SUPPLEMENTAL HEALTH PLAN FOR OTS RETIREES

SUMMARY PLAN DESCRIPTION

MARCH 2020

HONOLULU, HAWAII
UNION LABEL 503-M
LOCAL 501

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Information Needed	Contact the following
Eligibility, Enrollment, Benefits	Trust Fund Office c/o Benefit & Risk Management Services, Inc. 560 North Nimitz Highway, Suite 209 Honolulu, Hawaii 96817 Oahu: (808) 523-0199 Toll Free: 1 (866) 772-8989
UHA 600 Medical Plan	University Health Alliance (UHA) 700 Bishop Street, Suite 300 Honolulu, Hawaii 96813 Oahu: (808) 532-4000 Toll Free: 1 (800) 458-4600 *www.uhahealth.com*
Indemnity Prescription Drug Plan (Self-Insured)	OptumRx National Help Desk: 1 (888) 869-4600 *www.optumrx.com*
Kaiser Permanente Plan Kaiser Permanente Senior Advantage Plan	Kaiser Foundation Health Plan, Inc. 711 Kapiolani Boulevard Honolulu, Hawaii 96813 All Islands: 1 (800) 966-5955 TTY: 711 *www.kp.org*
HMSA Akamai Advantage Plan HMSA Medicare Part D Group Drug Plan	Hawaii Medical Service Association (HMSA) P.O. Box 860 Honolulu, Hawaii 96808-0860 Oahu: (808) 948-6000 Toll Free: 1 (800) 660-4672 TTY: 711 *www.hmsa.com/advantage*
Vision Care Plan	Vision Service Plan (VSP) Oahu: (808) 532-1600 Toll Free: 1 (800) 522-5162 (Hawaii) Toll Free: 1 (800) 877-7195 (Nationwide) *www.vsp.com*

THIS PLAN IS ADMINSTERED BY

Benefit & Risk Management Services, Inc.
Na Lama Kukui
(*Formerly known as* Gentry Pacific Design Center)
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817

Telephone:	(808) 523-0199 (Oahu)
	(808) 842-0392 (Satellite Office)
Toll Free:	1 (866) 772-8989 (Neighbor Islands)
Facsimile:	(808) 537-1074

IMPORTANT NOTICE

This booklet summarizes the eligibility rules and benefits for OTS RETIREES AND SPOUSES.

If you have any questions concerning this Plan, please contact the Hawaii Teamsters Health and Welfare Trust Office at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, Phone: (808) 523-0199 (Oahu) or 1 (866) 772-8989 (Toll Free for Neighbor Islands), from 8:00 a.m. to 4:30 p.m., Monday through Friday.

Retiree benefits are neither guaranteed nor vested and will be provided only as long as funds are available. The Board of Trustees reserves the right, at its sole discretion, to determine the nature and extent of benefits and rules governing eligibility, to require a contribution for the cost of benefits, or to terminate benefits at any time. Changes that are made may affect you and your dependent spouse. **Please read this booklet and subsequent notices that are mailed to you carefully.**

This booklet provides a summary of benefits for information purposes only. The Trust Agreement, policies, contracts, and rules and regulations adopted by the Board of Trustees are the final authorities in all matters related to the Hawaii Teamsters Health and Welfare Trust Supplemental Health Plan for OTS Retirees. Copies of these documents are available for inspection at the Trust Office during regular business hours.

The Trustees shall have full discretion and authority to interpret the benefits and to decide any factual question related to eligibility for and the extent of benefits provided by the Plan. Such interpretations are final and binding on participants, their dependents and providers.

HAWAII TEAMSTERS
HEALTH AND WELFARE TRUST

SUPPLEMENTAL HEALTH PLAN
FOR OTS RETIREES

Several important benefit changes have been made in your Health and Welfare benefits over the past few years. You have been previously notified of these changes and their effective dates. However, as part of our ongoing process to familiarize you with the benefit programs and to comply with Federal law, the changes have been incorporated in this booklet revision.

BENEFIT CHANGES

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

1. MEDICAL COVERAGE FOR MEDICARE RETIREES RESIDING OUT-OF-STATE

A. Effective January 1, 2015, medical benefits for Medicare eligible retirees who reside outside the State of Hawaii will no longer be provided through the Trust's Comprehensive Medical Plan. Out-of-state retirees must enroll in an approved Medicare Supplemental Insurance (MediGap) or Medicare Advantage Plan in their state of residence and file a claim for premium reimbursement with the Trust (page 20).

2. COMPREHENSIVE MEDICAL PLAN (SELF-INSURED)

A. Effective September 1, 2012, the Annual Deductible for a family of three or more is the first $300 of Eligible Charges incurred during a plan year for services or supplies which are subject to the Annual Deductible. Each family member must meet the individual deductible of $100 in Eligible Charges until the total amount of deductible expenses paid by all family members reaches $300.

B. Effective September 1, 2013, in accordance with the Patient Protection and Affordable Care Act of 2010, the total dollar value of essential health benefits available under the Plan increased from $1,250,000 to $2,000,000 per person per plan year.

C. Effective January 1, 2016, benefit payments for covered inpatient and emergency services rendered outside the State of Hawaii shall not exceed 170% of the Eligible Charge for the same or comparable

services rendered in Hawaii (previously limited to no more than 150% of the Eligible Charge for the same or comparable services rendered in Hawaii).

D. Effective June 1, 2016:

(1) The Comprehensive Medical Plan became a non-grandfathered health plan under the Patient Protection and Affordable Care Act of 2010.

(2) The $2,000,000 per person annual dollar maximum for essential health benefits is removed.

(3) Routine patient costs for services or items furnished in connection with participation in an approved clinical trial are covered for qualified beneficiaries in accordance with Federal law (previously not a benefit).

(4) Preventive Health Care services such as well child care visits, routine immunizations and screening services are covered at 100% of Eligible Charges when provided by a participating provider.

(5) Hospital emergency room physician services (medical or surgical) are covered at 90% of Eligible Charges for services of a non-participating provider (previously covered at 80% of Eligible Charges).

