AFL HOTEL AND RESTAURANT WORKERS HEALTH AND WELFARE TRUST FUND

HANDBOOK OF BENEFITS

(ACTIVES)

December 2012
IMPORTANT NOTICE

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

The administration and interpretation of the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund 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 sole authority, in the exercise of its discretion, to interpret, apply, and administer the Plan, and has the exclusive right to construe the terms of the Plan to determine eligibility and amounts of benefits under the Plan. 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.
AFL HOTEL AND RESTAURANT WORKERS
HEALTH AND WELFARE TRUST FUND
560 N. Nimitz Highway, Suite 209
Honolulu, Hawaii 96817
(808) 523-0199
1 (866) 772-8989

Employer Trustees
Ernest Nishizaki
Nona Tamanaha
Julie Walker

Union Trustees
Eric Gill
Hernando Tan

Employer Trustee Alternates
Kevin Gleason
Carla Thomas

Union Trustee Alternates
Ross Baniaga
Doryne Jardine

Plan Consultant
Benefit Plan Solutions, Inc.

Legal Counsel
Davis, Cowell & Bowe, LLP

Certified Public Accountant
Lemke, Chinen and Tanaka, CPA, Inc.

Custodian
First Hawaiian Bank

Contract Administrator
Benefit & Risk Management Services, Inc.
Dear Trust Fund Participant:

This booklet has been published to provide an updated description of the benefits which eligible employees of contributing employers are entitled to receive under the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund. The actual benefits which you are eligible for 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).

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. Effective July 1, 2008, the Student Coverage Self-Payment Program was revised to allow a student to continue single coverage for medical and prescription drug benefits for up to 12 consecutive months regardless of age. Previously, the program did not permit continuation of coverage beyond age 24. Effective January 1, 2011, the Student Self-Payment Program was terminated due to the removal of student certification as a requirement for continued dependent coverage.

2. Effective November 1, 2008, the Trust Fund Administrator was changed to Benefit & Risk Management Services, Inc. (page 11).

3. Effective July 1, 2009:
   a. If a dependent spouse or child is not enrolled in the Plan within 30 days of marriage, birth, adoption, or placement for adoption, there is no retroactive coverage. Coverage for such dependent will be effective on the first day of the month following the date of notification to the Trust Fund Office and submittal of the required documentation (page 27).
b. The Open Enrollment Period was changed from the month of July to the month of November (page 31).

4. Effective January 1, 2010:
   a. The definition of Spouse is expanded to include same gender couples (Domestic Partners) who meet certain eligibility criteria. This expanded definition means that Domestic Partners and their dependent children may be eligible for benefits. Benefits are limited to the Kaiser Plan (page 27).
   b. The Genetic Information Nondiscrimination Act of 2008 which regulates the use of genetic information in the administration of employee benefit plans applies to the Trust Fund (page 33).
   c. In accordance with the Mental Health Parity and Addiction Equity Act of 2008, the Self-Funded Comprehensive Medical Plan and Kaiser Plan implemented benefit changes to provide parity with respect to financial requirements and treatment limitations between mental health or substance abuse disorder benefits and medical/surgical benefits (pages 57-59 and 77).
   d. Michelle’s Law requires that when a serious illness or injury interrupts the ability of a student dependent from continuing to attend school, health plans are required to provide up to one year of continued coverage as though such dependent was still attending school. Effective January 1, 2011, Michelle’s Law no longer applies due to the removal of student certification as a requirement for continued dependent coverage (page 34).

5. Effective January 1, 2011:
   a. Eligible dependents include adult children under 26 years of age who are not eligible for other employer-sponsored health plan coverage (other than the group health plan of a parent) and without regard to marital or student status, dependency for financial support, or residency with a participant (page 26).
   b. The Student Self-Payment Program was terminated due to the extension of dependent coverage for adult children to age 26 and the removal of student certification as a requirement for continued dependent coverage.

6. SELF-FUNDED COMPREHENSIVE MEDICAL PLAN
   a. Effective December 20, 2006, the advance or loan provision for third party liability claims was reinstated and made applicable to injury or illness caused by a third party on and after March 9, 2005.
   b. Effective May 1, 2007, the Human Papilloma Virus (HPV) Quadrivalent vaccine is a covered immunization when the first dose is administered to an 11-12 year old girl, with the second or third dose administered prior to 13 years of age (page 45).
   c. Effective October 1, 2007, the meningococcal vaccine and rotavirus vaccine are covered under the Immunizations benefit (page 45).
   d. Effective January 1, 2008:
      1) The Human Papilloma Virus (HPV) Quadrivalent vaccine is a covered benefit for female beneficiaries 13 through 18 years of age at 50% of Eligible Charges (page 45).
2) Benefits for “Life Bed” electronic monitoring services are covered under Hospital Inpatient Services with prior authorization (page 48).

e. Effective July 1, 2008:
   1) The coverage for screening by low-dose mammography for women ages 40 and above was changed (page 50).
   2) The section entitled “If Hospitalized on your Effective Date” was revised (page 65).

f. Effective January 1, 2009:
   1) Services of Licensed Mental Health Counselors and Marriage and Family Therapists are covered under the Mental Illness and Alcohol or Drug Dependence benefits (pages 57-59).
   2) Longs Drugs pharmacies statewide were added as participating medical providers for dispensing immunization vaccines ordered by physicians. When you pick up your immunization vaccine from a Longs Drugs pharmacy, your copayment is 20% of the Eligible Charge for the vaccine.

g. Effective August 1, 2009, the Third Party Liability provision was amended (page 67).

h. Effective January 1, 2010, the benefit limitations under the Mental Illness and Alcohol or Drug Dependence benefits were changed (pages 57-59).

i. Effective January 1, 2011, in accordance with the Patient Protection and Affordable Care Act:
   1) The Annual Maximum benefit amount available was increased to $750,000 per person per calendar year.
   2) The Lifetime Maximum limit on the dollar value of essential health benefits payable no longer applies (page 37).

j. Effective March 1, 2011:
   1) All non-emergency out-of-state services require prior authorization (pages 41 and 69).
   2) The Eligible Charge for out-of-state services shall not exceed 150% of the Eligible Charge for the same services rendered in the State of Hawaii (page 69).

k. Effective October 1, 2011, the Plan provides coverage for one intrauterine device (IUD) implant for contraceptive purposes every five years at 50% of Eligible Charges (page 61).

l. Effective January 1, 2012, the Annual Maximum benefit amount available was increased to $1,250,000 per person per calendar year (page 36).

m. Effective September 1, 2012, the Plan will reimburse Neighbor Island beneficiaries for qualified inter-island travel expenses related to obtaining non-emergency medically necessary services which are not available on the island where the beneficiary resides, subject to prior authorization (page 63).
7. INDEMNITY PRESCRIPTION DRUG PLAN

a. Effective February 1, 2009:
   1) The Central Fill Program for long-term (maintenance) prescriptions is no longer available through Times pharmacies. Central Fill prescriptions may be filled at other designated pharmacies.
   2) The day supply limit under the Direct Reimbursement and Point-of-Service Programs is 15 days (pages 72 and 73).

b. Effective July 1, 2009, Prilosec OTC (Over the Counter) may be obtained with no copayment through Point of Service Program participating pharmacies. A physician’s prescription is required (page 70).

c. Effective August 1, 2009, the Mail Order Program for participants that reside in the State of Hawaii is through CVS Longs Drugs.

d. Effective January 1, 2012:
   1) Oral contraception is a covered benefit; however, coverage is limited to generic oral medications. For brand name medications with a generic equivalent, Prior Authorization from the Pharmacy Benefits Manager is required to be covered under the Plan (page 71).
   2) Beneficiaries who obtain a brand name medication with a generic equivalent will pay the applicable copayment plus the cost difference between the brand name medication and the generic equivalent. Beneficiaries who require the brand name medication in place of the generic equivalent must obtain Prior Authorization from the Pharmacy Benefits Manager (page 71).
   3) Quantity limitations will be placed on certain medications as recommended by the Food and Drug Administration (FDA). Beneficiaries requiring more than the recommended quantity per prescription must obtain Prior Authorization from the Pharmacy Benefits Manager (page 71).
   4) Step Therapy programs will be implemented for certain therapeutic drug categories. Beneficiaries who are prescribed a medication in one of these drug categories will be required to try a preferred medication prior to obtaining a non-preferred medication. Non-preferred medications will be covered only with Prior Authorization from the Pharmacy Benefits Manager (page 71).

8. KAISER MEDICAL PLAN

a. Effective January 1, 2007:
   1) The copayment for office visits and laboratory, imaging, and testing services was increased to $15.00 per visit.
   2) Injectable and oral travel immunizations are no longer covered.

b. Effective January 1, 2008:
   1) The copayment for emergency room visits was increased to $50.00 per visit.
   2) The copayment for inpatient services was increased to $50.00 per day.
3) The supplemental charges maximums were increased to $2,000 per person and $6,000 per family.

c. Effective January 1, 2010:
   1) The copayment for emergency room visits was increased to $75.00 per visit (page 77).
   2) The copayment for hospital inpatient services was increased to $75.00 per day (page 76).
   3) The supplemental charges maximums were increased to $2,500 per person and $7,500 per family.
   4) There is a lifetime maximum of $3,000,000 per person.

d. Effective January 1, 2011:
   1) The lifetime maximum is unlimited (page 78).
   2) The copayment for prescription drugs was increased to $12.00 per prescription (page 87).

e. Effective July 1, 2012:
   1) The copayment for office visits and outpatient laboratory, imaging, and testing services was increased to $18.00 per visit (page 76).
   2) The supplemental charges maximums were increased to $2,900 per person and $8,700 per family (page 78).

9 INDEMNITY VISION CARE PLAN
   a. Effective September 1, 2007, the vision care allowances were increased (page 91).

10. GENTLE DENTAL PLAN
   a. Effective January 1, 2007, the office visit copayment was increased to $10.00 per visit (page 102).
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INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

(Not provided elsewhere in this booklet)

PLAN SPONSOR AND ADMINISTRATOR
Board of Trustees
 c/o AFL Hotel and Restaurant Workers Health and Welfare Trust Fund
 560 N. Nimitz Highway, Suite 209
  Honolulu, Hawaii 96817-5315
Phone: Oahu (808) 523-0199
   Neighbor Islands toll free (866) 772-8989

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 participants and beneficiaries upon written request to the Plan Administrator.

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

TYPE OF PLAN
  Welfare - medical, prescription drug, vision care, chiropractic care, employee assistance program, dental, and death benefits.

TYPE OF ADMINISTRATION
  The Board of Trustees has engaged Benefit & Risk Management Services, Inc. at 560 N. 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
Carla Jacobs
Administrator
 c/o Benefit & Risk Management Services, Inc.
 560 N. 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 EACH TRUSTEE

EMPLOYER TRUSTEES

Ernest Nishizaki
Executive Vice President
Kyo-ya Company, LLC
2255 Kalakaua Avenue
Honolulu, Hawaii 96815

Nona Tamanaha
Regional Director
of Human Resources
Starwood Hotels & Resorts
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Honolulu, Hawaii 96815

Julie Walker
Director of Human Resources
Hilton Hawaiian Village
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Kevin M. Gleason (Alternate)
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Carla Thomas (Alternate)
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Koloa, Hawaii 96756

UNION TRUSTEES

Eric Gill
Financial Secretary – Treasurer
UNITE H.E.R.E. Local 5
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Honolulu, Hawaii 96826

Hernando Tan
President
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Doryne Jardine (Alternate)
Member and Staff Service Supervisor
UNITE H.E.R.E. Local 5
1516 S. 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 H.E.R.E. Local 5 Hawaii, and various Hawaii hotels and restaurants and other employers.

A copy of the Collective Bargaining Agreements may be obtained by participants and beneficiaries upon written request to the Contract Administrator and is available for examination by participants and beneficiaries at the Trust Fund Office.
SOURCE OF CONTRIBUTIONS

The funds out of which all benefits and expenses are paid are contributed by 1) employers who are parties to the Collective Bargaining Agreements, 2) the Union on behalf of its staff employees, and 3) active and retired participants (i.e., self-payments and COBRA payments). The amount of employer contributions is calculated by multiplying the contribution rate specified in the Collective Bargaining Agreement by the number of hours worked during the month by each covered employee. 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 First Hawaiian Bank, Main Branch, in Honolulu which serves as a Depository 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 as directed by the Contract Administrator. Self-Funded Comprehensive Medical, Indemnity Vision Care, and Indemnity Chiropractic Care (not available to Kaiser bargaining unit employees) benefits are paid for by the Trust Fund through Hawaii-Mainland Administrators, LLC, which handles the claims administration services for these programs. Indemnity Prescription Drug benefits are paid for by the Trust Fund through Catamaran, the Pharmacy Benefits Manager which handles the claims administration services for this program. Death benefits are paid for directly by the Trust Fund. Funds in excess of those needed for immediate requirements are held in savings accounts, Time Certificates of Deposit, and other investments in accordance with investment guidelines determined by the Trustees.

FISCAL YEAR

January 1 through December 31.

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, or 3) amend or eliminate benefits available under the Plan, at any time.

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 signing a written document.

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

If AFL Hotel and Restaurant Workers Health and Welfare Trust Fund 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 Trust Fund, should contact the insurance carriers of your choice for information on conversion to an individual plan offered by the respective insurance carriers.

