Care Plan)

The Board of Trustees of the Trust Fund has the discretionary authority to determine all questions of eligibility, to determine the amount and type of benefits payable to any beneficiary or provider in accordance with the terms of the Plan and related regulations, and to interpret the provisions of the Plan as necessary to determine benefits.

If your claim or that of your dependent(s) is wholly or partially denied, you will be provided with a written determination explaining the reasons for the denial.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

You can designate another person to act on your behalf in the handling of your benefit claims. In order to do so, you must complete and file a form with the Claims Administrator that identifies the individual that is authorized to act on your behalf as your authorized representative. If you designate an authorized representative to act on your behalf, all correspondence and benefit determinations will be directed to your authorized representative, unless you direct otherwise. You may also request that this information be provided to both you and your authorized representative.

In the case of a claim for urgent care, where you are not able to act on your own behalf, a health care professional who has knowledge of your medical condition will be recognized by the Plan as your authorized representative. A health care professional is a professional who is licensed, accredited, or certified to perform specified health services consistent with State law.

INITIAL CLAIMS

Upon the filing of a claim for benefits with the Claims Administrator, and all necessary information required to make a determination on your claim, a decision will be made within the following time periods.

Urgent Care Claims: 72 Hours

You will be notified within 72 hours from the receipt of your claim whether your claim is approved or denied. If you fail to follow the Plan's claims filing procedure or submit an incomplete urgent care claim, you will receive oral notification (or written notification, if you request) within 24 hours of the day the claim was received. The notification will indicate what the proper procedures

are for filing claims or what additional information is needed to complete your claim. You will be given 48 hours from the date you are notified to complete your claim.

You will receive a decision within 48 hours from the earlier of the following events:

- Receipt of the necessary information from you; or
- Expiration of the 48-hour period provided to you to submit the necessary information.

A claim for “urgent care” is any claim for care where failure to provide the services could seriously endanger your life, health, or ability to regain maximum functions, or could subject you to serious pain that could not be managed without the requested care. Your claim will be treated as “urgent” if a physician with knowledge of your medical condition says it is so, or if the Claims Administrator, in applying the judgment of a reasonable individual with an average knowledge of health and medicine, determines that your claim involves urgent care.

Pre-Service Claims: 15 Calendar Days (with possible 15-day extension)

You will be notified within 15 calendar days from the receipt of your claim whether your claim is approved or denied. A pre-service claim is any claim involving a requirement or request for approval before care is rendered. Pre-service claims include prior authorization and utilization review decisions.

For specific procedures on obtaining prior approvals for benefits, pre-authorizations or utilization reviews, refer to the specific sections of the self-funded benefits described in this booklet. If you fail to follow the Plan’s claims filing procedure, you will receive oral notification (or written notification, if you request) within five days of the day the claim was received. The notification will indicate what the proper procedures are or filing claims.

Post-Service Claims: 30 Calendar Days (with possible 15-day extension)

You will be notified within 30 calendar days from the receipt of your claim if your claim is denied. A post-service claim is any claim submitted after services have been provided to you.

Extensions for Pre-Service and Post-Service Claims: 15 Calendar Days

The Plan may extend the time to respond to a pre-service or post-service claim by 15 calendar days if there are circumstances beyond the Plan's control that interfere with a timely claim determination. The Plan must provide you with advance notice of the extension, identifying the circumstances which provide the basis for the extension and the date that the Plan is expected to make its decision, prior to the extension period taking effect. If the extension is necessary due to insufficient information to decide the claim, the notice of extension will indicate what additional information is needed to complete your claim. You will be given 45 days from the date you are notified to provide additional information to complete your claim.

Concurrent Care Claims: 24 Hours

If you are currently receiving ongoing treatment under the Plan, you will receive advance notice of any determination to terminate or reduce your treatment. The notice will be provided to you, in advance, to allow you to appeal the determination and have a decision rendered prior to the termination or reduction of your treatment. Any claim involving both urgent care and a request to extend a course of treatment that was previously approved by the Plan, must be decided as soon as possible, given the urgency of the medical conditions involved. You will receive notification within 24 hours after the receipt of your urgent and concurrent care claim provided your claim is received at least 24 hours prior to the expiration of your treatment. If your claim is received less than 24 hours prior to the expiration of treatment, you will be notified of the decision within 72 hours after receipt of the claim.