(6) Hospital emergency room facility services are covered at 100% of Eligible Charges for services of a non-participating provider (previously covered at 80% of Eligible Charges).

(7) Lactation counseling and rental of breastfeeding equipment are covered at 100% of Eligible Charges for services of a participating provider or 80% of Eligible Charges for services of a non-participating provider (previously not a benefit).

(8) Contraceptive services for women, including FDA approved contraceptive methods and patient education and counseling are covered at 100% of Eligible Charges for services of a participating provider or 80% of Eligible Charges for services of a non-participating provider (previously not a benefit).

(9) The $5,000 benefit limit for in vitro fertilization is removed. However, coverage is still limited to one procedure per lifetime.

(10) The Non-Emergency Inter-Island Travel benefit was enhanced to provide: (i) reimbursement of qualified lodging expenses up to a maximum of $100 per night for two nights (previously not covered), and (ii) travel benefits for members who reside on Oahu (previously limited to neighbor island beneficiaries only).

E. Effective September 1, 2017, the exclusion of sexual transformation services is removed.

F. Effective March 1, 2018:

(1) The Trust's Comprehensive Medical Plan (self-insured) was replaced by the UHA 600 Medical Plan, an insured plan provided through University Health Alliance. All eligible participants enrolled in the Comprehensive Medical Plan as of February 28, 2018 were automatically enrolled in the UHA 600 Medical Plan (page 36).

(2) Prescription drug benefits for UHA 600 Plan members will be provided through the Trust's Indemnity Prescription Drug Plan (page 90).

3. INDEMNITY PRESCRIPTION DRUG PLAN (SELF-INSURED)

A. Effective February 1, 2013, the Step Therapy Program was expanded to include other targeted medications (previously limited to cholesterol medications) (page 116).

B. Effective June 1, 2014, oral specialty medications are limited to a 30-day supply and require prior authorization (page 116).

C. Effective November 1, 2014, prior authorization is required for compounded medications costing more than $200 (page 116).

D. Effective June 1, 2016:

(1) The Indemnity Prescription Drug Plan became a non-grandfathered health plan under the Patient Protection and Affordable Care Act of 2010 (page 35).

(2) There is an Annual Copayment Maximum of $2,000 per individual and $4,000 per family of three or more for covered prescription drug services received during a plan year (previously there was no copayment maximum) (page 113).

(3) Prescription drug benefits for HMO Medical Plan members will be provided through the Indemnity Prescription Drug Plan.

E. Effective March 1, 2018:

(1) Prescription drug benefits for UHA 600 Medical Plan members will be provided through the Indemnity Prescription Drug Plan (page 113).

(2) Over-the-counter anti-obesity drugs are not covered.

F. Effective April 1, 2019, the Diabetic Sense Program was discontinued.

G. Effective October 1, 2019:

(1) For brand name medications with a generic equivalent, the generic equivalent will be substituted for the brand name drug. When you obtain a brand name medication and a generic equivalent is available, you 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, you or your physician must contact the Pharmacy Benefits Manager and obtain a Prior Authorization. If you obtain a Prior Authorization you will pay the brand name drug copayment (page 115).

(2) New FDA approved drugs released to the market within the most recent six-month period may be excluded from coverage until the Pharmacy Benefits Manager can property evaluate and provide clinical and coverage criteria for these new medications (page 117).

4. HMO MEDICAL PLAN (SELF-INSURED)

A. Effective September 1, 2011:

(1) The preventive care office visit for beneficiaries age two and older includes routine physical examinations, routine screening and check-ups, and physical examinations required by educational institutions for students in grades Kindergarten through age six.

(2) The $500 allowance for hearing aids is removed. Hearing aids are covered at 80% of Eligible Charges and limited to one device per ear every three years.

B. Effective January 1, 2016, benefit payments for covered inpatient and emergency services rendered outside the Service Area shall not exceed 170% of the Eligible Charge for the same or comparable services rendered within the Service Area (previously limited to no more than 150% of the Eligible Charge for the same or comparable services rendered within the Service Area).

C. Effective June 1, 2016:

(1) The HMO Medical Plan became a non-grandfathered health plan under the Patient Protection and Affordable Care Act of 2010.

(2) Routine patient costs for services or items furnished in connection with participation in an approved clinical trial are covered for qualified beneficiaries in accordance with Federal law (previously not a benefit).

(3) Well-child care physician visits are covered from birth through age 21 years at no charge (previously covered from birth through 18 months).

(4) One preventive care office visit per year for beneficiaries age 22 years and older is covered at no charge (previously covered from age two).

(5) Preventive Health Care services and items as defined by Federal law are covered at no charge.

(6) Standard immunizations for beneficiaries age 19 and older are covered at no charge (previously $10 per dose).

(7) The copayment for hospital emergency room services received outside the Service Area is $30 per visit (previously covered at 80% of Eligible Charges).

(8) Preventive Health Care screening services as defined by Federal law are covered at no charge (previously $14 per service per day for certain services).

(9) Laboratory tests prescribed in connection with well-child care are covered at no charge (previously $14 per service per day for certain tests).

(10) Lactation counseling and rental of breastfeeding equipment are covered at no charge (previously not a benefit).

(11) FDA approved contraceptive methods for women for the prevention of unwanted pregnancies are covered at no charge (previously covered at 50% of Eligible Charges).

D. Effective September 1, 2017:

(1) Life Bed services are not covered.

(2) The exclusion of sexual transformation services is removed.

E. Effective March 1, 2018, the coverage criteria for in vitro fertilization services is revised by (i) removing the requirement of 12 consecutive months of coverage under the Plan immediately preceding the in vitro fertilization procedure; and (ii) shortening the durational requirement for a history of infertility from five years to four years, 12 months of which must be consecutive months of coverage under the Plan.

F. Effective September 1, 2019, the Trust's HMO Medical Plan (self-insured) was replaced by the Kaiser Permanente Plan, an insured plan provided through Kaiser Foundation Health Plan, Inc. (page 124).

5. HMO PRESCRIPTION DRUG BENEFITS (SELF-INSURED)

A. Effective August 1, 2013, a beneficiary may obtain two 30-day supplies of a prescription or refill for maintenance drugs at two times the 30-day copay from a retail pharmacy under the Point of Service Program.