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.
# IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

The following is a reference list for the Trust Fund’s service providers:

<table>
<thead>
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<th>Contact the following</th>
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</table>
| Eligibility, benefits | Trust Fund Office  
c/o Benefit & Risk Management Services, Inc.  
560 N. Nimitz Highway, Suite 209  
Honolulu, Hawaii 96817-5315  
Oahu: 523-0199  
Neighbor Islands: 1 (866) 772-8989  
*Contract Administrator for the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund.* |
| Self-Funded Comprehensive Medical Plan | Hawaii-Mainland Administrators, LLC (HMA)  
1440 Kapiolani Boulevard, Suite 1020  
Honolulu, Hawaii 96814  
Oahu: 951-4621  
Neighbor Islands: 1 (866) 377-3977  
*Provides claims administration services for the Self-Funded Comprehensive Medical, Indemnity Vision Care, and Indemnity Chiropractic Care plans.* |
| Participating Providers Preadmission Review Prior Authorization Medical Necessity Claims Processing |  |
| HMO Plan Kaiser Permanente | Kaiser Permanente  
711 Kapiolani Boulevard  
Honolulu, Hawaii 96813  
Oahu: 432-5955  
Neighbor Islands: 1 (800) 966-5955  
*Provides prepaid medical and prescription drug benefits.* |
| Employee Assistance Benefits | Employee Assistance of the Pacific, LLC  
1221 Kapiolani Boulevard, Suite 730  
Honolulu, Hawaii 96814  
Oahu: 597-8222  
Neighbor Islands: 1 (877) 597-8222  
*Provides administration of the Employee Assistance Program.* |
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<td>Hawaii Dental Service</td>
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<tr>
<td></td>
<td>700 Bishop Street, Suite 700</td>
</tr>
<tr>
<td></td>
<td>Honolulu, Hawaii 96813-4196</td>
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<tr>
<td></td>
<td>Oahu: 529-9248</td>
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<td>Neighbor Islands: 1 (800) 232-2533 ext. 248</td>
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<td>Dental Care Centers</td>
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<td>of Hawaii (DCCH)</td>
<td>Dental Care Centers of Hawaii</td>
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<tr>
<td></td>
<td>95-1249 Meheula Parkway, Suite 115</td>
</tr>
<tr>
<td></td>
<td>Mililani, Hawaii 96789</td>
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<td></td>
<td>Oahu: 625-8630</td>
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<td>National Help Desk: 1 (888) 869-4600 or</td>
</tr>
<tr>
<td></td>
<td>1 (866) 251-3317</td>
</tr>
<tr>
<td>Claims Processing</td>
<td>Provides administration of the Indemnity Prescription Drug point of service, central fill, mail order, and direct member reimbursement programs.</td>
</tr>
</tbody>
</table>
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 H.E.R.E. Local 5 bargaining unit for an employer other than Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc., who has a signed collective bargaining agreement obligating the employer to contribute to the Trust Fund on your behalf at the negotiated 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.

ESTABLISHING ELIGIBILITY

To establish your initial eligibility for benefits, you must work at least 80 hours in a month. If you work at least 80 hours in any month, you will be eligible for benefits on the first day of the third consecutive month following the month in which you worked at least 80 hours.

Example: You work 80 hours in January and your employer made the required contribution in February. You will be eligible for benefits effective April 1st, the first day of the third calendar month.

New Employees

You are considered a “New Employee” if you have not been eligible for six consecutive months of eligibility in the past 12 months. New Employees are eligible for only medical, prescription drug, death, and EAP benefits for the first six months of continuous eligibility. On the seventh month of continuous eligibility, New Employees are eligible for vision and dental benefits.

CONTINUING ELIGIBILITY

Once you become eligible for benefits, your eligibility will continue on a month-to-month basis as long as you work at least 80 hours in each subsequent month and your employer makes the required contributions to the Trust Fund on your behalf. As long as you work at least 80 hours in each subsequent month, you will be eligible for benefits on the first day of the third consecutive month following that month.
HOUR BANK

All hours worked in excess of 80 hours in a month, up to a maximum of 40 hours per month, will be credited to your hour bank to be used for future eligibility. The maximum number of hours that may be accumulated in your hour bank is 100 hours.

Example: You work 100 hours in January. You will be eligible for benefits effective April 1st and 20 hours (100 hours – 80 hours = 20 hours) will be credited to your hour bank. You then work 130 hours in February. 80 hours will be used to continue your coverage through May and 40 hours will be credited to your hour bank. Your hour bank has now increased to 60 hours (20 hours + 40 hours = 60 hours). The remaining balance of 10 hours will not be credited to your hour bank since the maximum number of hours that may be accumulated in any month is 40 hours.

If you do not earn the required 80 hours needed for eligibility in any month, you may still retain eligibility by using the necessary amount of hours from your hour bank so that the total number of hours equals 80. If the total number of work hours plus your hour bank hours does not equal at least 80 hours, your eligibility will terminate as of the last day of the month for which you had sufficient hours for eligibility.

If you have not been eligible for a period of six consecutive months, any remaining hours in your hour bank will be reduced to zero (0).

IF YOU ARE DISABLED AND UNABLE TO WORK

Disability is defined as any illness or injury that prevents you from continuing work in the same capacity as prior to the onset of the illness or injury.

If while you are eligible for benefits you become disabled, you will be given credit for 20 hours of Credited Work per week of disability, up to a maximum of 900 hours total credits toward any disability in any 12 consecutive month period. When you return to work, either in the hotel industry or in any other type of employment, you will no longer continue to receive disability credits. No additional hours of credit will be given for any disability until you have requalified for eligibility as a new or continuing employee. After you have exhausted your eligibility extension under this provision, you may qualify for continuation of coverage under the Employee Self-Payment Program or the COBRA Program as explained on page 20.

You must have your doctor furnish proof that you are disabled and unable to work. Be sure to contact the Trust Fund Office and obtain the disability certification form for your doctor to complete. The disability certification form must be received by the Trust Fund Office within 60 days after the onset of your disability or within 60 days after the loss of eligibility due to a disability. Your disability must be certified by both your doctor and employer in terms of the length of time for your disability leave. Your right to disability credit will be denied if your disability certification form is not received within the stated time period, unless good cause is provided to the Board of Trustees.

Any employee who applies for disability credit under the above provisions shall provide the Trustees with such information as they may request in order to establish proof of eligibility or ineligibility for disability credits.
Failure to provide adequate responses to information requested by the Trustees shall result in ineligibility for disability credits.

WHAT ABOUT LEAVE OF ABSENCE?
If while eligible for benefits you are granted an authorized leave of absence (other than military leave) by an employer, you will be given credit for 20 hours of Credited Work per week of leave, up to a maximum of 600 hours total credits toward any one or subsequent leaves in any 12 consecutive month period. No additional hours of credit will be provided for any subsequent leave until you have requalified for eligibility as a new or continuing employee.

Be sure to have your Employer certify your authorized leave.
Leaves of absence covered under the Family and Medical Leave Act (FMLA) are described on page 20.

WHAT ABOUT STRIKES?
If while you are eligible for benefits a strike occurs, you will be given credit for 20 hours of Credited Work per week for the duration of the strike, up to a maximum of 300 hours for any one strike. If you lose coverage because of a strike, your eligibility shall be reinstated on the first day of the calendar month following the end of the strike upon resumption of employment with a contributing employer. Your coverage shall not again be subject to termination for failure to meet the minimum Credited Work requirement until you have been covered for a full Eligibility Quarter, provided you continue to be employed by a contributing employer.

LOSS OF ELIGIBILITY
You will continue to be eligible for benefits provided you continue to work the required number of hours for employers who make the required contribution to the Trust Fund. You will lose eligibility on the earliest of the following dates:
1. The last day of the calendar month for which you had the required 80 hours necessary for eligibility, or
2. The first day of the calendar month following the month in which you terminate your employment from an employer who contributes on your behalf to the Trust Fund, or
3. The first day of the second calendar month following the month in which your employer fails to make the contribution required by the Collective Bargaining Agreement, or
4. The date this Plan terminates.

Note: If your employer fails to make the required contributions on your behalf, your coverage will be reinstated prospectively on the first day of the second calendar month following the month in which your employer makes payment for the delinquent contribution. If you are already eligible due to hours from your hour bank or other work hours, then the hours up to 120 hours per month will be credited to your hour bank. However, your eligibility will not be terminated as long as you have sufficient hours in your hour bank for eligibility.
**IF YOU ENTER THE ARMED FORCES**

When you enter the Armed Forces, 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. 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 in December 2004.

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.

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 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.

For further information on the Family and Medical Leave Act, contact your employer.

**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 continue your coverage by electing one of the following options: 1) Employee Self-Payment Program or 2) COBRA Program. In addition, if you are covered under the Kaiser Plan, a conversion option may be available to you.

**Employee Self-Payment Program**

(Does not apply to retirees)

If you become ineligible for benefits and you were eligible immediately preceding your ineligibility, 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 for single coverage will be equal to 80 hours multiplied by the current contribution rate for the benefit package, which excludes HMO and retiree coverage. For family coverage, the amount you must pay each month will be equal to 140 hours multiplied by the current contribution rate for the benefit package, which excludes retiree coverage.

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 15TH DAY OF THE MONTH SHALL RESULT IN THE LOSS OF COVERAGE.

Contact the Trust Fund Office on Oahu at (808) 523-0199 or neighbor islands 1 (866) 772-8989 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 Trust Fund, in compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, currently offers qualified employees and dependents of employers 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 spouses and covered parents/legal guardians may elect COBRA for a 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.

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.
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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 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:

<table>
<thead>
<tr>
<th>Continued Coverage For</th>
<th>If/When</th>
<th>Maximum Period of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>You and your eligible dependents</td>
<td>You cease to be an Active Participant for reasons other than gross misconduct</td>
<td>18 months*,**</td>
</tr>
<tr>
<td>You and your eligible dependents</td>
<td>You become ineligible for coverage due to a reduction in your employment hours</td>
<td>18 months*,**</td>
</tr>
<tr>
<td>Your dependents</td>
<td>You die</td>
<td>36 months</td>
</tr>
<tr>
<td>Your spouse</td>
<td>You divorce or legally separate</td>
<td>36 months</td>
</tr>
<tr>
<td>Your dependent children</td>
<td>Your dependent children no longer qualify as dependents (for example, they reach age 26 or are no longer disabled)</td>
<td>36 months</td>
</tr>
<tr>
<td>Your dependents</td>
<td>You become covered for Medicare benefits</td>
<td>36 months***</td>
</tr>
</tbody>
</table>

* 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 within 60 days after the Social Security determination of disability is issued and before the 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. If the disability extension applies with respect to a Qualifying Event, it applies with respect to each Qualified Beneficiary entitled to COBRA continuation coverage because of that Qualifying Event. Thus, for example, the 29-month maximum coverage period applies to each Qualified Beneficiary who is not disabled as well as to the Qualified Beneficiary who is disabled, and it applies independently with respect to each of the Qualified Beneficiaries.

** 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 18-month COBRA period. Coverage may be extended for up to 36 months from the date they first qualified.

*** 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 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 should 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.**

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Election of 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. You, your spouse, and/or dependent children 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, chiropractic (Self-Funded Comprehensive Medical Plan only), dental, and death 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 amount required will be increased 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. 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. 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 otherwise would 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 Trust Fund is terminated,
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 group plan contains an exclusion or limitation with respect to any pre-existing condition, COBRA coverage may be continued until the end of the exclusion or limitation period.)

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

ENROLLMENT FORMS

In order to be covered for benefits, you and your eligible dependents must have a current Trust Fund enrollment form and all applicable insurance carrier enrollment forms 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 forms, listing your choice of medical and dental plans, 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 or adoption papers.

Newly hired employees and employees of employers who have just signed the Collective Bargaining Agreement should obtain their enrollment forms from the UNITE H.E.R.E. Local 5 Union Office, their Personnel Office, or the Trust Fund Office. The completed enrollment forms must be returned to the Trust Fund Office. The Trust Fund Office will process the insurance carrier enrollment forms and retain the Trust Fund enrollment form. No premiums will be paid until a Trust Fund enrollment form, the medical enrollment form, and the dental enrollment form are completed and filed with the Trust Fund Office. Upon receipt of the completed forms, you will be enrolled in the applicable medical and dental plans. No retroactive enrollment will be made.

It is also important to keep the Trust Fund Office informed of any changes in your personal or family situation or mailing address. Let the Trust Fund Office know if:
• You or your family members change mailing addresses or telephone numbers,
• You get married, divorced, widowed, or end a Domestic Partnership,
• You wish to add an additional dependent child (such as a new baby or an adopted child),
• You become disabled, or
• You or your dependent(s) become eligible for Medicare.

ELIGIBLE DEPENDENTS

Eligible dependents include your legal spouse and all children under 26 years of age, except for adult children who are eligible to enroll in another employer-sponsored health plan (other than a group health plan of a parent). 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. The term “children” includes natural children, stepchildren, legally adopted children, children under legal guardianship, and children placed in the home in anticipation of adoption.

You must submit an “Application for Dependent Addition” for each dependent added for coverage. The Board of Trustees may require any information necessary, including the signing of an affidavit, to determine the eligibility of a dependent under this section.
To add a 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. 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.

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. 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 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 January 1, 2010, the term “spouse” also includes Domestic Partners who are engaged in a Domestic Partnership and who are otherwise ineligible to marry under Hawaii law strictly because of gender. Benefits for Domestic Partners are limited to the Kaiser Medical and Prescription Drug Plan.

To qualify as a Domestic Partner, all of the following must be true. You and your partner:
1. Must be unable to marry under Hawaii law exclusively because you are of the same gender;
2. Must not be related by blood in such a way as to be prevented from marrying under Hawaii law;
3. Must be over the age of 18;
4. Must not be legally married to anyone else;
5. Must not be in a Domestic Partnership with anyone else;
6. Must have been living in a “spouse-like” arrangement for a minimum of 12 months with the intent of maintaining a long-term relationship. Evidence of your living arrangement must be provided in a form acceptable to the Trust Fund, including but not limited to:
a. Proof of two (2) items from the following list: joint bank account; joint lease or mortgage of mutual residence; joint billing statement (e.g. gas, electric, telephone, etc.); joint insurance documents (e.g. property, life, auto insurance); joint credit card accounts; joint automobile ownership; other titles or deeds which are jointly held; or cer-
tified copy of your Certificate of Civil Union issued by the State of Hawaii Department of Health.

b. Submission of tax returns as evidence of dependency status or completion of a notarized Affidavit of Dependency for Tax Purposes if your Domestic Partner and/or his or her dependents qualify as a dependent for tax purposes.