INITIAL BENEFIT DETERMINATION

Upon approval of a pre-service or urgent care claim by the Claims Administrator, you will receive a notice informing you of the approval. No approval notice will be provided for post-service claims.

If your claim is denied by the Claims Administrator, you will be provided written notice of the denial at no cost to you. Examples of a denied claim include a determination to reduce or terminate a benefit or a failure to make whole or partial payment of a benefit by the Plan. In the case of urgent care claims, the Plan may first notify you orally, with a written notice to follow in three days. The notice of denial, whether oral or written, will contain the following information:

1. The specific reason(s) for the denial, with reference(s) to the specific Plan provisions;
2. A description of any additional material or information necessary to complete your claim and why the information is needed;

3. A statement that you may request, free of charge, an explanation of the clinical or scientific judgment used to make the determination applying the terms of the Plan to your medical circumstances, if the denial was based on medical necessity, experimental treatment, or similar exclusion;
4. The identification of any internal rule, guideline, protocol, or other criteria the Plan relied upon in making the determination, and a statement that such rule, guideline, protocol, or other criteria is available to you, free of charge, upon your request;
5. A description of the Plan's review and appeals procedures, the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA following an adverse determination on appeal; and
6. A description of the expedited review process applicable to the claim, if the denial involved a claim for urgent care.

APPEALS

If you wish to appeal the denial of any claim for benefits, you have 180 days following your receipt of a Notice of Denial to file an appeal with the Board of Trustees. The Board of Trustees has appointed the Benefits and Appeals Committee to hear all appeals of denied claims.

An appeal may be initiated by you or your authorized representative (such as your physician). Appeals must be submitted in writing to the Board of Trustees at the following address:

Board of Trustees
Benefits and Appeals Committee
AFL Hotel and Restaurant Workers Health & Welfare Trust Fund
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817

Or, send a fax to: (808) 537-1074

You may ask for an expedited appeal of an urgent care claim by calling the Trust Administrator at (808) 523-0199 or 1 (866) 772-8989 (toll free).

Review of your appeal will be conducted by the Benefits and Appeals Committee without any preference for or deference given to the determination of the initial claim. The determination on appeal will be made by individuals who were not involved in the determination of the initial claim and who are not subordinates of anyone involved in the initial claim determination.

In considering the appeal, the Benefits and Appeals Committee is required to consider all evidence submitted by you or your authorized representative, whether or not the information was submitted or considered in the initial benefit determination. You have the right to submit written comments, documents, records, and other information relating to your claim for benefits.

If the initial denial involved medical judgment, the Benefits and Appeals Committee must consult with a health care professional who has the appropriate training and experience in the field of medicine. Examples of medical judgment include whether a treatment, drug, or other item is experimental, investigational, or medically necessary or appropriate. If a health care professional is required to be consulted on the appeal, the professional must not be the same individual who was involved in the initial determination of the claim, nor a subordinate of that individual.

Your Right to Information

The Plan will provide you with the following, free of charge:

1. Upon request, reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits;
2. The opportunity to submit written comments, documents, records and other information relating to your claim for benefits; and
3. Identification of any medical or vocational experts whose advice was obtained in connection with any claim denial without regard to whether the advice was relied upon in making the benefit determination.

Appeal of an Urgent Care Claim

If you are appealing a denial that is considered an urgent care claim, you have the option of submitting your appeal orally or in writing. All necessary information will be communicated to you through the quickest method available, such as telephone or fax. The Benefits and Appeals Committee must issue its decision as soon as possible, but no later than 72 hours from the time the appeal is received.

Appeal of a Pre-Service Claim

If you are appealing a denial that is considered a pre-service claim, you must submit a written request for review of the initial denial. The Benefits and Appeals Committee must issue its decision no later than 30 days from the time the appeal is received.