B. Effective June 1, 2016:

(1) Prescription drug benefits for HMO Medical Plan members will be provided through the Indemnity Prescription Drug Plan.

(2) There is an Annual Copayment Maximum of $2,000 per individual and $4,000 per family of three or more for covered prescription drug services received during a plan year (previously there was no copayment maximum).

C. Effective September 1, 2019, the Trust's HMO Plan was replaced by the Kaiser Permanente Plan. Eligible participants enrolled in the Kaiser Permanente Plan will receive prescription drug benefits under Kaiser Permanente's Prescription Drug Plan (page 151).

6. KAISER PERMANENTE PLAN

A. Effective September 1, 2013:

(1) Durable medical equipment and external prosthetics, devices and braces are covered at 80% of applicable charges (previously not a benefit) (page 131).

(2) Hearing aids are covered up to a $500 maximum once every three years (previously not a benefit).

B. Effective September 1, 2014, hearing aids are covered at 40% of applicable charges, once every three years (previously covered up to $500) (page 131).

C. Effective September 1, 2017:

(1) Up to 120 days of extended care services in a skilled nursing facility will be covered per plan year at no charge (previously covered up to 60 days per benefit period) (page 138).

(2) Eligible members may sign up for a Fit Rewards gym membership ($200 per contract year) or home fitness program ($10 per contract year) through American Specialty Health, Inc. (previously not a benefit). You can get your $200 annual gym membership fee back after working out at least 45 days each contract year (page 154).

D. Effective September 1, 2019:

(1) The Kaiser Permanente Plan became a non-grandfathered health plan under the Patient Protection and Affordable Care Act of 2010 (page 35).

(2) The Annual Copayment Maximum per calendar year is $2,000 per member and $6,000 per family unit (previously $1,750 per member and $5,250 per family unit) (pages 128).

(3) The copayment for Inpatient Hospital Services is $50 per day, not to exceed $200 per admission (previously $100 per admission) (page 128).

(4) The copayment for Emergency Services is $75 per visit (previously $25 per visit within the Hawaii service area and 20% of applicable charges outside the service area) (page 129).

(5) The copayment for prescription drugs obtained from Kaiser pharmacies is $12 for up to a 30-day supply (previously $15 per prescription) (page 130).

(6) For a more detailed summary of Kaiser Permanente Plan benefits, please refer to the Kaiser Permanente Plan section beginning on page 124.

7. CLAIMS AND APPEALS PROCEDURES

A. Effective September 1, 2014, following an adverse benefit determination on appeal, you have the right to bring a civil action under section 501(a) of ERISA within two years after receipt of the written notice of Initial Benefit Determination (previously there was no time limit) (page 168).

B. Effective June 1, 2016:

(1) Following an adverse benefit determination on appeal involving medical necessity or a rescission of coverage, a beneficiary may request an external review by an Independent Review Organization (page 173).

(2) Pending the outcome of an appeal, benefits for an ongoing course of treatment will not be reduced or terminated without advance notice and an opportunity for review (page 173).

C. Effective April 1, 2018, disability benefit claims will be subject to new claims and appeals procedures in accordance with Federal law (page 175).

If you have any questions concerning this Plan, please contact the Trust Office at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, Telephone: (808) 523-0199 (Oahu) or 1 (866) 772-8989 (Neighbor Islands), 8:30 a.m. - 4:30 p.m. Monday through Friday.

Sincerely,

BOARD OF TRUSTEES

HAWAII TEAMSTERS
HEALTH AND WELFARE TRUST

SUPPLEMENTAL HEALTH PLAN
FOR OTS RETIREES

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

SATELLITE OFFICE
Telephone: (808) 842-0392

BOARD OF TRUSTEES

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Pearl Lara
Jenny Lemaota
John Kim (Alternate)

UNION TRUSTEES
Wayne Kaululaau
Ronan Kozuma
Frederick Liva (Alternate)
Ryan Yoshida (Alternate)

CONTRACT ADMINISTRATOR
Benefit & Risk Management Services, Inc.

PLAN CONSULTANT
Benefit Plan Solutions, Inc.

LEGAL COUNSEL
Yee & Kawashima, LLLP

TRUST AUDITOR
Lemke, Chinen & Tanaka, CPA, Inc.

CUSTODIAN
First Hawaiian Bank

INVESTMENT MANAGER
First Hawaiian Bank

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

NAME OF THE PLAN

Supplemental Health Plan for OTS Retirees

PLAN SPONSOR AND PLAN ADMINISTRATOR

Board of Trustees
Hawaii Teamsters Health & Welfare Trust
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817
Phone: (808) 523-0199

Upon written request, participants and beneficiaries may receive information from the Plan Administrator as to whether a particular employer is a sponsor of the Plan and, if so, the sponsor's address.

IDENTIFICATION NUMBERS

Assigned by Internal Revenue Service - 99-6009135
Assigned by Plan Sponsor - Plan Number 501

TYPE OF PLAN

Welfare - medical, prescription drug, and vision care benefits

TYPE OF ADMINISTRATION

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

AGENT FOR SERVICE OF LEGAL PROCESS

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

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

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

EMPLOYER TRUSTEES

Pearl Lara
Human Resources Director
Paradise Beverages
1555 Kalani Street
Honolulu, Hawaii 96817

Jenny Lemaota
Senior Vice President and
Assistant General Manager
Oahu Transit Services, Inc.
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Honolulu, Hawaii 96819

John Kim (Alternate Trustee)
Vice President of Finance and
Administration
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811 Middle Street
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UNION TRUSTEES

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Honolulu, Hawaii 96819

Ronan Kozuma
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1817 Hart Street
Honolulu, Hawaii 96819

Frederick Liva (Alternate Trustee)
Vice President
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1817 Hart Street
Honolulu, Hawaii 96819

Ryan Yoshida (Alternate Trustee)
Secretary-Treasurer
Teamsters Union Local 996
1817 Hart Street
Honolulu, Hawaii 96819

APPLICABLE COLLECTIVE BARGAINING AGREEMENT

The Supplemental Health Plan for OTS Retirees is maintained pursuant to a collective bargaining agreement between the Hawaii Teamsters and Allied Workers Union, Local 996 and Oahu Transit Services, Inc.