To add a qualified Domestic Partner, you must notify the Trust Fund Office by submitting the proper documentation as required by the Trust Fund, in writing, during the Annual Open Enrollment Period in the month of November. Coverage will be effective on January 1 of the following year. The dependent children of a qualified Domestic Partner enrolled in the Plan are eligible for coverage if they meet the Trust Fund’s eligibility criteria for dependent children.

**NOTE:** If your covered spouse and/or dependent children are working more than 20 hours per week for a four consecutive week period, he or she must obtain medical coverage for himself or herself through his or her employer, if it is available. If medical coverage for your working spouse and/or dependent children is not obtained as stated above, you will be assessed an amount presently equal to $40.00 per month to maintain coverage for your working spouse and dependent children covered under the Plan. Failure to remit the assessed amount on a timely basis will be cause for termination of coverage for each affected dependent.

**How to Continue Coverage when a Dependent Ceases to be Eligible for Dependent Coverage**

A former 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, or if enrolled in the Kaiser 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.

**Exclusions for Eligibility of Dependents:**

1. No person who permanently resides outside of the United States may be eligible for coverage under the Trust Fund.
2. An eligible person may be covered as either an employee or 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. In addition, 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. However, you must request enrollment within 30 days after the date of marriage, birth, adoption, or placement for adoption. 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 under Medicaid or CHIP, 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 a 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 Trust Fund (except to the extent required by law).

Any medical child support order 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 Trust Fund.

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 Trust Fund will be enrolled in the Trust Fund. 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.
CHOICE OF MEDICAL AND DENTAL PLANS

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 plans:

1. The Self-Funded Comprehensive Medical Plan which is available on all islands, or
2. The Kaiser Foundation Health Plan which is available on Oahu, Maui, Molokai, Lanai, Kauai, and the island of Hawaii.

If you choose the Self-Funded Comprehensive Medical Plan, you will be eligible for the Indemnity Plan prescription drug, vision care, and chiropractic benefits. If you choose the Kaiser Plan, you will be eligible for Kaiser’s prescription drug benefits and the Indemnity Plan’s vision care benefits.

If you reside outside the Kaiser Hawaii service area for more than 90 days, you are not eligible to enroll in the Kaiser Plan. If you are enrolled in the Kaiser Plan and subsequently move outside of the Kaiser Hawaii service area for more than 90 days, you will not be allowed to continue coverage under the Kaiser Plan and must enroll in the Self-Funded Comprehensive Medical Plan.

You may also choose one of the following two dental plans:

1. The Hawaii Dental Service (HDS) fee-for-service plan which is available on all islands, or
2. The Dental Care Centers of Hawaii (dba Gentle Dental) prepaid plan which is available on Oahu and Hawaii (Kona only).

The principal benefit provisions of the Self-Funded Comprehensive Medical, Kaiser, HDS, and Gentle Dental plans are summarized in this booklet. You should compare the benefits carefully before deciding which plans you want.

If you are a new employee, you should make sure that the Trust Fund Office has your enrollment form and the appropriate insurance carrier application forms, which list your dependents and choice of medical and dental plans.

OPEN ENROLLMENT PERIOD

You may change medical and 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 of the following year. No change between medical and dental plans may be made at any other time, except if:

1. You are enrolled in the Kaiser Plan and subsequently move outside of the Kaiser Hawaii service area for more than 90 days, or
2. You meet one of the requirements specified in the Special Enrollment Periods section on pages 28-29 of the Summary Plan Description.
WHAT EVIDENCE WILL I HAVE THAT I AM COVERED?

If you select the Self-Funded Comprehensive Medical Plan, Hawaii-Mainland Administrators, LLC (HMA) will mail you an ID card. If you select the Kaiser Plan, you will receive a membership card from Kaiser. Contact the Trust Fund Office if you have not received, or have lost, your membership card.

HOW TO OBTAIN BENEFITS

If you are a Self-Funded Comprehensive Medical Plan member, show the doctor, hospital, or laboratory your membership card issued by HMA. If you do not have your membership card when you are scheduling or seeking medical care, be sure to tell the provider in advance that you are a Self-Funded Comprehensive Medical Plan member and you belong to the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund.

If you are a Kaiser Plan member, show your Kaiser membership card whenever you go to the Kaiser Hospital or Clinic for services. If you do not have your membership card when you are scheduling medical care, be sure to tell the appointment clerk that you are a Kaiser Plan member and you belong to the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund.

If you do not have your membership card available, ask the doctor or facility rendering services to contact the Trust Fund Office to confirm your eligibility.

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.

An employee covered under a group plan will receive a certificate of creditable coverage issued by the insurance carrier or plan whenever a cancellation of coverage occurs. This certificate acknowledges “credit” for time covered under the health plan. The credit will be applied toward any exclusion period for a pre-existing condition which may be required under some individual and out-of-state plans. The term “pre-existing condition” is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months of enrolling in a new plan.

You will be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer if you request it before losing coverage or up to 24 months after losing coverage, when:

1. You lose coverage under the plan, or
2. You become entitled to elect COBRA continuation coverage, or
3. Your COBRA continuation coverage ceases.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for up to 12 months (18 months for late enrollees) after your enrollment date in a new plan.
Any certificates that you receive should be kept in a safe place. It will be important if you ever seek coverage under a health plan that has an exclusion period for a pre-existing condition.

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 caesarean 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)

In compliance with the Women’s Health and Cancer Rights Act, the Self-Funded Comprehensive Medical Plan and Kaiser Permanente Plan provide coverage for the following services in connection with a mastectomy:

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

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, the Self-Funded Comprehensive Medical Plan and Kaiser Permanente Plan implemented benefit changes in accordance with the Mental Health Parity and Addiction Equity Act of 2008, a Federal law that requires parity with respect to financial requirements and treatment limitations between mental health or substance abuse disorder benefits and medical/surgical benefits.

MICHELLE’S LAW

Effective January 1, 2010, when a serious illness or injury interrupts the ability of a dependent child who is covered as a full-time student from continuing to attend school, Federal law requires health plans to provide up to one year of continued coverage as though such dependent child was still attending school. However, such coverage shall not extend beyond the normal termination date for student coverage. At the end of the extension period or upon the termination of student coverage, the student may continue coverage under the COBRA Program, if applicable.

NOTE: Effective January 1, 2011, Michelle’s law does not apply to this Plan due to the removal of student certification as a requirement for continued dependent coverage.

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 coverage, provided through the Self-Funded Comprehensive Medical Plan, the Indemnity Prescription Drug Plan, and the Kaiser Permanente Plan, is a “grandfathered health plan” 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 N. 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.
SELF-FUNDED COMPREHENSIVE MEDICAL PLAN
(Self-Insured)

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

Hawaii-Mainland Administrators, LLC
1440 Kapiolani Boulevard, Suite 1020
Honolulu, Hawaii 96814
Phone: (808) 951-4621 or
Toll free: 1 (866) 377-3977

UNDERSTANDING THE SELF-FUNDED COMPREHENSIVE MEDICAL PLAN

The Self-Funded Comprehensive Medical Plan has been designed to cover a wide range of medical services while keeping the cost affordable. The Self-Funded Comprehensive Medical 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 Self-Funded Comprehensive Medical Plan.

Knowing what services the Self-Funded Comprehensive Medical 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 MAXIMUM

In accordance with the Patient Protection and Affordable Care Act, the total dollar value of benefits available under the Self-Funded Comprehensive Medical Plan, on an incurred basis, is $1,250,000 per person per calendar year. The Annual Maximum will increase to $2,000,000 per person per calendar year, effective January 1, 2013, and will be eliminated effective January 1, 2014.

In determining whether an individual has received benefits that meet or exceed the Annual Maximum, only payments made for essential health
**benefits** will be taken into account. If you have any questions about whether a particular service or item is an essential health benefit, contact the Claims Administrator.

**LIFETIME MAXIMUM**

Effective January 1, 2011, in accordance with the Patient Protection and Affordable Care Act, there is no Lifetime Maximum limit on the dollar value of **essential health benefits** paid or provided under this Plan on your behalf.

**MAXIMUM ANNUAL COPAYMENT**

Under the Self-Funded Comprehensive Medical Plan, the following Maximum Annual Copayments shall be applicable per calendar year:

<table>
<thead>
<tr>
<th>Employee Category</th>
<th>Maximum Annual Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active employees</td>
<td>$2,500 per person, $7,500 per family</td>
</tr>
<tr>
<td>Retired employees</td>
<td>$2,500 per person, $7,500 per family</td>
</tr>
</tbody>
</table>

If the above Maximum is reached, you owe no copayment for covered services for the rest of that calendar year. However, you will still owe non-participating providers all charges in excess of the Eligible Charges. The following payments do not count toward the Maximum Annual Copayment:

- Your copayments for prescription drug services, and
- Any benefit reduction as a result of not obtaining the required preapproval under the Care Management Program.

**CHOICE OF HEALTH CARE PROVIDERS**

You are free to go to a licensed physician of your choice and receive coverage under the Self-Funded 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 HMA, has contracted with physicians, hospitals, laboratories, and other health care providers throughout Hawai‘i to provide the medical services covered by this Plan. When you go to one of these **participating providers**, HMA 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 39).
Nonparticipating Providers
When you go to a nonparticipating provider, HMA has no contract with the provider to guarantee limited copayments. HMA 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 39).

ELIGIBLE CHARGES
Benefit payments are based on the Trust Fund’s determination of an Eligible Charge for a covered service. Here’s how the Trust Fund determines the Eligible Charge.

Participating Providers
Eligible Charges for covered services of participating providers are part of the contract between the Claims Administrator and each participating provider to guarantee you limited out-of-pocket payments.

Nonparticipating Providers
The Eligible Charge for physician and most medical services of nonparticipating providers is the lower of the following two charges:
• The Eligible Charge approved by the Trust Fund, or
• The actual charge to you.

Infrequent Services
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 is not available. In these cases, HMA’s Medical Consultants, who are qualified practicing physicians, will recommend the Eligible Charge by comparing the complexity of the infrequent service with similar, frequent services. The Trust Fund will make the final determination on this Eligible Charge.
HOW TO USE THE SELF-FUNDED COMPREHENSIVE MEDICAL PLAN

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

<table>
<thead>
<tr>
<th>If You Go to a</th>
<th>If You Go to a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Provider</td>
<td>Nonparticipating Provider</td>
</tr>
<tr>
<td>Plan Pays Provider – <strong>90%</strong> of the Eligible Charge</td>
<td>Plan Pays You – <strong>80%</strong> of the Eligible Charge</td>
</tr>
<tr>
<td>You Owe Provider – Copayment (<strong>10%</strong> of the Eligible Charge) and tax. You do not owe any amount above the Eligible Charge.</td>
<td>You Owe Provider – <strong>Total charge</strong>, made up of the Plan payment (<strong>80%</strong> of the Eligible Charge), your copayment (<strong>20%</strong> of the Eligible Charge), any amount of the Provider’s charge above the Eligible Charge, and tax.</td>
</tr>
</tbody>
</table>

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

You should ask your physician or call HMA 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 Self-Funded Comprehensive Medical Plan. Updated directories are available upon request from HMA.

KEEPING YOUR COVERAGE AFFORDABLE

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

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 HMA and your physician may not agree. When this happens, HMA’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.

HMA’s 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. HMA’s Medical Consultants will then consult with agencies and specialists outside the State of Hawaii. If more research is required, HMA 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 HMA’s Health Services Department for an evaluation before the service is performed. HMA’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 Self-Funded 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.

**CARE MANAGEMENT PROGRAM**

Under the Care Management Program, you (or your physician on your behalf) must call the HMA Health Services Department at 951-4621 (Neighbor Islands call toll free 1 (866) 377-3977) and obtain prior autho-
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 HMA Health Services Department within 48 hours or by the next working day.

**Authorizations and Requirements**

Prior Authorization: The following services require prior authorization through the HMA Health Services Department. Failure to obtain prior authorization may result in a reduction of benefits. You or your physician must call the HMA Health Services Department before the services are provided.

| INPATIENT ADMISSIONS       | • All inpatient admissions, including acute, skilled and observation stays*  
|                           | • Life bed electronic monitoring services |
| 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  
|                           | • Speech Therapy  
|                           | • Occupational Therapy |
| OTHER MEDICAL SERVICES    | • Durable Medical Equipment (DME)  
|                           | • Hospice Care  
|                           | • Home Health Services  
|                           | • Infusion Therapy  
|                           | • Human Growth Hormone Therapy |
| MENTAL HEALTH AND SUBSTANCE ABUSE 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

*For emergency or maternity admissions, you must notify the HMA Health Services Department within 48 hours or by the next business day, whichever is later.*

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**If you do not notify HMA’s Health Services 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 HMA’s Health Services Department. Before scheduling any of the listed Surgical Services, you (or your physician on your behalf) must notify HMA’s Health Services Department and request a Surgical Review. Based on the results of its Surgical Review, HMA 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**

Under the Care Management Program, 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 HMA’s Health Services 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, HMA’s Health Services Department will determine whether or not a second surgical opinion is required. If a second surgical opinion is required and arranged by HMA, 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, 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.**
SELF-FUNDED COMPREHENSIVE MEDICAL PLAN

The Self-Funded Comprehensive Medical Plan provides for payment of all covered services described in the following sections. The Plan pays a percentage of the Eligible Charge. The percentage that is not paid is your copayment. When your copayments for covered services reach $2,500 per person or $7,500 per family for the calendar year, the Plan then pays 100% of the Eligible Charge for covered services for the remainder of that calendar year.