Appeal of a Post-Service Claim

If you are appealing a denial that is considered a post-service claim, you must submit a written request for review of the initial denial. The Benefits and Appeals Committee must issue its decision no later than 60 days from the time the appeal is received.

NOTIFICATION OF DETERMINATION ON APPEAL

You will receive written notification informing you of the determination on appeal. If your claim is denied, the notice of denial will contain the following information:

1. The specific reason(s) for the denial on appeal, with reference(s) to the specific Plan provisions;
2. A statement that you may request, free of charge, an explanation of the clinical or scientific judgment used to make the determination applying the terms of the Plan to your medical circumstances, if the denial was based on medical necessity, experimental treatment, or similar exclusion;
3. The identification of any internal rule, guideline, protocol, or other criteria the Plan relied upon in making the determination, and a statement that such rule, guideline, protocol, or other criteria is available to you, free of charge, upon your request;
4. A statement that you are entitled to receive, upon request and at no charge to you, access to and copies of documents relevant to your claim;
5. A statement that "You and the Plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or your State Insurance regulatory agency";
6. A description of the Plan's review procedures and the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA following an adverse determination on appeal; and
7. A statement describing any voluntary appeals procedure that may be available to you and a statement of your right to bring civil action under Section 502(a) of ERISA.

INSURED CLAIMS

(Kaiser Permanente Plan, Hawaii Dental Service Plan and Dental Care Centers of Hawaii Plan)

Participants may obtain information concerning claims and appeals procedures for the following fully insured benefits by referring to the applicable benefit section of this booklet or by contacting the insured plans at the addresses listed below.

KAISER PERMANENTE MEDICAL & DRUG BENEFITS

Kaiser Foundation Health Plan, Inc.
711 Kapiolani Blvd.
Honolulu, Hawaii 96813
ATTN: Member Services

HAWAII DENTAL SERVICE BENEFITS

Hawaii Dental Service
700 Bishop Street, Suite 700
Honolulu, Hawaii 96813-4196
ATTN: Customer Service Manager

DENTAL CARE CENTERS OF HAWAII BENEFITS

Dental Care Centers of Hawaii, Inc.
92-230 Opuakii Place
Kapolei, Hawaii 96707
ATTN: Membership Services Department

DISABILITY CLAIMS

A disability claim is any claim for which the Plan must make a determination of disability in order for the beneficiary to receive the benefit. One example is the continuation of benefits for a disabled dependent child beyond age 26.

Effective on and after April 1, 2018, any claim for a disability benefit shall be subject to the following claims and appeal procedures. **Exception:** When the Plan provides a benefit that is conditioned on a finding of a disability made by a party other than the Plan (e.g., the Social Security Administration), then a claim for such benefits is **not** treated as a disability claim under this section.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

You can designate another person to act on your behalf in the handling of your benefit claims. In order to do so, you must complete and file a form with the Trust Fund Office that identifies the individual that is authorized to act on your behalf as your authorized representative. The Trust Fund Office serves as the Administrator of the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund.

If you designate an authorized representative to act on your behalf, all correspondence and benefit determinations will be directed to your authorized representative, unless you direct otherwise. You may also request that this information be provided to both you and your authorized representative.

INITIAL CLAIMS

Upon the filing of a claim for disability benefits with the Trust Administrator, and all necessary information required to make a determination on your claim, a decision will be made within 45 days. This period may be extended by the Plan for up to 30 days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you prior to expiration of the initial 45-day period of the circumstances requiring the extension and the date by which the Plan expects to make a decision. If, prior to the end of the first extension period, the Administrator determines that due to matters beyond the control of the Plan a decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Plan notifies you prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date by which the Plan expects to make a decision.

In the case of any extension, the notice of extension shall explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You will be given 45 days from the date you are notified to provide the specified information to complete your claim.

INITIAL BENEFIT DETERMINATION

If your claim is approved, you will receive a notice informing you of the approval.