A copy of the collective bargaining agreement 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 Hawaii Teamsters Health and Welfare Trust Office.

SOURCE OF CONTRIBUTIONS

The funds to pay for Plan benefits and expenses are contributed by: 1) Oahu Transit Services, Inc., 2) retired participants (i.e., COBRA payments), and 3) investment earnings. The amount of employer contributions is calculated by multiplying the contribution rate specified in the applicable collective bargaining agreement by the total number of covered work hours. The amount of retiree contributions is established annually by the Board of Trustees.

FUNDING MEDIUM

All contributions to the Supplemental Health Plan for OTS Retirees are deposited in a savings account. Funds are then withdrawn and deposited into a checking account out of which premium payments are made to the insurance carriers that provide benefits, as directed by the Contract Administrator, and benefits are paid to participants. Self-insured prescription drug benefits are paid by the Trust through the Pharmacy Benefits Manager OptumRx. Funds in excess of those needed for immediate requirements are invested in accordance with general investment guidelines as determined and reviewed by the Trustees.

FISCAL YEAR

September 1 through the following August 31

PLAN AMENDMENT AND TERMINATION

The Trust Agreement for the Hawaii Teamsters Health and Welfare Trust gives the Board of Trustees the authority to terminate the Plan or amend or eliminate eligibility requirements and 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 does not have the funds to pay for the benefits being provided.

The Trust 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.

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

If the Hawaii Teamsters Health and Welfare Trust is terminated, benefits may 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 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, and once notified of the termination of the Plan, should contact the insurance carriers of your choice for information on conversion to an individual plan offered by the respective carriers.

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

ELIGIBILITY RULES

WHO IS ELIGIBLE?

When you retire from Oahu Transit Services, Inc. (OTS), you may be eligible for benefits under the Supplemental Health Plan for OTS Retirees provided you meet the following requirements:

1. You received Health and Welfare benefits from the Hawaii Teamsters Health and Welfare Trust immediately preceding retirement;
2. You retire on or after July 1, 1984;
3. You are at least 62 years of age at the time of retirement; and
4. You are fully vested by the Western Conference of Teamsters Pension Plan.

Your eligible dependent includes your legal spouse. Coverage of your spouse will continue as long as you are eligible for benefits.

Benefits for retirees shall cease upon the earliest of the following events:

1. Death of the retiree;
2. Suspension of benefits because of reemployment (see reemployment below); or
3. Termination of the Plan, or with respect to any particular benefit under the Plan, termination or reduction of that benefit.

REEMPLOYMENT

If, after retiring from Oahu Transit Services (OTS) you are gainfully employed for 20 or more hours per week for four (4) consecutive weeks, you will not be eligible for retiree benefits under the Supplemental Health Plan for OTS Retirees. However, upon termination of gainful employment, you may request re-enrollment in this Plan within 30 days under the Special Enrollment Periods provision on page 19. If you do not request re-enrollment within this 30-day period, your coverage will not be effective until the next open enrollment period following the date of notification to the Trust.

CONTINUATION OF COVERAGE UNDER COBRA

The Supplemental Health Plan for OTS Retirees, in compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, currently offers Qualified Beneficiaries who lose coverage as a result of a "Qualifying Event" the opportunity to continue coverage for a specified period of time as outlined below. 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. The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event.

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

* Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become totally disabled within the meaning of Title II or Title XVI of the Social Security Act. This additional 11 months is available to employees

and enrolled dependents if notice of disability is provided to the Trust Office 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. The extended COBRA coverage period of up to 29 months for disability not only applies to the disabled Qualified Beneficiary or the disabled covered employee but also to all other Qualified Beneficiaries covered with the disabled beneficiary through the same initial Qualifying Event.

** 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.

There are no Qualifying Events for retired OTS employees. Therefore, retired employees who lose coverage under the Supplemental Health Plan are not Qualified Beneficiaries and cannot enroll in COBRA continuation coverage.

Notifying the Plan of a Qualifying Event

You or your spouse is responsible for notifying the Trust Office, in writing, within 60 days in the event of a Qualifying Event such as divorce or legal separation. That written notice should be sent to the Hawaii Teamsters Health and Welfare Trust Office located at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, phone (808) 523-0199 or 1 (866) 772-8989. The written notice can be sent via first class mail or hand-delivered to the Trust Office, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation, such as divorce documents.

NOTE: If such notice is <u>not</u> received by the Trust Office within the 60-day period, your spouse will not be entitled to choose COBRA continuation coverage.

Electing COBRA Continuation Coverage

When the Hawaii Teamsters Health and Welfare Trust Office receives notice or otherwise determines that a Qualifying Event has occurred, the Trust Office will notify you regarding COBRA continuation coverage within 14 days. You and/or your spouse will have 60 days after the date coverage under the Trust terminates or the date the Trust Office sends notice to you and/or your spouse, whichever is later, to elect COBRA continuation coverage (the "election period"). **If you do not elect coverage during the election period, you will lose your right to continue coverage under COBRA.**

Each Qualified Beneficiary is entitled to make his or her own independent election to continue coverage under COBRA.

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 a Qualified Beneficiary is covered under another employer's group health plan or Medicare prior to COBRA election, such prior coverage will not disqualify a Qualified Beneficiary from being able to elect COBRA.

The COBRA Continuation Coverage that Will Be Provided

Under the COBRA Program, if you (the Qualified Beneficiary) are 65 years of age or older, you will be covered for medical, prescription drug and vision benefits. If you are under 65 years of age, you may choose to be covered for only core benefits (medical and prescription drug benefits) or core plus non-core benefits (medical, prescription drug and vision benefits). Once a selection is made, 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 must pay an amount equal to 102% of the actual cost of the benefits, as determined by the Board of Trustees.

The first COBRA payment must be received by the Hawaii Teamsters Health and Welfare Trust 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 Supplemental Health Plan for OTS Retirees through the date that COBRA election is made. Subsequent payments must be made monthly and received by the Trust Office within 30 days after the first day of the period covered by the payment.