PHYSICIAN SERVICES

<table>
<thead>
<tr>
<th>PHYSICIAN SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
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<tbody>
<tr>
<td>Physician Visits</td>
<td>You owe a copayment of 10% of Eligible Charges (You owe no copayment for a required second surgical opinion on the necessity of surgery if the second opinion is arranged by HMA)</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Baby Care Visits</td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Eight visits during the first two years of a child’s life, and one visit each year during ages two, three, four, and five. Well-baby immunizations are covered under Immunizations below. Well-baby routine laboratory tests are covered under Outpatient Laboratory and X-ray Services.</td>
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<td></td>
</tr>
<tr>
<td>PHYSICIAN SERVICES</td>
<td>PARTICIPATING PROVIDER</td>
<td>NONPARTICIPATING PROVIDER</td>
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<tr>
<td>----------------------------</td>
<td>-------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
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<tr>
<td>Cholera, diphtheria,</td>
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<tr>
<td>hepatitis, influenza,</td>
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<tr>
<td>measles, mumps, rubella,</td>
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<tr>
<td>whooping cough, polio,</td>
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<tr>
<td>smallpox, tetanus, typhoid,</td>
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<td></td>
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<tr>
<td>typhus, chicken pox,</td>
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<tr>
<td>human papilloma virus,</td>
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<tr>
<td>meningococcal, rotavirus,</td>
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<tr>
<td>and streptococcus pneumonia</td>
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<td>Notes for coverage</td>
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<tr>
<td>limitations.</td>
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<tr>
<td><strong>Hospital Visit</strong></td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
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<tr>
<td>One per day during an</td>
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<tr>
<td>inpatient confinement</td>
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<tr>
<td><strong>Skilled Nursing Facility Visit</strong></td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
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<tr>
<td>One per day during an</td>
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<tr>
<td>inpatient confinement, up to</td>
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<td></td>
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<tr>
<td>120 visits per calendar year</td>
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<tr>
<td><strong>Consultation Visit</strong></td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Medical or surgical, one</td>
<td></td>
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<tr>
<td>visit per specialty per</td>
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<tr>
<td>confinement in a hospital</td>
<td></td>
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<tr>
<td>or skilled nursing facility</td>
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<tr>
<td>as required by the</td>
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<tr>
<td>attending physician</td>
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<tr>
<td><strong>Surgery</strong></td>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Inpatient or outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHYSICIAN SERVICES</td>
<td>PARTICIPATING PROVIDER</td>
<td>NONPARTICIPATING PROVIDER</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges</td>
</tr>
</tbody>
</table>

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.

**PHYSICIAN SERVICES SPECIAL NOTES**

**Well-Baby Visits**

- When a well-baby visit cannot be scheduled within the 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 visits allowed is not exceeded.

**Immunizations**

- Human Papilloma Virus (HPV) quadrivalent vaccine is:
  - Covered when the first dose is administered to an 11-12 year old female with the second or third dose administered prior to 13 years of age.
  - 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 18 year old female with the second or third dose administered prior to 19 years of age.
- The Meningococcal vaccine is 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.
- The Rotavirus vaccine is 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.

**Surgical**

- 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.
• 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.
• 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.

Reconstructive Surgery
• The Plan will pay benefits for reconstructive surgery only when it is required to restore, reconstruct, and 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.)
• Reconstructive surgery of the breast on which a 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 lymphedemas, are covered when medically necessary.

Oral Surgery
• 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.
• Physician benefits are available for certain oral surgical services provided by a physician or a dentist. Services of a dentist are covered only when: a) the dentist is performing emergency services or surgical services and b) these services could also be performed by physicians (M.D. or D.O.).
• 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 Self-Funded 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, primary intrinsic tumors of the brain), liver (excluding liver transplants for metastatic malignancies to the liver, and Hepatitis B antigen or core antibody positive), heart, heart-lung, and lung. In addition, for active employees who have been continuously covered under this Plan for 12 consecutive months prior to transplant surgery, simultaneous kidney-pancreas transplants are covered up to a maximum of $120,000 per transplant. 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.

HOSPITAL INPATIENT SERVICES

<table>
<thead>
<tr>
<th>HOSPITAL INPATIENT SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 365 days per calendar year of hospital inpatient services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Room & Care**
Based on semi-private room rate
- You owe no copayment
- You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges

**Intermediate Care and Isolation Unit**
- You owe no copayment
- You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges

**Intensive Care or Coronary Care Unit**
Operated according to standards acceptable to the Trust Fund
- You owe no copayment
- You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
**HOSPITAL INPATIENT SERVICES**

<table>
<thead>
<tr>
<th>Services</th>
<th>Participating Provider</th>
<th>Nonparticipating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancillary Inpatient Services</td>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Operating room, surgical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>supplies, drugs, dressings,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospital anesthesia</td>
<td></td>
<td></td>
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<tr>
<td>services and supplies,</td>
<td></td>
<td></td>
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<tr>
<td>oxygen, antibiotics,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospital blood transfusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory and X-ray Services</td>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>X-ray films, Laboratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services and Diagnostic Tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Radiotherapy for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>treatment of malignancies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiotherapy for treatment of</td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>non-malignancies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HOSPITAL INPATIENT SERVICES SPECIAL NOTES**

- 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 a participating provider or 20% of Eligible Charges and the difference between actual and Eligible Charges for a nonparticipating provider. In no event will the Plan pay more than if the hospital charged separately for these services.
- If you choose to receive inpatient services in a private room, you may be responsible for additional room charges not covered by the Plan.
- 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.
- “Life Bed” electronic monitoring services are covered with prior authorization from the Claims Administrator.
# OUTPATIENT LABORATORY AND X-RAY SERVICES

<table>
<thead>
<tr>
<th>OUTPATIENT LABORATORY AND X-RAY SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services ordered by a physician for the diagnosis or treatment of an injury or illness</td>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td><strong>X-ray films, Radiotherapy for treatment of malignancies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory Services and Diagnostic Tests</strong></td>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td><strong>Routine Pap Smear</strong></td>
<td>Limited to one per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Prostate Specific Antigen Test</strong></td>
<td>Limited to one per calendar year for men age 50 and above</td>
<td></td>
</tr>
<tr>
<td><strong>Tuberculin Tine Test</strong></td>
<td>Limited to one per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Screening by Low-Dose Mammography</strong></td>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td><strong>Radiotherapy for treatment of non-malignancies</strong></td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
</tbody>
</table>
OUTPATIENT LABORATORY AND X-RAY SERVICES SPECIAL NOTES

- Laboratory tests in connection with well-baby care visits are limited to the following tests through age five: two tuberculin tests (tine or skin sensitivity), two blood tests (hemoglobin or hematocrit), and one urinalysis.
- Screening by low-dose mammography 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.

SKILLED NURSING FACILITY SERVICES

<table>
<thead>
<tr>
<th>SKILLED NURSING FACILITY SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 120 days per calendar year of skilled nursing facility services</td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td><strong>Room and Care</strong>&lt;br&gt;Based on semi-private room rate</td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td><strong>Inpatient Services</strong>&lt;br&gt;Routine surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics, and blood transfusion services</td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td><strong>Laboratory and X-ray Services</strong>&lt;br&gt;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 Laboratory and X-ray Services</td>
<td>See Outpatient Laboratory and X-ray Services for benefits</td>
<td></td>
</tr>
</tbody>
</table>

50
SKILLED NURSING FACILITY SERVICES SPECIAL NOTES

• To be eligible for benefits, the facility must meet Medicare standards and be approved by the Trust Fund’s Claims 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.
• Custodial care is not covered.

OUTPATIENT SURGICAL CENTER SERVICES

<table>
<thead>
<tr>
<th>OUTPATIENT SURGICAL CENTER SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating room, surgical supplies,</td>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>drugs, dressings, anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>services and supplies, oxygen,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>antibiotics, blood transfusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered services include routine</td>
<td>See Outpatient</td>
<td>See Outpatient Laboratory and X-ray Services for benefits</td>
</tr>
<tr>
<td>laboratory and X-ray services</td>
<td>Laboratory and X-ray</td>
<td></td>
</tr>
<tr>
<td>associated with the surgery.</td>
<td>Services for benefits</td>
<td></td>
</tr>
</tbody>
</table>

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 Claims Administrator.
HOME HEALTH CARE SERVICES

<table>
<thead>
<tr>
<th>HOME HEALTH CARE SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
<td></td>
</tr>
<tr>
<td>Up to 150 visits per calendar year for part-time skilled medical services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HOME HEALTH CARE SERVICES SPECIAL NOTES

- To be eligible for benefits, services must be provided by a qualified home health agency that meets Medicare standards and is approved by the Trust Fund’s Claims Administrator.
- Your physician must certify that a) you need skilled medical services because you are homebound due to an injury or illness, b) require part-time skilled health services, and c) 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.
- 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

<table>
<thead>
<tr>
<th>HOSPICE CARE SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>You owe no copayment</td>
<td>Not a benefit</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HOSPICE CARE SERVICES SPECIAL NOTES

- To be eligible for benefits, services must be received from a hospice agency which is under contract with the Trust Fund’s Claims 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.
• 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.

EMERGENCY SERVICES

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>See Physician Services for benefits</td>
<td>See Physician Services for benefits</td>
</tr>
<tr>
<td>Automobile Ambulance</td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Air Ambulance</td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
</tbody>
</table>

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
• Services must be received from a properly licensed or certified automobile or air ambulance service.
• Transportation must be for the purpose of emergency treatment and begin a) at the place where an injury or illness occurred or first required emergency care, or b) at the hospital or nursing facility of 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 service 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. The total amount paid for covered air ambulance services shall not exceed $15,000 per beneficiary per calendar year.

**MATERNITY SERVICES**

<table>
<thead>
<tr>
<th>MATERNITY SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>See Physician Services for benefits</td>
<td>See Physician Services for benefits</td>
</tr>
<tr>
<td>For pregnancy, childbirth, or other termination of pregnancy and related medical conditions; caesarean section and surgery; and routine nursery visits to newborn child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery for Complications of Pregnancy</td>
<td>See Physician Services for benefits</td>
<td>See Physician Services for benefits</td>
</tr>
<tr>
<td>Including ectopic pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Services</td>
<td>Participating Provider</td>
<td>Nonparticipating Provider</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Nurse-Midwife Services</td>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>See Hospital Inpatient Services for benefits</td>
<td>See Hospital Inpatient Services for benefits</td>
</tr>
<tr>
<td>Birthing Center Services</td>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>In Vitro Fertilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One procedure per lifetime,</td>
<td>See Hospital Inpatient Services for benefits</td>
<td>See Hospital Inpatient Services for benefits</td>
</tr>
<tr>
<td>whether successful or not, up</td>
<td></td>
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<tr>
<td>to a maximum of $5,000 for all</td>
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<tr>
<td>covered services (including</td>
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<tr>
<td>physician services, lab and</td>
<td></td>
<td></td>
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<tr>
<td>X-ray services and prescription</td>
<td></td>
<td></td>
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<tr>
<td>drugs), subject to limitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and exclusions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>See Hospital Inpatient Services for benefits</td>
<td>See Hospital Inpatient Services for benefits</td>
</tr>
<tr>
<td>Physician Services</td>
<td>See Physician Services for benefits</td>
<td>See Physician Services for benefits</td>
</tr>
<tr>
<td>Laboratory and X-ray Services</td>
<td>See Outpatient Laboratory and X-ray Services for benefits</td>
<td>See Outpatient Laboratory and X-ray Services for benefits</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>See Indemnity Prescription Drug section for benefits</td>
<td>See Indemnity Prescription Drug section for benefits</td>
</tr>
</tbody>
</table>
MATERNITY SERVICES SPECIAL NOTES

• The Self-Funded Comprehensive Medical Plan complies with the Federal Newborns’ and Mothers’ Health Protection Act. This law requires health plans that offer maternity coverage to allow mothers and their infants to stay in the hospital no less than 48 hours after a normal delivery and no less than 96 hours following a caesarean delivery. Your physician does not need to obtain authorization to prescribe a length of stay within these limits. However, the law generally does not prohibit the attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

• 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 Claims 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.

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

NOTE: Enrollment of your newborn child must be made through the Trust Fund Office and not through the Claims Administrator.

In Vitro Fertilization

Limitations:

• Only participants who have been covered under the Self-Funded Comprehensive Medical Plan for 12 consecutive months immediately preceding the in vitro fertilization procedure are eligible for these benefits. Coverage is limited to one procedure per lifetime whether successful or not. Benefits are limited to $5,000 for all covered services.

• Beneficiary’s oocytes are to be fertilized with beneficiary’s spouse’s sperm.

• 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 com-
monly 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 procedures are performed at medical facilities that conform to American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to American Fertility Society minimal standards for programs of in vitro fertilization.
- “Spouse” means the person lawfully married to the beneficiary under Hawaii State law.

Exclusions:

- Cost of equipment and of collection, storage, and processing of sperm.
- In vitro fertilization requiring the use of either donor sperm or donor eggs.
- Artificial insemination requiring the use of donor sperm.
- Services related to conception by artificial means, other than artificial insemination and in vitro fertilization as specified above.

MENTAL ILLNESS AND ALCOHOL OR DRUG DEPENDENCE SERVICES

<table>
<thead>
<tr>
<th>MENTAL ILLNESS AND ALCOHOL OR DRUG DEPENDENCE SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>INPATIENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital and Facility Services</td>
<td>See Hospital Inpatient Services for benefits</td>
<td>See Hospital Inpatient Services for benefits</td>
</tr>
<tr>
<td>Services received by a beneficiary as a registered bed patient in a Hospital or Qualified Treatment Facility shall count against the 365-day maximum for inpatient hospital benefits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### MENTAL ILLNESS AND ALCOHOL OR DRUG DEPENDENCE SERVICES

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist, Psychologist, Clinical Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist Services</td>
<td>See Physician Services for benefits</td>
<td>See Physician Services for benefits</td>
</tr>
</tbody>
</table>

**OUTPATIENT**

<table>
<thead>
<tr>
<th>Services</th>
<th>You owe a copayment of 10% of Eligible Charges</th>
<th>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Facility, Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist Services</td>
<td>You owe a copayment of 10% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
</tbody>
</table>

### MENTAL ILLNESS AND ALCOHOL OR DRUG DEPENDENCE SERVICES SPECIAL NOTES

**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.

**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.
General Limitations

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

Mental Illness Limitations

- 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 and Drug Dependence Limitations

- 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.