If your claim is denied, you will be provided a written Notice of Denial at no cost to you. Examples of a denied claim include a determination to reduce or terminate a benefit, or a failure to make whole or partial payment of a benefit by the Plan. The Notice of Denial will contain the following information:

1. The specific reason(s) for the denial, with reference(s) to the specific Plan provisions on which the determination is based.
2. A description of any additional material or information necessary to complete your claim and why the information is needed.
3. A description of the Plan's review and appeal procedures, the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.
4. Identification of any internal rule, guideline, protocol, or other criteria the Plan relied upon in making the determination and a statement that such rule, guideline, protocol, or other criteria is available to you, free of charge, upon your request; or a statement that such rules, guidelines, protocols, or criteria do not exist.
5. A statement that you may request, free of charge, an explanation of the clinical or scientific judgment used to make the determination applying the terms of the Plan to your medical circumstances, if the denial was based on medical necessity, experimental treatment, or similar exclusion.
6. A discussion of the decision, including an explanation of the Plan’s basis for disagreeing with or not following: (a) the views of health care professionals who treated you or vocational professionals who evaluated you; or (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan without regard to whether the advice was relied upon in making the benefit determination; or (c) a disability determination made by the Social Security Administration.
7. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.
8. A statement that if you are not proficient in English and have questions about the claim denial, you should contact the Trust Fund Office to find out if language assistance is available.

APPEAL OF A DENIED CLAIM

If your disability claim is denied in whole or in part or you disagree with the decision made on a claim, you may ask for a review (appeal the decision). The Board of Trustees has appointed the Benefits and Appeals Committee to hear all appeals of denied claims.

An appeal may be initiated by you or your authorized representative. Appeals must be submitted in writing to the Board of Trustees at the following address:

Board of Trustees
Benefits and Appeals Committee
AFL Hotel and Restaurant Workers Health & Welfare Trust Fund
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817

Or, send a fax to: (808) 537-1074

If you wish to appeal the denial of any disability claim, you have 180 days following your receipt of a Notice of Denial to file an appeal with the Board of Trustees.

Review of your appeal will be conducted by the Benefits and Appeals Committee without any preference for or deference given to the determination of the initial claim. The determination on appeal will be made by individuals who were not involved in the determination of the initial claim and who are not subordinates of anyone involved in the initial claim determination.

In considering the appeal, the Benefits and Appeals Committee is required to consider all evidence submitted by you or your authorized representative, whether or not the information was submitted or considered in the initial benefit determination. You have the right to submit written comments, documents, records, and other information relating to your claim for benefits.

If the initial denial involved medical judgment, the Benefits and Appeals Committee must consult with a health care professional who has the appropriate training and experience in the field of medicine. Examples of medical judgment include whether a treatment, drug, or other item is experimental, investigational, or medically necessary or appropriate. If a health care professional is required to be consulted on the appeal, the professional must not be the same individual that was involved in the initial determination of the claim, nor a subordinate of that individual.

The Plan will provide you with the following, free of charge:

1. Upon your request, reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits;
2. Identification of any medical or vocational experts whose advice

was obtained in connection with any claim denial without regard to whether the advice was relied on in making the benefit determination; and

3. Any new or additional evidence considered, relied upon or generated by or for the Plan in connection with the denied claim, and any new or additional rationale on which a claim denial is based, as soon as possible and in sufficient time to give you a reasonable opportunity to respond prior to the date the appeal is decided.

The Benefits and Appeals Committee will review your disability appeal and make its benefit determination no later than 60 days from the time your appeal is received, unless special circumstances require an extension of time for processing your appeal, in which case the benefit determination shall be rendered as soon as possible, but not later than 120 days after your appeal is received. If an extension is required, the Plan will provide you a Notice of Extension prior to the end of the initial 60-day review period and indicate the special circumstances that make the extension necessary and the date by which the benefit determination will be made. The decision of the Benefits and Appeals Committee will be written in clear, easily understood language and provide the reasons why the decision was made and the specific Plan provisions that support it. The Trust Administrator will notify you of the benefit determination no later than five days after the benefit determination is made.