When COBRA Ends

If COBRA is elected, the continued coverage will begin on the date that coverage under the Supplemental Health Plan for OTS Retirees would otherwise be lost and end on the earliest of the following dates:

1. The last day of the applicable maximum coverage period described above;
2. The first day of the payment period for which timely payment of premium is not made (a payment is considered timely only if made within 30 days of the date it is due);
3. The date the Supplemental Health Plan for OTS Retirees ceases to provide any health coverage;
4. The date, after the date of the COBRA election, on which the individual first becomes entitled to Medicare (usually age 65); or
5. The first day on which the individual becomes covered under another employer's group health plan. (Exception - If the new group plan contains an exclusion or limitation with respect to any pre-existing condition of the individual, then COBRA coverage may be continued until the earlier of the end of the exclusion or limitation period, or the occurrence of one of the other events stated above).

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

GENERAL INFORMATION

ENROLLMENT FORMS

To be covered for benefits, each participant must complete a Trust enrollment form and all other applicable insurance carrier enrollment forms. If you have not done so already, you should complete the enrollment forms, listing your choice of medical plan and naming your spouse, if applicable, as your eligible dependent. If you are married, you must also submit a certified copy of your marriage certificate and spouse's birth certificate. Return the completed enrollment forms to the Trust Office. The Trust Office will process the insurance carrier enrollment forms and retain the Trust enrollment form for its records.

Important Notice

It is important to keep the Trust informed of any change in your personal or family situation, or your contact information. You or your dependents must notify the Trust Office, in writing, and submit the proper documentation, preferably within 30 days but no later than 60 days, after any of the following events occur:

- You change your name, address, or telephone number.
- You get married, divorced, or legally separated.
- A covered family member dies.
- You have other health care coverage.
- You enroll in Medicare.
- You return to work.

Failure to give timely notice to the Trust may cause:

- You to be liable to the Trust for any benefits paid to an ineligible person;
- Benefit payments being delayed until eligibility issues have been resolved; or
- Your spouse to lose the right to continue coverage under COBRA.

ELIGIBLE DEPENDENTS

Only your legal spouse, regardless of age, is eligible as a dependent. The term “spouse” shall refer to individuals who are lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages.

To add a new spouse, you must submit the proper documentation, in writing, to the Trust Office within 30 days of your date of marriage. Coverage will be effective on the date of marriage. If you do not notify the Trust Office within this 30-day period, you must wait until the next open enrollment period to add your new spouse.

Exception: If you did not add your spouse within 30 days of your marriage because he or she was covered under another health plan, you do not need to wait until the next open enrollment period to add your spouse if he or she subsequently loses coverage under that plan. However, you must request special enrollment for your spouse within 30 days after coverage under the other plan ends. (Exception: If your spouse was covered under Medicaid, you must request special enrollment within 60 days after coverage ends.) If you do not enroll your spouse within this special enrollment period, he or she may not be added until the next open enrollment period.

When your Spouse is No Longer Eligible for Dependent Coverage

A covered spouse who loses eligibility upon divorce, legal separation, or the death of the retiree may continue coverage by electing and making payments under the COBRA Program, as described in the COBRA Program section, or if covered under the Kaiser Permanente Plan, may apply in writing or call the Kaiser Foundation Health Plan, Inc. for conversion to an Individual or Family Plan within 30 days of the date the change in eligibility status occurs.

You must notify the Trust Office, in writing, on or before the first day of the calendar month following the date on which eligibility ceased and provide the proper documentation, as required by the Trust.

Example: If your divorce is finalized (i.e. the divorce decree is signed by the judge) on July 1, you must notify the Trust Office by August 1 and provide the proper documentation such as a copy of the divorce decree. Dependent coverage for your spouse will terminate on July 31 unless COBRA continuation coverage is elected.

NOTE*:* If you fail to notify the Trust Office and the Plan makes payments for services provided to an ineligible dependent, you or your dependents will be responsible for reimbursing the Plan for the amount of such payments.

Restrictions on Dual Coverage

An eligible person may be covered under this Plan as either 1) a retired OTS employee, or 2) as the spouse of a retired OTS employee, but not both.

SPECIAL ENROLLMENT PERIODS

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Trust allows enrollment in the Supplemental Health Plan for OTS Retirees during a special enrollment period if you qualify under one of the following requirements:

1. If you initially declined enrollment under this Plan for yourself and/or your spouse because of coverage under another health plan, you may enroll yourself and/or your spouse in this Plan if you or your and/or your spouse lose eligibility for that other coverage or if the employer stops contributing

towards the other health plan coverage. However, you must request enrollment within 30 days after coverage under the other health plan ends (or after the employer stops contributing toward the other coverage).

2. If your coverage under Medicaid is terminated due to loss of eligibility or you become eligible for a premium assistance subsidy through Medicaid, you may enroll yourself and your spouse in this Plan provided you request enrollment within 60 days of such event.

3. If you are enrolled in this Plan but declined coverage for your spouse, you may enroll your spouse in this Plan if your spouse's coverage under Medicaid is terminated due to loss of eligibility or your spouse becomes eligible for a premium assistance subsidy through Medicaid, provided you request enrollment within 60 days of such event.

4. If you are enrolled in this Plan and you obtain a new spouse through marriage, you may enroll your new spouse in this Plan provided you request enrollment within 30 days after your date of marriage.

If you fail to request enrollment during this special enrollment period, coverage for yourself and/or your spouse will not be effective until the next open enrollment period following the date of notification to the Trust. To request special enrollment or to obtain more information, contact the Trust Office.

BENEFITS FOR RETIRED OTS EMPLOYEES

MEDICAL AND PRESCRIPTION DRUG BENEFITS

Non-Medicare Retirees and Spouses (Under Age 65)

- Retirees and spouses under 65 years of age who are not eligible for Medicare will be covered under their choice of the UHA 600 Medical Plan described on pages 25-76 or the Kaiser Permanente Plan described on pages 84-108.
- If you are enrolled in the UHA Medical Plan, you will be eligible for prescription drug benefits provided through the Trust's self-insured Indemnity Prescription Drug Plan (administered by OptumRx), described on pages 77-83.
- If you are enrolled in the Kaiser Permanente Plan, you will be eligible for Kaiser Permanente's Prescription Drug benefits, described on pages 102-103.