OTHER MEDICAL SERVICES

<table>
<thead>
<tr>
<th>OTHER MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER</th>
<th>NONPARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Testing</td>
<td>You owe no copayment</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>One testing series per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Treatment Materials</td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>OTHER MEDICAL SERVICES</td>
<td>PARTICIPATING PROVIDER</td>
<td>NONPARTICIPATING PROVIDER</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>Appliances and Durable Medical Equipment</strong></td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td><strong>Blood, Blood Products, and Blood Bank Service Charges</strong></td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Chemical agents and their administration (other than oral) for treatment of malignancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dialysis and Supplies</strong> (if not covered by Medicare)</td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td><strong>Evaluations for the Use of Hearing Aids</strong></td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>OTHER MEDICAL SERVICES</td>
<td>PARTICIPATING PROVIDER</td>
<td>NONPARTICIPATING PROVIDER</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Intrauterine Device (IUD) Implant for Contraceptive purposes</td>
<td>You owe a copayment of 50% of Eligible Charges</td>
<td>You owe a copayment of 50% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>One IUD implant every 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrient Solutions for Primary Diet prescribed by a Physician for Hereditary Metabolic Disorders</td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Outpatient Injections</td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Outpatient services and supplies for the injection or intravenous administration of medication or nutrient solutions required for primary diet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Physical therapy from a registered physical therapist (R.P.T.) or Registered Occupational Therapist (O.T.R.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Speech therapy from a certified speech therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transplant Donor Services</td>
<td>You owe a copayment of 20% of Eligible Charges</td>
<td>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</td>
</tr>
<tr>
<td>Services related to the donor or organ bank</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
OTHER MEDICAL SERVICES SPECIAL NOTES

Appliances and Durable Medical Equipment
• The Self-Funded Comprehensive Medical Plan pays benefits 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.

Limitations:
• The Plan will pay only for the Appliances and Durable Medical Equipment listed above.
• 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
• Benefits are 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 for which the Plan pays 90% of Eligible Charges for services of a participating or nonparticipating provider.
• If prior approval from the Trust Fund’s Claims Administrator is not received, no benefit will be paid.
• Total Plan payments shall not exceed $10,000 per beneficiary per calendar year.

Physical and Speech Therapy
• Physical therapy services must be rendered by a registered physical therapist (R.P.T.) or registered occupational therapist (O.T.R).
• Speech therapy services must be rendered by a certified speech therapist.
• Services must be ordered by a physician under an individual treatment plan.
• The outpatient therapy treatment plan prescribed by the physician must be submitted to the HMA Health Services 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.)
• For physical therapy, group exercise programs are not covered.
• Speech therapy for children with developmental learning disabilities (developmental delay) is not a benefit.

Transplant Donor Services
• Services related to the donor or organ bank (for bones, corneas, etc.) are covered only if a beneficiary is the recipient.
• 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

No benefits will be paid under the Self-Funded Comprehensive Medical Plan in connection with:
• Cosmetic services (services, supplies or drugs that may improve 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 doctor of optometry for the diagnosis and management of diseases and disorders of the visual system as well as diagnosis of related systemic conditions;
• 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, and 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 for well-baby care and the screening services provided under Outpatient Laboratory and X-ray Services;
• Services for work-related injuries or illnesses;
• Care furnished by government agencies and available at no cost to you;
• Expenses which you have no legal obligation to pay or for which no charge would be made if you had no health plan coverage;
• Services by a member of your immediate family or household;
• Services or expenses connected with confinement which is primarily for custodial or domiciliary care;
• Services due to acts of war (whether or not a state of war legally exists) or required during a period of active duty that exceeds 30 days in any armed forces;
• Reversal of sterilization;
• Fertilization by artificial means and all drugs or services related to the diagnosis or treatment of infertility (except for one in vitro fertilization program per married couple who qualify under Hawaii law);
• Services and prosthetic devices related to sex transformations or 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 this Plan;
• Weight loss or weight control programs;
• A physician’s waiting or stand-by time;
• Outpatient prescription drugs;
• 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 (e.g., experimental or investigative services);
• Services not described as covered in this booklet or the Self-Funded Comprehensive Medical Plan Document;
• 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 of eligibility under this Plan. 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:
<table>
<thead>
<tr>
<th>Patient</th>
<th>Employee’s Plan</th>
<th>Spouse’s Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>Employee’s Spouse</td>
<td>Secondary</td>
<td>Primary</td>
</tr>
<tr>
<td>Dependent Children*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee’s birthday is</td>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>earlier in the calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse’s birthday is</td>
<td>Secondary</td>
<td>Primary</td>
</tr>
<tr>
<td>earlier in the calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 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.

Once primary and secondary plans are determined, a claim may be filed (see “How to File Claims”). 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 Self-Funded 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 an employer or group health plan, applicable Federal laws or regulations will determine which plan is primary.
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 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 papers it requires to secure its rights of 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.

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 insur-
ance 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

HOW TO FILE CLAIMS FOR SELF-FUNDED COMPREHENSIVE MEDICAL PLAN BENEFITS

When you obtain the services of a physician or hospital:
• Present your HMA membership ID card. This card is for identification purposes only and does not guarantee eligibility for benefits.
• Be sure that the physician, hospital, and HMA have your correct mailing address.
• Ask your physician and/or the hospital 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 HMA after the one-year period will be denied.

PAYMENT OF MEDICAL BENEFITS

• If you go to a participating provider, payment will be made directly to the provider.
• If you go to a nonparticipating provider, payment will be made directly to you.
• HMA will mail you an Explanation of Benefits (EOB) after your claim has been processed showing the services performed, the amount charged, the amount allowed, and the amount paid by HMA.
• Retain your EOB and receipts for tax purposes. HMA will not be able to supply duplicate reports.

All provisions of the Self-Funded 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 HMA for assistance in locating a participating provider who will perform the required services. However, there is no guarantee that HMA will be able to find an out-of-state participating provider.

• If you receive services from a nonparticipating provider, send HMA a claim form signed by the provider and attach a copy of the itemized bill or receipt. (You can obtain claim forms from the HMA Office 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 HMA Health Services Department for out-of-state hospital admissions, services, or procedures before the services are received. For emergency or maternity admissions, you must notify HMA within 48 hours or by the next working day (see Care Management Program on pages 40-42).

• For covered services 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.

DISCLAIMER

None of the Self-Funded Comprehensive Medical Plan 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.

The preceding is for informational purposes only and is only a summary of coverage. Its contents are subject to the provisions of the Self-Funded 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 BENEFITS
(Self-Insured)

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

The Trust Fund has contracted Catamaran (formerly Catalyst Rx) 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 the Pharmacy Benefits Manager at:

CATAMARAN
National Help Desk
Toll Free: 1 (888) 869-4600
(Help is available 24 hours daily, 7 days a week)

DRUGS COVERED

The Indemnity Prescription Drug Plan will cover only medically necessary prescription drugs which are federally controlled and prescribed by a physician. However, although your physician may prescribe a particular prescription drug, this will not guarantee coverage under the Plan. If you have any questions about a particular prescription drug, ask your physician to submit a Prior Authorization Request Form to the Pharmacy Benefits Manager before the drug is dispensed.

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 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. Prior authorization is required.
- 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
- Over-the-Counter (OTC) Proton Pump Inhibitor (Prilosec OTC, Prevacid OTC, etc.)
- Eye and Ear Medications
- Miscellaneous: Gamma Globulin, Epinephrine, USP, Ephedrine Sulfate – 25 mg. (3/8 gr.), Ferrous Sulfate, USP
Oral Contraceptives

Effective January 1, 2012, oral contraception is a covered benefit. Coverage is limited to oral generic medications for the prevention of pregnancy. 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

Effective January 1, 2012, Step Therapy Programs were implemented in a few therapeutic medication categories such as nasally inhaled steroids and medications to treat acid reflux, severe heartburn, high blood pressure, and osteoporosis. A step therapy uses treatment guidelines to recommend drug therapy for medications that will work for the vast majority of patients with the least number of side effects and at the right economic price.

If you are prescribed a medication in one of these targeted drug categories, you will be required to try a preferred medication prior to obtaining a non-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.

Quantity Duration Management Program

Effective January 1, 2012, quantity level limits were placed on certain medications as recommended by the Food and Drug Administration (FDA). If you are prescribed one of these medications and require more than the recommended quantity per valid prescription, your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager.

Brand Name Medication with a Generic Equivalent

Effective January 1, 2012, Plan beneficiaries who obtain a brand name medication with a generic equivalent 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.

DRUGS NOT COVERED

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

- Injectable drugs, including injectable drugs administered by a physician or physician’s nurse, other than insulin and medications related to diabetes (Byetta, Victoza, etc.) (prior authorization is required for Byetta and Victoza);
- 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.

INDEMNITY PRESCRIPTION DRUG BENEFIT PROGRAMS

You have the following options for filling a prescription:
1. The Direct Member Reimbursement program,
2. The Point of Service program,
3. The Central Fill program, and
4. The Mail Order program.

To obtain services through the Point of Service or Central Fill Programs, you must use participating or designated pharmacies and present your HMA/Catalyst Rx identification card. To obtain prescriptions through the Mail Order Program, you must complete the mail order form which is available from the Pharmacy Benefits Manager. For a current list of participating pharmacies, contact the Trust Fund Office or the Pharmacy Benefits Manager.

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:

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.

Days Supply Limit

15 days*

* 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.catamaranrx.com.

Step 1: Present your HMA/Catalyst Rx 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 the Pharmacy Benefits Manager within 90 days from the date of purchase. Payment will be made directly to you.

Claim forms submitted for prescription drugs purchased from a participating Point of Service 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.

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

A short-term prescription is a prescription drug that you need for an acute or limited illness or injury, usually for less than fifteen (15) days. For short-term prescriptions, you may use the Point of Service program.

Under the Point of Service program, you pay the copayments listed below when you obtain your prescription drug from a participating pharmacy. For a current list of participating pharmacies, contact the Pharmacy Benefits Manager at 1 (888) 869-4600 or visit www.catamaranrx.com.

<table>
<thead>
<tr>
<th>Participating Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs, Insulin, Diabetic Supplies</td>
</tr>
<tr>
<td>Brand Name Drugs</td>
</tr>
<tr>
<td>Days Supply Limit</td>
</tr>
</tbody>
</table>

* 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.

CENTRAL FILL PROGRAM (through any Participating Central Fill Pharmacy)

If you need to obtain a long-term or maintenance prescription drug that you take daily or regularly, for more than a 15-day supply, 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 or visit www.catamaranrx.com.
To use the Central Fill Program:
Step 1: Go to the nearest Central Fill pharmacy and present your prescription and HMA/Catalyst Rx identification card.
Step 2: 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:

15-day Supply Limit
(1st time fill)
Generic Drugs, Insulin, Diabetic Supplies $6.00 copayment
Brand Name Drugs $18.00 copayment

Step 3: 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 (3) days before your prescription supply runs out and request a refill.
Step 4: Go to the Central Fill pharmacy and pick up your prescription refill for up to a 60-day supply at the following copayment:

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

MAIL ORDER PROGRAM
If you prefer to have your long-term prescription drugs delivered to your home or mailing address, you may use the Mail Order program. Under the Mail Order program, you may obtain up to a 60-day supply at the copayments listed below.

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

To use this program, contact the Pharmacy Benefits Manager for a Mail Order Registry and/or Brochure and mailing instructions.

The preceding Indemnity Prescription Drug benefits are self-insured 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. This document is on file with the Trust Fund Office. Please refer to this document for specific questions about coverage.
KAISER FOUNDATION
HEALTH PLAN, INC.

MEDICAL AND
PRESCRIPTION DRUG BENEFITS

The Kaiser Permanente Plan is designed to provide quality medical care at a reasonable cost. The Kaiser Permanente Plan provides prepaid medical and hospital services for members, as well as preventive health benefits like health evaluations.

When you join, you and other enrolled members of your family are encouraged to follow a health maintenance program with covered benefits such as periodic 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 and physicians. You may choose your personal doctor from a staff of over 450 highly qualified physicians representing all major specialties. 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.

A list of providers is included in the Kaiser Permanente Member Handbook which is provided to you at no charge.

LOCATIONS

For your convenience, Kaiser Permanente operates multiple outpatient facilities on Oahu, Maui, and the Big Island. On Kauai, Molokai, and Lanai, Kaiser Permanente has contracted with various independent physicians and pharmacies. You can obtain care at the facility or facilities of your choice. Members on Oahu receive hospital care in semiprivate rooms (private room, if medically necessary) at the Moanalua Medical Center. Members on Maui receive hospital care at the Maui Memorial Medical Center. Members on the Big Island receive hospital care at the Kona Community Hospital, Hilo Medical Center, or North Hawaii Community Hospital. Members on Kauai receive hospital care at the Samuel Mahelona Memorial Hospital, West Kauai Medical Center, or Wilcox Memorial Hospital. Members on Molokai receive hospital care at Molokai General Hospital and on Lanai, at Lanai Community Hospital.

For detailed information on the Kaiser Permanente locations, please contact the Customer Service Center at 432-5955 (Oahu), or 1 (800) 966-5955 (neighbor islands), or visit the website at www.kaiserpermanente.org.
OFFICE VISITS

You may schedule routine visits to physicians or other health professionals by calling in advance 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.