NOTIFICATION OF DETERMINATION ON APPEAL

You will receive written notification informing you of the determination on appeal. If your claim is denied, the notice of denial will contain the following information:

1. The specific reason(s) for the denial on appeal, with reference(s) to the specific Plan provisions on which the determination is based.
2. Identification of any internal rule, guideline, protocol, or other criteria the Plan relied upon in making the determination and a statement that such rule, guideline, protocol, or other criteria is available to you, free of charge, upon your request; or a statement that such rules, guidelines, protocols, or criteria do not exist.
3. A statement that you may request, free of charge, an explanation of the clinical or scientific judgment used to make the determination applying the terms of the Plan to your medical circumstances, if the denial was based on medical necessity, experimental treatment, or similar exclusion.
4. A discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following: (a) the views of health care professionals who treated you or vocational professionals who evaluated you; or (b) the views of medical or vocational experts whose

advice was obtained on behalf of the Plan without regard to whether the advice was relied upon in making the benefit determination; or (c) a disability determination made by the Social Security Administration.

5. A statement that you are entitled to receive, upon request and at no charge to you, access to and copies of documents relevant to your claim.

6. A statement that "You and the Plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or your State Insurance regulatory agency."

7. A description of the Plan's review procedures, the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA following an adverse determination on appeal.

8. A statement describing any voluntary appeals procedure that may be available to you and a statement of your right to bring civil action under Section 502(a) of ERISA.

9. A statement of the claimant's right to bring an action under section 502(a) of the Act shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

10. A statement that if you are not proficient in English and have questions about the claim denial, you should contact the Trust Fund Office to find out if language assistance is available.

SELF-FUNDED DEATH BENEFIT CLAIMS

Upon receipt of a death benefit claim and all documentation necessary to make a determination, the Administrator of the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund will make a decision on the claim within 90 days. If the claim is approved, the proceeds from your death benefit will be paid to your beneficiary. If the claim is wholly or partially denied, the claimant will be provided with a written Notice of Denial explaining the reasons for the denial, reference to the Plan provisions upon which the denial was based, a description of any additional information or material necessary for the claimant to perfect the claim and an explanation of why it is necessary, and a description of the Plan's review and appeal procedures and the applicable time limits.

The claimant (or the claimant's authorized representative) may appeal the denial by filing a written Application for Review with the Board of Trustees at the following address:

Board of Trustees
AFL Hotel and Restaurant Workers Health & Welfare Trust Fund
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817

Or, send a fax to: (808) 537-1074

The Application for Review must be filed within 60 days after receiving the Notice of Denial. The claimant may also submit any documents, records, and other information in support of the claim not already furnished to the Plan. Upon request, the claimant will be provided reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim, free of charge.

Upon receipt of the Application for Review, the Board of Trustees (or a subcommittee thereof) will review the claim and take into account all evidence submitted by the claimant without regard to whether such evidence was submitted or considered in the initial benefit determination. It will be up to the Board of Trustees (or a subcommittee thereof) to decide whether or not a hearing will be useful in reviewing the claim. If a hearing is to be held, the claimant will receive at least two weeks prior notice of the time and place of the hearing (unless the claimant agrees in writing to a shorter notice period). The claimant (or the claimant's authorized representative) may appear at the hearing.

The Board of Trustees (or a subcommittee thereof) will render its decision in writing within 60 days after receipt of the Application for Review, unless special circumstances require an extension of time for processing the request, in which case the decision shall be rendered as soon as possible, but not later than 120 days after receipt of the Application for Review. If

an extension is required, the Board of Trustees (or a subcommittee thereof) must notify the claimant in writing, prior to the end of the initial 60-day review period and indicate the special circumstances that make the extension necessary and the date by which a decision is expected. The decision of the Board of Trustees (or a subcommittee thereof) will be written in clear, easily understood language and provide the reasons why the decision was made and the specific Plan provisions that support it.