Medicare Retirees and Spouses (Age 65 and Older) Residing in Hawaii

- Retirees and spouses age 65 years and older who are eligible for and enrolled in Medicare Parts A and B will be covered under their choice of HMSA's Akamai Advantage Plan or Kaiser Permanente's Senior Advantage Plan. Medicare benefits must be assigned to either HMSA or Kaiser depending on which plan is selected.

- If you choose the HMSA Akamai Advantage Plan, you will be covered for prescription drug benefits under HMSA's Medicare Group Drug Plan. For a complete description of HMSA's Akamai Advantage Plan and Medicare Group Drug Plan, refer to the separate Description of Benefits brochure and Member handbook which is available from HMSA.
- If you choose the Kaiser Permanente Senior Advantage Plan, you will be covered under Kaiser Permanente's Prescription Drug Plan which includes Medicare Part D. For a complete description of Kaiser Permanente's Senior Advantage Plan and Prescription Drug benefits, refer to the separate Description of Benefits brochure and Member handbook which is available from Kaiser.

Medicare Retirees and Spouses (Age 65 and Older) Residing Out-of-State

- Retirees and spouses age 65 years and older who are eligible for and enrolled in Medicare Parts A and B must enroll in an approved Medicare Supplemental Insurance (MediGap) or Medicare Advantage Plan in their state of residence to receive medical benefits through the Trust. The Trust will reimburse you for the plan premium, on a monthly basis, up to the Medicare premium reimbursement rate approved by the Trustees, or your cost, whichever is lower.
- To receive prescription drug benefits, you must enroll in an approved Medicare Part D plan in your state of residence. The Trust will reimburse you for the Medicare Part D premium, on a monthly basis, up to the Medicare Part D premium reimbursement rate approved by the Trustees, or your cost, whichever is lower.
- To receive reimbursement for your Medicare Plan premiums, you must submit to the Trust Office:
    1. Confirmation of your enrollment in an approved Medicare Plan (e.g. Medicare Supplemental Insurance, Medicare Advantage, Medicare Part D Plan and/or Limited Income Subsidy (LIS) Plan);
    2. A copy or description of that plan;
    3. Proof of payment for your Medicare Plan premium (e.g. receipt from the insurance carrier, copy of your cancelled check or money order); and
    4. A completed "Application for Out-of-State Medicare Premium Reimbursement" form, which is available upon request from the Trust Office.

Medicare Retirees with Medicaid

- A Retiree with Medicaid is not eligible for the Trust's Medicare supplemental medical or prescription drug coverage while enrolled by Medicaid. However, upon termination of your Medicaid coverage, you may request enrollment within 60 days after your Medicaid coverage ends (See Special Enrollment Periods on page 19).

How to Secure Medicare Coverage

All Retirees and spouses eligible for Medicare must enroll in Medicare Part A and Part B, when eligible. When you or your spouse becomes eligible for Medicare benefits provided under the Social Security Law, you should contact your local Social Security office and arrange for both Part A and Part B coverage. Part A covers hospital care while Part B covers physician services. You will be covered by Medicare as soon as you reach your eligible age (currently age 65) only if you apply during the three-month period just prior to reaching your eligible age. If you fail to apply during the 90 days prior to your eligible age, you may still apply during the first three months of any later calendar year. However, you may lose some Medicare benefits during the period that you are not enrolled.

VISION CARE BENEFITS

· Retirees and spouses are eligible for Vision Care benefits provided through the VSP Advantage Plan as described on pages 109-112.

MEDICAL BENEFITS

CHOICE OF PLANS

Non-Medicare Retirees and Spouses (Under Age 65)

You may choose one of the following medical – hospital – surgical plans:

1. The UHA 600 Medical Plan (UHA Plan), or
2. The Kaiser Permanente Plan.

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

The principal benefit provisions of the UHA Plan and Kaiser Permanente Plan are summarized in this booklet. You and your spouse should compare the benefits of each plan carefully before selecting your medical plan.

Medicare Retirees and Spouses (Age 65 and Older) Residing in Hawaii

You may choose one of the following Medicare Advantage insurance plans:

1. The HMSA Akamai Advantage Plan, or
2. The Kaiser Permanente Senior Advantage Plan.

To enroll in the Kaiser Permanente Senior Advantage Plan, you must reside within the Hawaii service area which includes the islands of Oahu, Maui, and Hawaii (except for zip codes 96718, 96772 and 96777 on the island of Hawaii). If you are enrolled in the Kaiser Permanente Senior Advantage Plan and subsequently move outside of the Hawaii service area or are absent from the service area for more than six months, you will not be allowed to continue coverage under the Kaiser Permanente Senior Advantage Plan and must enroll in the HMSA Akamai Advantage Plan.

For a complete description of HMSA's Akamai Advantage Plan, refer to the separate Description of Benefits brochure and Member handbook or contact HMSA Customer Relations on Oahu at 948-6000 or toll free 1 (800) 776-4672.

For a complete description of the Kaiser Permanente Senior Advantage Plan, please refer to the separate Description of Benefits brochure and Member Handbook or contact Kaiser Member Services on Oahu at (808) 432-5955 (Oahu) or toll free 1 (800) 966-5955.

You and your spouse should compare the benefits of each plan carefully before selecting your Medicare plan.

Medicare Retirees and Spouses (Age 65 and Older) Residing Out-of-State

If you reside outside the State of Hawaii you must enroll in an approved Medicare plan in your state of residence. Please refer to page 20 for information on how to obtain reimbursement of your premiums from the Trust Fund.

For specific benefits and other information regarding your Medicare Parts A and B coverage, please refer to Medicare & You, the official government handbook, or visit the Medicare website at www.mymedicare.gov.