### BASIC MEDICAL BENEFITS

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>MEMBER COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTPATIENT SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Doctors’ and other health professionals’ office visits</td>
<td>$18.00 per visit</td>
</tr>
<tr>
<td>Health evaluations</td>
<td>$18.00 per visit</td>
</tr>
<tr>
<td>Preventive care office visits</td>
<td>No charge</td>
</tr>
<tr>
<td>• Well-child care visits (at birth and at ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months)</td>
<td>No charge</td>
</tr>
<tr>
<td>• Preventive care visits, one per calendar year for members 2 years of age and over</td>
<td>No charge</td>
</tr>
<tr>
<td>• Preventive gynecological visits, one per calendar year for female members</td>
<td>No charge</td>
</tr>
<tr>
<td>Eye exams for eyeglasses</td>
<td>$18.00 per visit</td>
</tr>
<tr>
<td>Outpatient surgery and procedures</td>
<td>$18.00 per visit</td>
</tr>
<tr>
<td>Short-term physical, speech, and occupational therapy</td>
<td>$18.00 per visit</td>
</tr>
<tr>
<td>Laboratory procedures</td>
<td>$18.00 per department per day</td>
</tr>
<tr>
<td>Imaging services</td>
<td>$18.00 per department per day</td>
</tr>
<tr>
<td>Diagnostic services</td>
<td>$18.00 per department per day</td>
</tr>
<tr>
<td>Radiation therapy</td>
<td>$18.00 per department per day</td>
</tr>
<tr>
<td>Routine immunizations</td>
<td>No charge</td>
</tr>
<tr>
<td>Unexpected mass immunizations</td>
<td>50% of applicable charges</td>
</tr>
<tr>
<td>Oral chemotherapy medications for the treatment of cancer</td>
<td>No charge</td>
</tr>
<tr>
<td>(Office visit copayment applies)</td>
<td></td>
</tr>
<tr>
<td>Casts and dressings</td>
<td>No charge</td>
</tr>
<tr>
<td>(Office visit copayment applies)</td>
<td></td>
</tr>
</tbody>
</table>

### HOSPITAL SERVICES

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>MEMBER COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and board – Semi-private, Private (when prescribed) or Intensive Care Unit</td>
<td>$75.00 per day</td>
</tr>
<tr>
<td>Operating room</td>
<td>No charge</td>
</tr>
<tr>
<td>Doctor’s medical and surgical services</td>
<td>No charge</td>
</tr>
<tr>
<td>Hospital anesthesia services</td>
<td>No charge</td>
</tr>
<tr>
<td>Drugs and dressings</td>
<td>No charge</td>
</tr>
<tr>
<td>Laboratory procedures, prescribed imaging, and other diagnostic services</td>
<td>No charge</td>
</tr>
<tr>
<td>Radiation therapy</td>
<td>No charge</td>
</tr>
<tr>
<td>Short-term physical, speech, and occupational therapy</td>
<td>No charge</td>
</tr>
</tbody>
</table>
SERVICES MEMBER COPAYMENT

Special duty nursing when prescribed ........................................No charge
Blood transfusions ........................................................................No charge

EXTENDED CARE SERVICES

Up to 60 days of extended care services in a
Skilled Nursing Facility per benefit period ...............................No charge

EMERGENCY CARE SERVICES

Coverage for initial emergency treatment only
At a facility in the Hawaii service area .................................................. $75.00 per visit, plus other applicable plan charges
At a facility outside the Hawaii service area ...........................................20% of applicable charges, plus other applicable plan charges

OBSTETRICAL CARE, FAMILY PLANNING, AND INFERTILITY SERVICES

Doctors’ services (prenatal, delivery, and care in hospital)........No charge
Routine care for newborn during mother’s hospital stay ........No charge
Caesarean sections (medically necessary) .................................No charge
Elective interrupted pregnancy
(limited to two procedures per lifetime) .................................$18.00 per visit
In vitro fertilization .................................................................20% of applicable charges
• Limited to one procedure per lifetime under Kaiser Permanente
• Limited to female members using spouse’s sperm
Family planning services ..........................................................$18.00 per visit
Infertility services (not including lab, prescription drugs) ...............................$18.00 per visit
Contraceptive drugs and devices (FDA approved)
to prevent unwanted pregnancies .........50% of applicable charges

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

Outpatient Services .................................................................$18.00 per visit
Hospital Inpatient Care ...........................................................$75.00 per day
(Hospital care includes services of physicians and mental health professionals or physician’s visits in a Specialized Facility)
Specialized Facility Services
(Services in a specialized mental health or chemical dependence treatment unit or facility approved by the Hawaii Permanente Medical Group)
Day treatment or partial hospitalization services ...........$18.00 per visit
Non-hospital residential services ..............................................$75.00 per day

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SERVICES

MEMBER COPAYMENT

OTHER SERVICES
Prescribed drugs that are on the Formulary and must be administered at Kaiser Permanente Medical Offices, Emergency Departments or urgent care centers ........................................No charge for most drugs (Office visit copayment applies)
Ambulance services ...........................................20% of applicable charges, plus any charges above applicable charges
Home health services for homebound members (when prescribed by a Kaiser Permanente physician) ..........................................................No charge for nurse and home health aide visits
Hospice Care ................................................................................No charge
Internal prosthetics, devices, and aids ..........................................No charge

LIFETIME MAXIMUM ..........................................................Unlimited

SUPPLEMENTAL CHARGES MAXIMUM
Your out-of-pocket expenses for covered Basic Health Services are capped each year by a Supplemental Charges Maximum $2,900 per member, $8,700 per family unit (3 or more members), for a calendar year

You must retain your receipts for the charges you have paid, and when the maximum amount has been paid, you must present these receipts to Kaiser’s Business Office at the following locations: Moanalua Medical Center, Honolulu Clinic, Waipio Clinic, or to the cashier at other clinics, or the Patient Accounting Office at 711 Kapiolani Blvd., Honolulu, Hawaii 96813. After verification that the Supplemental Charges Maximum has been paid, you will be given a card which indicates that no additional Supplemental Charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits to get the Supplemental Charges waived.

All payments are credited toward the calendar year in which the services were received.

Once you have met the Supplemental Charges Maximum, please submit your proof of payment as soon as reasonably possible. No refunds will be made for receipts turned in after February 28 of the year following the one in which the services were received.

Basic Health Services include covered: office visits, hospital services, short-term physical, speech, and occupational therapy, obstetrical care, laboratory, diagnostic testing procedures, x-rays, radiation therapy, emergency and ambulance services, in vitro fertilization (not including drugs), immunizations, and mental health services and chemical dependence services.

Some benefits are not considered Basic Health Services. These include,
but are not limited to: allergy test and treatment materials, radioactive materials, charges for blood, prescribed drugs, contraceptive drugs and devices, complementary alternative medicine, dental services, prostheses, durable medical equipment, braces, diabetes supplies and equipment, medical foods, injectable and oral travel immunizations, charges above reasonable and customary charges, charges above Medicare approved charges, and skilled nursing facility charges. Your payments for these items and excluded and non-covered services do not count toward the Supplemental Charges Maximum.

EMERGENCY SERVICES

GENERAL PROVISIONS

Emergency medical conditions need immediate medical attention to avoid a serious threat to your body or your health. These conditions might include:

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

If you think you are having an emergency, go immediately to the Emergency Department. Do not take the time to call Kaiser Permanente as precious time may be wasted. If you think you need an ambulance, call 911.

Emergency services (when judged to be an emergency) or ambulance services (when judged to be medically necessary) will be paid in accordance with your health plan benefits. Emergency Room visits that do not meet the prudent layperson definition of an emergency will be deemed non-emergent and will not be covered.

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. This must be done, 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.

Emergency care is available seven days a week, 24 hours a day at Kaiser Permanente’s Moanalua Medical Center, 3288 Moanalua Road, Honolulu, Hawaii 96819, phone: (808) 432-0000. On the neighbor islands, emergency care is available seven days a week, 24 hours a day at these facilities:

- Maui: Maui Memorial Medical Center
- Hawaii: Hilo Medical Center
- Kona: Community Hospital
- North Hawaii Community Hospital

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CARE RECEIVED OUTSIDE THE KAISER PERMANENTE SYSTEM

The only care from non-Kaiser Permanente practitioners or providers that may be covered are:

- Authorized referrals when your Kaiser Permanente physician refers you for care that is not available from Kaiser Permanente,
- Emergency care, and
- Out-of-area urgent care when you temporarily travel outside the Hawaii service area.

Outside the Hawaii service area, benefits are limited to authorized referrals (when your Kaiser Permanente physician determines the services you require are not available in the Hawaii service area), emergency benefits, ambulance services, and out-of-area urgent care when you are temporarily away from the Hawaii service area. Urgent care means initial care for a sudden and unforeseen illness or injury when:

- You are temporarily away from the Hawaii service area,
- The care is required to prevent serious deterioration of your health, and
- The care cannot be delayed until the member is medically able to safely return to the Hawaii service area or travel to a Kaiser Permanente facility in another Health Plan region.

Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered. When you are temporarily traveling outside the Hawaii service area, you may require medical services for emergency or urgent problems. Please have your 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.

Services at other Kaiser Permanente region’s facilities are provided while you are temporarily visiting the area for less than 90 days. Visiting member services are different from the coverage you receive in your home region. Be sure you have your ID card with you at all times. The visiting member program is not a plan benefit, but a service offered to members as a courtesy. Changes to the program may occur at any time.

Health Plan will terminate the membership of members who move anywhere outside the Hawaii service area. Until that time, you will only be covered for initial emergency care in accordance with your Health Plan benefits. Before you move outside the Hawaii service area, you should contact the Trust Fund Office to discuss your options.
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, therapeutic or diagnostic 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, such as eyeglasses, corrective lenses, and hearing aids.
- 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, fresh frozen plasma, and Rh immune globulin. Donor directed units are not covered. There is no charge to Medicare members for blood, blood products, blood derivatives, or blood components covered under Medicare or for their administration.
- Cardiac rehabilitation.
- Chiropractic services, except Medicare members are entitled to manual manipulation of the spine to correct subluxation when prescribed by a Kaiser Permanente physician and performed by a Health Plan designated provider.
- Services for confined members (confined in criminal institutions or quarantined).
- 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 physical appearance, which will not 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 x-rays, dental implants, dental appliances, or orthodontia and services relating to Temporomandibular Joint Dysfunction (TMJ) or Craniomandibular Pain Syndrome.
- Durable medical equipment, such as crutches, canes, oxygen-dispensing equipment, hospital beds, and wheelchairs used in the member’s home (including an institution used as his or her home), except diabetes glucose monitors and external insulin pumps for non-Medicare members. Medicare members are covered for DME as provided for under Medicare.
- 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.
- External prosthetic devices, such as artificial limbs, except Medicare covered devices for Medicare members.
- Eye examinations for contact lenses and vision therapy, including orthoptics, visual training and eye exercises.
- Eye surgery solely for the purpose of correcting refractive defects of the eye, such as Radial keratotomy (RK), and Photo-refractive keratectomy (PRK).
- Routine foot care, unless medically necessary.
- Health education: specialized health promotion classes and support groups (such as the bariatric surgery program).
- Homemaker services.
- The following costs and services for infertility treatment, in vitro fertilization or artificial insemination:
  - The cost of equipment and of collection, storage, and processing of sperm.
  - In vitro fertilization using either donor sperm or donor eggs.
  - In vitro fertilization that does not meet state law requirements.
  - Services related to conception by artificial means other than artificial insemination or in vitro fertilization, such as ovum transplants, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT); including prescription drugs related to such services and donor sperm and donor eggs used for such services.
  - Services to reverse voluntary, surgically-induced infertility.
- 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; physical, occupational, and speech therapy deficits due to developmental delay; therapies not expected to result in significant, measurable improvement in physical function with short-term therapy.
- Services not generally and customarily available in the Hawaii Region 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.
- All services, drugs, prosthetics, devices, or surgery related to gender reassignment.
- Take-home supplies for home use, such as bandages, gauze, tape, antiseptics, ace type bandages, drug and ostomy supplies, catheters and tubing, except Medicare covered take home supplies for Medicare members.
- The following costs and services for transplants:
  - Non-human and artificial organs and their transplantation.
  - Bone marrow transplants associated with high-dose chemotherapy for the treatment of solid tumors, except for germ cell tumors and neuroblastoma in children.
- 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:

- 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.
- 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.
- Members are covered for contraceptive drugs and devices only when the prescription drugs meet all of the following criteria: 1) prescribed by a licensed Prescriber, 2) the drug is one for which a prescription is required by law, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc.
- Internally implanted prosthetics, devices, and aids (such as pacemakers, hip joints, surgical mesh, stents, bone cement, bolts, screws, and rods) are subject to Medicare coverage guidelines and limitations.
- Diabetes equipment and supplies necessary to operate them are subject to Medicare coverage guidelines and limitations, must be preauthorized.
in writing by Kaiser Permanente, and obtained from a Health Plan designated vendor.

- Short-term physical, occupational and speech therapy services means medical services provided for those conditions which meet all of the following criteria: a) the therapy is ordered by a Physician under an individual treatment plan; b) in the judgment of a Physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy; c) the therapy is provided by or under the supervision of a Physician-designated licensed physical, speech, or occupational therapist, as appropriate; and d) as determined by a Physician, the therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury.

Neurological and/or musculoskeletal function is sufficient when one of the following first occurs: i) neurological and/or musculoskeletal function is the level of the average healthy person of the same age, ii) further significant functional gain is unlikely, or iii) the frequency and duration of therapy for a specific medical condition as specified in Kaiser Permanente Hawaii’s Clinical Practice Guidelines has been reached.

Occupational therapy is limited to hand rehabilitation services, and medical services to achieve improved self-care and other customary activities of daily living.

Speech-language pathology is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin.

- Tuberculin skin test is limited to one per calendar year, unless medically necessary.

- Transplant services for transplant donors. Health Plan will pay for medical services for living organ and tissue donors and prospective donors if the medical services meet all of the requirements below. 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.

THIRD PARTY LIABILITY, MOTOR VEHICLE ACCIDENTS AND SURROGACY HEALTH SERVICES

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.

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.