ELIGIBILITY AND OTHER APPEALS

The Trust Fund Office serves as the Administrator of the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund and maintains the records regarding your eligibility for the benefits described in this booklet. Questions regarding enrollment, change of employee status (such as a leave of absence or retirement) or change in dependent coverage (such as the birth or adoption of a new dependent) can be directed to the Trust Fund Office. Any disagreement regarding your eligibility status or the status of your dependents which cannot be resolved by the Administrator may be submitted to the Board of Trustees for review.

You (or your authorized representative) may appeal any decision of the Administrator based on Plan rules adopted by the Board of Trustees (e.g. denial of eligibility or loss of eligibility) by filing a written Application for Review with the Board of Trustees at the following address:

Board of Trustees
AFL Hotel and Restaurant Workers Health & Welfare Trust Fund
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817

Or, send a fax to: (808) 537-1074

The Application for Review must be filed within 60 days after receipt of the Administrator's decision and should describe your version of the facts and reasons why you feel the Administrator's decision was not proper. You should also submit any documents, records, and other information in support of your claim not already furnished to the Plan. Upon request, you (or your authorized representative) may review and obtain copies of all Plan documents, records, and other information relevant to your claim, free of charge.

Upon receipt of your written Application for Review, the Board of Trustees (or a sub-committee thereof) will review your claim and take into account all evidence submitted by you without regard to whether such evidence was submitted or considered in the initial benefit determination. It will be up to the Board of Trustees (or a sub-committee thereof) to decide whether a hearing will be useful in reviewing your claim. If a hearing is to be held,

you will receive at least two weeks prior notice of the time and place of the hearing (unless you agree in writing to a shorter notice period). You (or your authorized representative) may appear at the hearing.

The Board of Trustees (or a subcommittee thereof) will render its decision in writing, within 60 days after receipt of the Application for Review, unless special circumstances require an extension of time for processing your request, in which case the decision shall be rendered as soon as possible, but not later than 120 days after receipt of the Application for Review. If an extension is required, the Board of Trustees (or a subcommittee thereof) must notify you, in writing, prior to the end of the initial 60-day review period and indicate the special circumstances that make the extension necessary and the date by which a decision is expected. The decision of the Board of Trustees (or a sub-committee thereof) will be written in clear, easily understood language and provide the reasons why the decision was made and the specific Plan provisions that support it.

EXHAUSTION OF ADMINISTRATIVE REMEDIES / LIMITATION ON TIME TO FILE A LAWSUIT

You or any other claimant may not file a lawsuit to claim Plan benefits until all administrative remedies have been exhausted including this Plan's claims appeal review procedures. In the event your claim is denied, you must commence any lawsuit under Section 502(a) of ERISA respecting such claim not later than the first anniversary of the date of the written notice of decision on the appeal denying such claim.

The preceding is for informational purposes only and is a summary of the Trust Fund's claims and appeals procedures. This summary is subject to applicable law and the provisions of the Plan Documents and all amendments made thereto, which are on file with the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund Office. In the event of a conflict between the information contained in this booklet and the Plan Documents, the Plan Document will control. Please refer to these documents for specific questions about the Trust Fund's claims and appeals procedures.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Federal law, to maintain the privacy of your health information. The Trust Fund and its business associates may use or disclose your health information to the extent permitted by and in accordance with HIPAA and the regulations issued thereunder, including without limitation for the following purposes:

- Treatment;
- Payment;
- Health plan operations and plan administration; and
- As permitted or required by law.

Other than for the purposes stated above, your health information will not be used or disclosed without your written authorization. If you authorize the Trust Fund to use or disclose your health information, you may revoke that authorization at any time in writing.

Under HIPAA, you have the following rights regarding your health information. You have the right to:

- Request restrictions on certain uses and disclosures of your health information;
- Receive confidential communications of your health information;
- Inspect and copy your health information;
- Request amendment of your health information if you believe your health records are inaccurate or incomplete; and
- Request a list of certain disclosures by the Trust Fund of your health information.