How to Secure Benefits

The medical plan you select will send you a member ID card. Contact the Trust Office if you have not received or have lost your member ID card. You should have your member ID card available whenever you schedule or seek medical care. If you do not have your ID card, be sure to tell the provider in advance the name of your plan and that you belong to the Hawaii Teamsters Health and Welfare Trust. You should also ask the doctor or facility rendering services to contact the Trust Office to confirm your eligibility.

OPEN ENROLLMENT PERIOD

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

1. You are enrolled in the Kaiser Permanente Plan or the Kaiser Permanente Senior Advantage Plan and subsequently move outside the Hawaii service area, or
2. You are enrolled in the HMSA Akamai Advantage Plan and subsequently move outside the state of Hawaii, or
3. You meet one of the requirements specified in the "Special Enrollment Periods" section on page 19 of this booklet.

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

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

Procedure for Requesting and Receiving a HIPAA Certificate of Creditable Coverage

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

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. 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, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

Effective September 1, 2010, the following provisions apply to the Hawaii Teamsters Health and Welfare Trust. 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 September 1, 2010, provisions of the Mental Health Parity and Addiction Equity Act of 2008 apply to group health plans offered through the Trust. This Federal law generally requires that financial requirements and treatment limitations that apply to mental health and substance abuse disorder benefits cannot be more restrictive than the financial requirements and treatment limitations that apply to medical/surgical benefits.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (PPACA) - CHANGE FROM GRANDFATHERED TO NON-GRANDFATHERED HEALTH PLAN STATUS

Effective June 1, 2016, the Hawaii Teamsters Health and Welfare Trust elected to change the status of its Comprehensive Medical Plan (Self-insured), HMO Plan (Self-insured) and Indemnity Prescription Drug Plan (Self-insured) from “grandfathered” to “non-grandfathered” health plan status under the Patient Protection and Affordable Care Act of 2010 (PPACA or Affordable Care Act).

Effective September 1, 2019, medical and prescription drug coverage provided through the Kaiser Permanente Plan changed from “grandfathered” to “non-grandfathered” health plan status under the Affordable Care Act.

Questions regarding the change from grandfathered to non-grandfathered health plan status can be directed to the Trust Administrator at *560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, telephone: (808) 523-0199 or Neighbor Islands Toll Free: 1 (866) 772-8989.*

UNIVERSITY HEALTH ALLIANCE (UHA)
UHA 600 MEDICAL PLAN

Note: Effective March 1, 2018, the Trust's Comprehensive Medical Plan was replaced by the UHA 600 Medical Plan provided through University Health Alliance (UHA). All eligible participants enrolled in the Comprehensive Medical Plan as of February 28, 2018 were automatically enrolled in the UHA 600 Plan. Should you have any questions about your Plan or payments made by UHA, please contact Customer Services at the number listed below.

UNIVERSITY HEALTH ALLIANCE
700 BISHOP STREET, SUITE 300
HONOLULU, HAWAII 96813

CUSTOMER SERVICES

PHONE:	(808) 532-4000
TOLL FREE:	1 (800) 458-4600
FAX:	1 (866) 572-4393
WEBSITE:	uhahealth.com

GENERAL INFORMATION

UHA 600 ("UHA Plan" or "Plan") is a Preferred Provider Organization (PPO) plan that provides flexibility in the way you obtain your medical benefits. The Plan's focus on keeping you healthy and well makes this coverage special.

Many wellness services are covered at little or no cost to you, emphasizing the prevention and early detection of serious diseases such as cancer and heart disease, plus identification and treatment of risk factors for life-threatening and disabling diseases.

In addition, the Plan provides you with the following tools to get well and stay well:

- Nutritional counseling programs for disease management
- Smoking cessation program
- Diabetes self-management training and education
- Asthma education program

These programs are offered to you at no cost—they're fully covered by the Plan. At the same time, you'll enjoy the traditional benefits, which protect you against financial loss from illness or injury.

This booklet provides you with necessary information about your UHA Plan. Please review it so you understand how your plan works and keep it handy for reference. Should you have any questions about your Plan, please contact Customer Services at the number listed above.

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

ANNUAL AND LIFETIME BENEFIT MAXIMUMS

There is no annual or lifetime ***dollar benefit maximum*** for benefits paid or provided under this Plan on your behalf. However, certain services have annual benefit maximums. For example, home health care is limited to 150 visits per calendar year. Please see the Medical Plan Benefits section on pages 36-61 for a description of these benefit maximums as well as other limitations that may apply to covered services.

ANNUAL DEDUCTIBLE

This Plan has no annual deductible.

ELIGIBLE CHARGE

Benefit payments and your copayments are based on UHA's determination of an Eligible Charge for a covered service. The Eligible Charge for some services may be a per case, per treatment, or per day fee, rather than an itemized amount (fee for service).

1. For Participating Providers, the Eligible Charge for covered services is a contracted rate with UHA.

2. For Non-Participating Providers, the Eligible Charge for covered services will be the lesser of the following charges:
    - UHA's determination of an Eligible Charge for a covered service, or
    - The actual charge to you.

Participating Providers agree to accept the Eligible Charge for covered services; Non-Participating Providers usually do not. Therefore, if you receive services from a Non-Participating Provider, you are responsible for the amount of your copayment plus any difference between the Eligible Charge and the provider's actual charge.

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

Example: Let's say that you have a sore throat and go to a physician to have it checked. The physician's submitted or actual charge is $100 and UHA's Eligible Charge is $60.

If You Go to A Participating Provider	**If You Go to A Non-Participating Provider**
• **You Owe Physician** – Your copayment which is equal to 10% of the Eligible Charge or **$6**.	• **You Owe Physician** – Your copayment which is equal to 30% of the Eligible Charge ($18) **plus** the $40 difference between the actual charge ($100) and the Eligible Charge ($60), a combined total of **$58**.
• **Plan Pays Physician** – The remaining Eligible Charge ($54) after your $6 copayment.	• **Plan Pays You** – The remaining Eligible Charge ($42) after your $18 copayment.

COPAYMENT AND COINSURANCE

A copayment or coinsurance is the amount of the Eligible Charge you pay for a covered service. It can be a fixed dollar amount (for example, $10 copayment for a visit to your participating Chiropractic physician) or a percentage of the Eligible Charge (for example, 20% coinsurance if you utilize the services of a Participating laboratory).