BINDING ARBITRATION

Except for certain situations outlined in your Group Medical and Hospital Service Agreement, all claims, disputes, or causes of action arising out of, or related to, your Group Medical and Hospital Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, are subject to binding arbitration. **For claims, disputes, or causes of action subject to binding arbitration, all parties give up the right to jury or court trial.** For a complete description of arbitration procedures, please refer to your Group Medical and Hospital Service Agreement, which you may obtain from your Trust Fund Office. After exhausting Kaiser Permanente’s internal appeals process, members with Employee Retirement Income Security Act (ERISA) benefit claims (whose plans are governed by ERISA) have the option of choosing binding arbitration or filing a lawsuit.
ADDITIONAL KAISER PERMANENTE INFORMATION

CUSTOMER SERVICE
When you need help, ask the Customer Service Center:
• Oahu: (808) 432-5955
• Neighbor Islands and outside the Hawaii service area: 1 (800) 966-5955
• TTY hearing/speech impaired: 1(877) 447-5990
• Phonenumber hours:
  Monday through Friday...............8:00 a.m. – 5:00 p.m.
  Saturday ................................8:00 a.m. – 12:00 noon
When you have questions, ask Kaiser Permanente. Kaiser Permanente can tell you about:
• Your benefits
• Claims and billing
• How to file an appeal
• Changing your address on Kaiser Permanente’s records
• Replacing your ID card
• Professional qualifications of primary and specialty practitioners

IDENTIFICATION CARD
Your Kaiser Permanente identification card is all that’s needed to receive care and services from Kaiser Permanente. Please carry it with you at all times. Use your identification card to register online, make appointments, fill prescriptions, and get care at Kaiser Permanente facilities. Write down your medical record number and keep it safe for reference.

Your identification card is good for a lifetime – as long as you remain a member. If you lose or damage your ID card or were a previous Kaiser Permanente Hawaii member and no longer have your ID card, call the Customer Service Center to request a new one. Both new and returning health plan members should carry a temporary ID (found on the last page of the enrollment form) for at least 30 days or, for first time Kaiser Permanente members, until the permanent one is mailed to your home.

It is a good idea to write down your Member Identification Number on the back of the booklet.

YOUR CURRENT ADDRESS
It is vitally important that Kaiser Permanente has your current address and phone number. “Partners in Health” and other publications are mailed regularly. Kaiser Permanente also may need to contact you quickly if a member of your family comes in for emergency treatment. Notify the Customer Service Center 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, you may apply for a Kaiser Permanente conversion membership under an individual account. However, you must apply within 30 days. Full details on how to retain your Kaiser Permanente membership are available from the Customer Service Center.

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 the Customer Service Center and/or a clinic pharmacy.

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>MEMBER COPAYMENT</th>
</tr>
</thead>
</table>
| 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,  
- On the Health Plan Formulary and used in accordance with Formulary criteria, guidelines, or restrictions,  
- The drug is one for which a prescription is required by law,  
- Obtained at pharmacies in the service area that are operated by Kaiser Foundation Hospital, or Kaiser Foundation Health Plan, Inc., or pharmacies Kaiser Permanente designates,  
- The drug does not require administration or observation by medical personnel.  
Insulin | $12.00 per prescription |
MAIL ORDER SERVICE

Members may also request refills of maintenance drugs through the mail order service, in which members are entitled to a 90-day supply for a $24.00 copayment. Please mail your refill order before you are down to your last 10 days supply. Allow one to two weeks to receive your medication for refillable orders.

EXCLUSIONS

The following are excluded from coverage under the Kaiser Permanente Prescription Drug Plan:

- Drugs for which a prescription is not required by law (e.g., over-the-counter drugs) including condoms, contraceptive foams and creams, or other non-prescription substances used individually or in conjunction with any other prescribed drug or device, except insulin is covered.
- Drugs and their associated dosage strengths and forms in the same therapeutic category as a non-prescription drug that has the same indications as the non-prescription drug.
- Prescribed drugs or supplies that are necessary or associated with services excluded or not covered under this plan.
- Drugs or supplies not included in the Kaiser Permanente Hawaii Drug Formulary unless a non-formulary drug or supply has been specifically prescribed and authorized by the licensed prescriber.
- Diabetes supplies such as blood glucose test strips, lancets, syringes and needles.
- Brand-name drugs requested by a member when there is a generic equivalent.
- Drugs to shorten the duration of the common cold.
- Drugs related to enhancing athletic performance (including weight training or bodybuilding).
- Any packaging other than the dispensing pharmacy's standard packaging.
- Replacement of lost, stolen, or damaged drugs.
- Immunizations, including travel immunizations.
- Contraceptive drugs and devices to prevent unwanted pregnancies.
- Abortion drugs.
- Non-prescription vitamins.
- Drugs when used primarily for cosmetic purposes.
- Drugs related to sexual dysfunction.
- Medical supplies such as dressings and antiseptics.
- Reusable devices such as blood glucose monitors and lancet cartridges.
- Drugs obtained from a pharmacy not operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy designated by Kaiser.
LIMITATIONS

Benefits and services are subject to the following limitations:

• The mail order program does not apply to certain pharmaceuticals such as controlled substances as determined by state or federal regulations, bulky items, medication affected by temperature, injectables, and other products and dosage forms as identified by the Pharmacy and Therapeutics Committee.

• Mail order drugs will not be sent to addresses outside the service area.

Your Kaiser Permanente membership contract entitles you to a maximum one-month supply per prescription (for each copayment, if applicable). It is the policy of Kaiser Permanente’s pharmacies, as a convenience to Kaiser Permanente members, to dispense as much as a three-month supply of certain prescriptions, if so requested. This is done in good faith, presuming the member will remain with Kaiser Permanente throughout the three-month period. If you terminate your membership with Kaiser Permanente before the end of the three-month period, you will be charged the retail price for your remaining drugs that exceed the one-month allowable supply.
OTHER KAISER PERMANENTE INFORMATION

Customer Service
Service assistance, individual plan enrollment, benefit information, out-of-plan emergency claims ................................................................. 432-5955
(Toll Free) 1 (800) 966-5955

Membership Accounting
Name and address changes, eligibility, group and direct pay billings ................................................................. 432-5310

Patient Accounting
Industrial, No-Fault, Tri Care, and filing other insurances ......... 432-5340

Mainland Kaiser Facilities
Kaiser Permanente offers medical care in the District of Columbia and eight (8) states (California, Colorado, Georgia, Maryland, Ohio, Oregon, Virginia, and Washington). If you need medical care while you are in one of these service areas, call for information during normal business hours. Kaiser Permanente service areas are subject to change at any time.

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 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 Kaiser Group Medical and Hospital Service Agreement and Face Sheet; Kaiser Permanente Group Plan Benefit Schedule; Laboratory, Imaging and Testing Rider; and Prescription Drug Rider 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.
INDEMNITY VISION CARE BENEFITS
(Self-Insured)

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund has contracted with Hawaii-Mainland Administrators, LLC (HMA) 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 HMA, you should contact HMA. HMA is only the Claims Administrator and does not guarantee benefits provided by the Plan.

Hawaii-Mainland Administrators, LLC
1440 Kapiolani Boulevard, Suite 1020
Honolulu, Hawaii 96814
Telephone: (808) 951-4621 or Toll Free: 1 (866) 377-3977

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 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 Plan.

WHAT ARE THE INDEMNITY 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.

The Trust Fund will pay up to the following amounts:

<table>
<thead>
<tr>
<th>Allowances</th>
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<tbody>
<tr>
<td>Eye Examination</td>
</tr>
<tr>
<td>Ophthalmologist (M.D.)</td>
</tr>
<tr>
<td>Optometrist (O.D.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appliances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single vision lenses and frame</td>
</tr>
<tr>
<td>Multifocal lenses and frame</td>
</tr>
<tr>
<td>Contact lenses</td>
</tr>
<tr>
<td>Frame only</td>
</tr>
</tbody>
</table>

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.
Exclusions

- 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

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

HOW ARE INDEMNITY 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 has 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 VISION CARE CLAIM

If you go to a participating provider:
- Present your HMA membership 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 HMA membership ID card to the provider of services.
- Send your receipt for payment of services and/or appliances to HMA 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 HMA after the 90-day period will be denied.
WHAT ABOUT OTHER VISION CARE COVERAGE?

If you or any of your eligible dependents have coverage under another group plan which is in any way sponsored, subsidized, or otherwise provided by or through an employer, any benefit payable by that other plan will be taken into consideration in determining the benefits payable by the Indemnity Vision Care Plan.

Vision care benefits are self-insured 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.
INDEMNITY CHIROPRACTIC BENEFITS
(Self-Insured)

If you are covered by the Self-Funded Comprehensive Medical Plan, you and your eligible dependents are eligible for chiropractic benefits.

WHAT ARE THE CHIROPRACTIC CARE BENEFITS?
You and your eligible dependents are eligible for 12 visits per calendar year from any licensed chiropractor.

The Trust Fund will pay as follows:
• $5.50 for each first office visit.
• $5.00 for each subsequent office visit.
• Up to $50.00 maximum for x-rays per calendar year.
Note: Home visits by a chiropractor are not covered.

HOW TO FILE A CHIROPRACTIC CLAIM
• Ask your chiropractor to file a claim form with the claims administrator, Hawaii-Mainland Administrators, LLC, on your behalf. You must arrange to pay the chiropractor the total charge for the chiropractic services. You will be reimbursed for payments made to chiropractors, up to the allowances shown above.

All claims must be filed within six months from the date services were rendered. Any claim received by HMA after the 6-month period will be denied.

Chiropractic benefits are self-insured 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 Chiropractic 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.
HAWAII DENTAL SERVICE

GETTING STARTED

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, view your own tooth chart, search for a participating dentist, view your Explanation of Benefits reports, and more!

To register:
1. Log on at www.deltadentalhi.org
2. Click on “New User”
3. Complete the “Member Registration” form
4. Click on “Register User” button

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

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 www.deltadentalhi.org 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 ensure HDS processes 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. 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 www.deltadentalhi.org 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 236,500 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 child 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 www.deltadentalhi.org and click on “Members/Find a Participating Dentist.” Click on the link at the bottom of the page to search for a Mainland dentist. Select “Delta Dental Premier” as your plan type. 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.

Because non-participating dentists have no agreement with HDS limiting the amount they can charge for services, your Patient Share is likely to be higher. Further, the amount reimbursed by HDS is generally lower if a non-participating dentist renders the services.

- On your first visit, advise the non-participating dentist that you have an HDS dental plan and present your HDS membership card.
- In most cases you will need to pay in full at the time of service.
- The non-participating dentist will render services and may send you the completed claim form (universal ADA claim form) to submit to HDS.

Mail the completed claim form for processing 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 Explanation of Benefits (EOB) report.

Whether you visit a participating or non-participating dentist, please be sure to let your dentist know that you have an HDS plan and 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.

You can receive EOBS through the mail or electronically. If you receive EOBS through the mail, you will not receive an EOB for services with no patient share or when only tax is due.
To receive EOBs electronically, register as a user on HDS’s website at www.deltadentalhi.org. Select “New User” and complete the “Member Registration” form. If you are already a registered user, login and select “Edit My Profile,” then select “yes” under “Request Electronic EOB.”

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).

<table>
<thead>
<tr>
<th>Dentist’s Allowed Amount</th>
<th>X % Plan Covers</th>
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</thead>
<tbody>
<tr>
<td>HDS Payment</td>
<td></td>
</tr>
<tr>
<td>Dentist’s Allowed Amount</td>
<td>&lt;minus HDS Payment&gt;</td>
</tr>
<tr>
<td>Patient Share</td>
<td></td>
</tr>
</tbody>
</table>

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(800) 232-2533 extension 248.

If you are not satisfied with the plan benefit determination, a request for reconsideration may be sent to the Director of Dental Claims within one year of the date of service. A copy of HDS’s claims appeal process may be obtained from Customer Service.

DUAL COVERAGE/COORDINATION OF BENEFITS

- Dual coverage is not allowed under the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund’s HDS dental plan.
- 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

Quality assurance 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(800) 505-9227
E-mail: HDSCompliance@hdsonline.org

SUMMARY OF DENTAL BENEFITS

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>PLAN COVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIAGNOSTIC</td>
<td></td>
</tr>
<tr>
<td>• Examinations</td>
<td>100%</td>
</tr>
<tr>
<td>• Bitewing x-rays</td>
<td>100%</td>
</tr>
<tr>
<td>• Other x-rays (full mouth limited to once every three years)</td>
<td>70%</td>
</tr>
<tr>
<td>PREVENTIVE</td>
<td></td>
</tr>
<tr>
<td>• Cleanings</td>
<td>100%</td>
</tr>
<tr>
<td>• Fluoride (through age 17)</td>
<td>70%</td>
</tr>
<tr>
<td>• Space maintainers (through age 17)</td>
<td>70%</td>
</tr>
<tr>
<td>RESTORATIVE</td>
<td>70%</td>
</tr>
<tr>
<td>• Amalgam (silver-colored) fillings</td>
<td></td>
</tr>
<tr>
<td>• Composite (white-colored) fillings – limited to the anterior (front) teeth</td>
<td></td>
</tr>
<tr>
<td>• Crowns and gold restorations (once every five years when teeth cannot be restored with amalgam or composite fillings)</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE</strong>: 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.</td>
<td></td>
</tr>
<tr>
<td>ENDODONTICS</td>
<td>70%</td>
</tr>
<tr>
<td>• Pulpal therapy</td>
<td></td>
</tr>
<tr>
<td>• Root canal treatment, retreatment, apexification, apicoectomy</td>
<td></td>
</tr>
</tbody>
</table>
## BENEFIT PLAN COVERS

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

### ORAL SURGERY

### ADJUNCTIVE GENERAL SERVICES
- Palliative treatment (for relief of pain but not to cure)

## BENEFIT 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.
- 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 the Schedule of Benefits, which is included in the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund’s dental contract.
HOW TO CONTACT HDS

HDS WEBSITE (www.deltadentalhi.org)
You can visit the website to:
• Check whether you and/or your dependents are eligible for HDS benefits
• Check what services are covered by your plan
• Search for an HDS participating dentist or Delta Dental participating dentist
• View your EOB statements
• Print an HDS membership card

VISIT HDS DENTEL
From Oahu: 545-7711
Toll free: 1-800-272-7204
HDS DenTel is an automated phone service that allows HDS members to:
• Find out when they are eligible for coverage for their next dental visit
• Obtain claims information
• Have a summary of their plan benefits faxed or mailed to them; simply by following the prompts on the phone.

CUSTOMER SERVICE REPRESENTATIVES
From Oahu: 529-9248
Toll free: 1 (800) 232-2533 ext. 248
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: HDSCustomerService@hdsonline.org

The preceding dental benefits are 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
(dba GENTLE DENTAL)

WHAT IS THE DENTAL CARE CENTERS OF HAWAII PLAN?
It 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 $10.00 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 AFL Hotel and Restaurant Workers Health and Welfare 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 of the Dental Care Centers.