You also have the right to make complaints to the Trust Fund as well as the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust Fund should be made in writing to: *Privacy Officer, AFL Hotel and Restaurant Workers Health and Welfare Trust Fund Office, 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817.* You will not be retaliated against, in any way, for filing a complaint.

The Trust Fund has designated Benefit & Risk Management Services, Inc. as the Trust Fund's Privacy Officer and as its contact person for all issues regarding patient privacy and your privacy rights. For a copy of the privacy notice which provides a complete description of your rights under HIPAA's privacy rules, contact the Trust Fund's Privacy Officer at *560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, phone: 523-0199 (Oahu) and 1 (866) 772-8989 (neighbor islands), Monday through Friday, 8:00 a.m. to 4:30 p.m.*

For any questions or complaints regarding your health information and privacy rights related to the benefits provided through the plans listed below, contact the following:

COMPREHENSIVE MEDICAL PLAN

For Initial Claims:

Privacy Officer
Pacific Southwest Administrators
560 North Nimitz Highway, Suite 217E
Honolulu, Hawaii 96817
Phone: (808) 275-2520 (Oahu)
Toll free: 1 (844) 808-2520

For Appeals:

Privacy Officer
AFL Hotel and Restaurant Workers Health and Welfare Trust Fund
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817
Phone: 523-0199 (Oahu)
Toll Free:1 (866) 772-8989

INDEMNITY PRESCRIPTION DRUG PLAN

For Initial Claims:

Privacy Office
OptumRx
17900 Von Karman Avenue
M/S: CA016-0203
Irvine, California 92614
Toll free: 1 (877) 598-3646

For Appeals:

Privacy Officer
AFL Hotel and Restaurant Workers Health and Welfare Trust Fund
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817
Phone: 523-0199 (Oahu)
Toll Free:1 (866) 772-8989

INDEMNITY VISION PLAN

For Initial Claims:

Privacy Officer
Pacific Southwest Administrators
560 North Nimitz Highway, Suite 217E
Honolulu, Hawaii 96817
Phone: (808) 275-2520 (Oahu)
Toll free: 1 (844) 808-2520

For Appeals:

Privacy Officer
AFL Hotel and Restaurant Workers
Health and Welfare Trust Fund
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817
Phone: 523-0199 (Oahu)
Toll Free:1 (866) 772-8989

KAISER PERMANENTE PLAN

Privacy Officer
Kaiser Foundation Health Plan, Inc.
711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Phone: 1 (800) 966-5955 (Member Services)

HDS DENTAL PLAN

Privacy Officer
Hawaii Dental Service
700 Bishop Street, Suite 700
Honolulu, Hawaii 96813
Phone: (808) 529-9248 (Customer Service)
Toll free: 1 (844) 379-4325

DCCH DENTAL PLAN

Membership Services Department
Dental Care Centers of Hawaii, Inc.
92-230 Opuakii Place
Kapolei, Hawaii 96707
Phone: (808) 284-6545 (Plan Administrator)

STATEMENT OF ERISA RIGHTS

As a participant in the AFL Hotel and Restaurant Workers Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension Welfare Benefit Administration).

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request a certificate before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion in your coverage for 12 months (18 months for late enrollees) after your enrollment date.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may

also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT

In this booklet, we have attempted to explain as briefly as possible the benefits provided to eligible employees and their dependents. The Trust Agreement, Plan Documents, policies, contracts, and various rules and regulations adopted by the Board of Trustees are the final authorities in all matters related to the AFL Hotel and Restaurant Workers Health and Welfare Plan. Copies of these documents are available for you to inspect at the Trust Fund Office during regular business hours.

DISCLAIMER

None of the self-funded benefits described in this booklet are insured by any contract of insurance and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Trust Fund collected and available for such purpose. No participant or dependent shall have accrued or vested rights to benefits under this Plan.

NOTE:
RETAIN YOUR PAY STUBS AS PROOF OF RECORD

CHANGE-OF ADDRESS NOTIFICATION

In order to assure accurate records on your behalf, please notify the Trust Fund Office of any change.