CHOOSING YOUR OWN PERSONAL DENTIST
Each dental center 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.

MAJOR BENEFITS AND COVERED SERVICES

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>MEMBER COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>$10.00</td>
</tr>
<tr>
<td>Oral examinations</td>
<td>No charge</td>
</tr>
<tr>
<td>Full mouth x-ray</td>
<td>No charge</td>
</tr>
<tr>
<td>Panorgraphic x-ray</td>
<td>No charge</td>
</tr>
<tr>
<td>Each additional film</td>
<td>No charge</td>
</tr>
<tr>
<td>Emergency treatment</td>
<td>No charge</td>
</tr>
<tr>
<td>Prophylaxis (teeth cleaning)</td>
<td></td>
</tr>
<tr>
<td>Regular cleaning (semiannual)</td>
<td>No charge</td>
</tr>
<tr>
<td>Topical fluoride</td>
<td>No charge</td>
</tr>
<tr>
<td>Scaling and polishing</td>
<td>No charge</td>
</tr>
<tr>
<td>Restorative Dentistry (amalgam fillings)</td>
<td></td>
</tr>
<tr>
<td>Cavities involving one surface</td>
<td>No charge</td>
</tr>
<tr>
<td>Cavities involving two surfaces</td>
<td>No charge</td>
</tr>
<tr>
<td>Cavities involving three surfaces</td>
<td>No charge</td>
</tr>
</tbody>
</table>
BENEFIT MEMBER COPAYMENT

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

Orthodontics (Braces)
A discounted orthodontic program which covers 24 months of usual and customary treatment for your family at predetermined fees is available.

PRINCIPAL EXCLUSIONS AND LIMITATIONS
1. Cosmetic dentistry performed solely to improve appearance.
2. Dispensing of drugs.
3. Hospitalization when desired by the patient for any dental procedure.
4. Services reimbursable under any other insurance or health care plan.
5. Services for injuries or conditions covered by Workers’ Compensation or employer’s liability law.
6. Services which DCCH dentists do not feel are necessary for dental health.
7. Services that cannot be performed because of the general health of the patient.
8. Treatment required for conditions resulting from a major disaster or epidemic.

\(^1\)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.
WHAT IF I ALREADY HAVE 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.

OFFICE FACILITIES

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

DENTAL CARE CENTERS OF HAWAII LOCATIONS

(dba GENTLE DENTAL)

Gentle Dental Aiea/Pearlridge
Bank of Hawaii Building
98-211 Pali Momi Street, Suite 715
Aiea, Hawaii 96701
Phone: 488-8119

Gentle Dental Honolulu
1136 Union Mall, Suite 502
Honolulu, Hawaii 96813
Phone: 536-3405

Gentle Dental Makakilo
92-605 Makakilo Drive
Makakilo, Hawaii 96707
Phone: 672-0397

Gentle Dental Mililani
The Town Center of Mililani
95-1249 Meheula Parkway, Suite 115
Mililani, Hawaii 96789
Phone: 623-2888

Gentle Dental Waianae
86-078 Farrington Highway, Suite 210
Waianae, Hawaii 96792
Phone: 697-1310

PROVIDER:

Gentle Dental Kona
Crossroad Medical Center, #203
76-1028 Henry Street
Kailua Kona, Hawaii 96740
Phone: 329-4425
The preceding dental benefits are insured under a contract issued by Dental Care Centers of Hawaii, Inc. (DCCH), 95-1249 Meheula Parkway, Suite 115, 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.
EMPLOYEE ASSISTANCE PROGRAM
(PROVIDED THROUGH EMPLOYEE ASSISTANCE OF THE PACIFIC, LLC)

The AFL Hotel and Restaurant Workers Health and Welfare Trust Fund has contracted with the Employee Assistance of the Pacific, LLC to provide an employee assistance program.

WHAT IS THE EMPLOYEE ASSISTANCE PROGRAM?

Employers recognize that personal problems can interfere with an employee’s work and peace of mind. From time to time, each of us can use some assistance coping with life’s problems. The Employee Assistance Program (EAP) is a short-term counseling service which will assist you in identifying problems that may be interfering with your job or personal life and help you to resolve them.

The EAP can help you with:
- Marital/relationship issues
- Interpersonal difficulties (friends, co-workers)
- Depression, anxiety, stress
- Concerns regarding children and adolescents
- Substance misuse (alcohol and other drugs)
- Financial or legal referrals
- Referrals for child/elder care
- Other personal issues or concerns

HOW DOES THE EAP WORK?

Appointments can be arranged by calling the following:
- Oahu: 597-8222
- Neighbor Islands: 1 (877) 597-8222 (toll free)

Services are available on all islands. Staff members have flexible schedules and will try to arrange an appointment that is convenient for you.

WHAT ARE THE EAP BENEFITS?

There is no cost to you or your family members for this service.
- Employees are eligible for up to six sessions per calendar year.
- An employee’s dependent is eligible for up to four sessions per calendar year.
- If additional counseling or other services are needed, the eligible individual will be referred to an appropriate community resource or a provider who accepts the employee’s medical insurance.

CANCELLATIONS AND NO SHOWS

If you are not able to keep your appointment, call the Employee Assistance of the Pacific 24 hours in advance. No shows and appointments cancelled less than 24 hours in advance may be charged against your or your dependent’s benefit.
PERSON TO CONTACT IN THE EVENT OF PROBLEMS
Carey Brown, LSW, CSAC, CEAP
General Partner
Employee Assistance of the Pacific, LLC
1221 Kapiolani Blvd., Suite 730
Honolulu, Hawaii 96814

The preceding employee assistance benefits are provided under a contract issued by the Employee Assistance of the Pacific, LLC, (EAP), 1221 Kapiolani Blvd., Suite 730, Honolulu, Hawaii 96814.
The preceding is for informational purposes only and is only a summary of coverage. Its contents are subject to the provisions of the Employee Assistance Program Services Agreement 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-Insured)

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

<table>
<thead>
<tr>
<th>Amount</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Employee</td>
<td>$7,500</td>
</tr>
<tr>
<td>Spouse (of Active Employee)</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

You may designate anyone you choose as your beneficiary. Unless you request otherwise in your filed designation, payment will be made as follows:

1. If more than one beneficiary is named, each will be paid an equal share.
2. If any named beneficiary dies before you, his/her share will be divided equally among 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 your spouse does not survive you, in equal shares to your surviving children; or
   c. If no child survives you, in equal shares to your surviving parents; or
   d. If neither parent survives you, 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.

The death benefit is self-insured 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.
HEALTH AND WELFARE BENEFITS
FOR RETIRED EMPLOYEES

If you were covered for health and welfare benefits under the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund for the twelve (12) consecutive months immediately preceding your retirement, please refer to pages 17-18 of the Handbook of Benefits for Retirees for the eligibility rules for health and welfare benefits upon your retirement. If you retire under conditions other than those specified on pages 17-18 of the Handbook of Benefits for Retirees, you will lose coverage as of the first day of the calendar month for which you no longer have the Credited Work hours.

Health and welfare benefits for retirees under the Trust Fund are not vested or guaranteed for the life of the retiree, spouse, or dependent children. The Board of Trustees, at its sole discretion, may change or terminate benefits or change the copayments required, if applicable, at any time. If you are thinking about retiring, contact the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund for information and assistance.
CLAIMS AND APPEALS PROCEDURES

SELF-INSURED CLAIMS FOR BENEFITS PROVIDED DIRECTLY FROM THE AFL HOTEL AND RESTAURANT WORKERS HEALTH AND WELFARE TRUST FUND (i.e., Self-Funded Comprehensive Medical, Indemnity Prescription Drug, Indemnity Vision Care, and Indemnity Chiropractic Care benefits)

CLAIMS

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 this Plan as necessary to determine benefits.

If your claim or that of your dependent(s) for any benefit under the Self-Funded Comprehensive Medical Plan, Indemnity Prescription Drug Plan, Indemnity Vision Care Plan, or Indemnity Chiropractic Care Plan is wholly or partially denied by the Claims Administrator, 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. Once the necessary information has been provided, 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)**
  A pre-service claim is any claim which requests or requires approval before care is rendered. Pre-service claims include pre-authorizations 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-insured 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 for filing claims.

- **Post-Service Claims: 30 Calendar Days (with possible 15-day extension)**
  A post-service claim is any claim submitted after services have been provided to you.

- **Extensions for Pre-Service and Post-Service Claims**
  The Plan may extend the time to respond to a pre-service or post-service claim by 15 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**
  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 of the receipt of the claim.

INITIAL BENEFIT DETERMINATION

Upon the 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 procedures, the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA to appeal a denial based on the review of an earlier decision; and
6. A description of the expedited review process applicable to the claim, if the denial involved a claim for urgent care.

APPEALS

SELF-INSURED CLAIMS

If you wish to appeal the denial of any claim for benefits by the Claims Administrator, you have 180 days following your receipt of an adverse benefit determination notice 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.
The appeal will be conducted by the Benefits and Appeals Committee without any preferential treatment 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 at 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

Upon your request, the Plan will provide you with the following, free of charge:

1. Reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits; and
2. The identity of any medical or vocational experts that were hired on behalf of the Plan to provide advice in connection with your initial benefit determination, whether or not their advice was relied upon in making the determination.

Appeal of an Urgent Care Claim

If you are appealing a denial of 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 of 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 of 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 of the appeal. The notification will be written in plain language and will essentially contain the same types of information provided in the initial benefit determination as well as a description of any voluntary appeals procedure that may be available to you.

DEATH BENEFIT CLAIMS

If your claim for death benefits is wholly or partially denied by action of the Board of Trustees or by the Contract Administrator, your authorized representative will be provided with a written Notice of Denial explaining the reasons for the denial. Your authorized representative may appeal the denial by filing an Application for Review with the Board of Trustees within 60 days after receipt of the Notice of Denial.

Upon receipt of the Application for Review, the Board of Trustees (or a subcommittee thereof) will review the case and render a decision within 60 days after receipt of the Application, unless special circumstances require an extension of time for processing the Application, in which case the decision shall be rendered as soon as possible, but not later than 120 days after receipt of the Application. If an extension is required, the Board of Trustees (or subcommittee thereof) must notify your authorized representative 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.

It will be up to the Board of Trustees (or subcommittee thereof) to decide whether or not a hearing will be useful in reviewing the Application. If a hearing is to be held, your authorized representative will receive at least two weeks prior notice of the time and place of the hearing (unless your representative agrees in writing to a shorter notice period). Your authorized representative may appear at the hearing.

The decision of the Board of Trustees (or subcommittee thereof) on the Application for Review shall be final and written in clear, easily understood language and provide the reasons why the decision was made and the specific Plan provisions that support it.

GENERAL 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 leave of absence or retirement), and change in your dependent coverage (such as birth, adoption, or the 26th birthday of a dependent) can be directed to the Trust Fund Office at (808) 523-0199 (neighbor islands: 1 (866) 772-8989). Any disagreement regarding your status or the status of your dependents which cannot be resolved by the Administrator may be submitted to the Board of Trustees for review under the same Application for Review procedure described above for death benefit claims.
The preceding is for informational purposes only and is a summary of the Trust Fund’s claims and appeals procedures in general. This summary is subject to 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.

**INSURED CLAIMS**

Medical and prescription drug benefits are also provided through Kaiser Foundation Health Plan, Inc. for members who select that plan for their coverage. Dental benefits are provided through Hawaii Dental Service and Dental Care Centers of Hawaii (dba Gentle Dental). Information concerning the appeals procedures for these insured plans may be obtained by contacting the carrier at the address listed below.

**KAISER FOUNDATION HEALTH PLAN, INC.**
711 Kapiolani Blvd.
Honolulu, Hawaii 96813
Attn: Customer Service

**HAWAII DENTAL SERVICE**
700 Bishop Street, Suite 700
Honolulu, Hawaii 96813-4196
Attn: Customer Service Manager

**DENTAL CARE CENTERS OF HAWAII (DBA GENTLE DENTAL)**
The Town Center of Mililani
95-1249 Meheula Parkway, Suite 115
Mililani, Hawaii 96789
Attn: Membership Services Department
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 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 N. 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 N. 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:

Self-Funded Comprehensive Medical Plan and Indemnity Vision and Chiropractic Plans
Privacy Officer
Hawaii-Mainland Administrators, LLC
1440 Kapiolani Boulevard, Suite 1020
Honolulu, Hawaii 96814
Phone: 951-4621

Indemnity Prescription Drug Plan
Privacy Officer
Catamaran
800 King Farm Boulevard, Suite 400
Rockville, Maryland 20850
Phone: 1 (888) 869-4600

Kaiser Medical and Prescription Drug Plan
Privacy Officer
Kaiser Foundation Health Plan, Inc.
711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Phone: 432-5955

HDS Dental Plan
Privacy Officer
Hawaii Dental Service
700 Bishop Street, Suite 700
Honolulu, Hawaii 96813
Phone: 529-9248 (Customer Service)

DCCH Dental Plan (DBA Gentle Dental)
Compliance Officer
Interdent Service Corporation
222 N. Sepulveda Boulevard, Suite 740
El Segundo, California 90245-4354
Phone: 625-8630 (DCCH Executive Office - Hawaii)

Employee Assistance of the Pacific
Employee Assistance Program
Privacy Officer
Employee Assistance of the Pacific, LLC
1221 Kapiolani Boulevard, Suite 730
Honolulu, Hawaii 96814
Phone: 531-3271
STATEMENT OF ERISA RIGHTS

As a participant in the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund, 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.

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 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 actual Trust Fund Plan Document, the Trust Agreement, policies, contracts, and the various rules and regulations adopted by the Trustees are the final authorities in all matters related to the AFL Hotel and Restaurant Workers Health and Welfare Trust Fund. Copies of these documents are available for you to inspect at the Trust Fund Office during regular business hours.
IMPORTANT NOTICE

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.