ANNUAL OUT-OF-POCKET MAXIMUM

When the total of your copayments and coinsurance amounts reach **$2,500 per person**, or **$7,500 per family**, in any calendar year, this Plan pays 100% of the Eligible Charge for covered services rendered for the rest of that calendar year for medical care. However, the following payments do not apply toward meeting the Annual Out-of-Pocket Maximum:

- When you receive services from a Non-Participating Provider, any difference you pay between the Eligible Charge and the provider's actual charge
- Penalties for not obtaining Prior Authorization for services subject to prior approval
- Your copayments for Chiropractic and Acupuncture benefits
- If a service is subject to a maximum limitation and you have reached that maximum, any amounts that you pay after meeting the maximum
- Your payments for non-covered services

CHOICE OF HEALTH CARE PROVIDERS

You are free to go to any licensed physician of your choice and receive coverage under this Plan. Your choice of physician or other health care provider can make a difference in how much you will owe after Plan benefits have been paid. A provider may be **"Participating"** with UHA or **"Non-Participating"**. In general, you will experience lower out-of-pocket costs when you obtain services from a UHA Participating Provider.

Participating Providers

"Participating" means that a physician, hospital, or other licensed health care provider has signed a contract with UHA to provide benefits under this Plan. The contract requires that the provider collect only:

1. The Eligible Charge paid by UHA for the covered services delivered;
2. The applicable copayment;
3. Billed charges for non-covered services; and
4. The applicable state excise tax, based on the Eligible Charge.

Participating Providers also agree to participate in and abide by UHA's credentialing, quality improvement and utilization management programs.

There are many Participating Providers throughout Hawaii. Please refer to the UHA Participating Physicians and Health Care Provider Directory for a listing.

If you did not receive a Directory at the time of your enrollment, please call UHA Customer Services and they will send one to you free of charge. This listing may have changed since the date of printing, therefore, it is always a good idea to check with the provider to make sure he or she is still participating with this Plan. A Directory is also available on UHA's website at uhahealth.com.

It is also important to understand that a specific physician or other provider may be a Participating Provider at one office location, and Non-Participating at another location. Additionally, a hospital may be a participating hospital, but some of the physicians or other licensed providers who practice at that hospital may not be participating providers with UHA. It is always a good idea to verify that each provider is participating with UHA before you receive services in order to help minimize your health care costs.

Non-Participating Providers

A **Non-Participating Provider** is any health care provider who does not have a contract with UHA to participate with this Plan, including out-of-state providers.

You may visit a provider that is not participating with UHA. UHA will pay **you** (the participant) the Eligible Charge for covered services less your copayment or coinsurance. You will then pay the provider the total charge (which includes any difference between UHA's payment and the total actual charge) plus the applicable taxes for each service. UHA has no contract with Non-Participating Providers to guarantee the amount of charges you are assessed. UHA does not recognize assignment of benefits to Non-Participating Providers. However, at its sole discretion, UHA will make payments directly to Non-Participating hospitals for inpatient services.

***Please note*:** Your Participating Provider may refer services to a Non-Participating Provider and you may incur a higher out-of-pocket expense. For example, your Participating Provider may send you to a Non-Participating specialist for additional care. You can ask for your referral to be to a Participating Provider to help minimize your health care costs.

If you are referred to a specialist who is a UHA participating physician, your cost for the office visit will be the 10% coinsurance, plus the applicable excise tax and charges for non-covered services. If the physician does not participate with UHA, UHA will pay the Eligible Charge for covered services, less your applicable copayment or coinsurance, and the payment will be made directly to you. You will also be responsible for any difference between the Eligible Charge and the amount charged by the specialist, plus the applicable taxes.

SERVICES OUTSIDE THE SERVICE AREA

The **Service Area** for this Plan is the State of Hawaii.

UHA has an agreement with a mainland contractor to help you control your health care expenses in the event of a travel emergency. A travel emergency is a medical emergency that occurs while you are traveling outside of the Service Area. For example, you suffer a broken arm while vacationing in Las Vegas. Treatment for a condition which occurred or was diagnosed before your trip will be subject to the same Prior Authorization requirements as any non-emergent treatment outside of the State of Hawaii.

UHA reserves the right to modify the agreement with the mainland contractor which may affect coverage for services. Please check with UHA before you travel to determine the extent of coverage through the mainland contractor in the area you are visiting. For a list of facilities that are **not** contracted, please visit UHA's website at uhahealth.com under "Search Mainland Provider". ***Please note*:** The agreement between UHA and the mainland contractor does not include coverage for Chiropractors and Acupuncturists.

The agreement between UHA and the mainland contractor also covers medical care provided on the mainland to:

1. Your dependent children under 26 years of age who reside on the mainland;
2. You and your dependents if your employer requires that you reside on the mainland; and
3. You and your dependents who reside on the mainland during any period of continued coverage under COBRA.

If you have two addresses, UHA will only recognize the Hawaii address which provides coverage in the Plan's Service Area.

The following require Prior Authorization (see Health Care Services Program, pages 30-34):

- If you are a Hawaii resident and require medical services that are not available in Hawaii, your physician should contact UHA for an authorization for referral to a mainland provider.
- Hawaii residents seeking services or procedures on the mainland when clinically similar services are performed and available in Hawaii.
- Mainland residents seeking elective ambulatory surgery center (ASC) or hospital based procedures, or any advanced imaging.

For covered services rendered outside the Service Area, UHA will pay benefits as described in this booklet, but in no event will the Eligible Charge for such covered services exceed the Eligible Charge for similar services rendered in the State of Hawaii.

If you receive care on the mainland, your plan coverage may be significantly less than if you receive care within Hawaii. This may result in high out-of-pocket costs to you. Please contact the Health Care Services Department at 532-4006 (or 1-800-458-4600 from the Neighbor Islands) for questions about out-of-state care.

If it is reasonable for you to receive elective services in Hawaii, but you elect to have the service(s) performed on the mainland, then services obtained from providers participating with the mainland contractor may be paid at the Non-Participating Provider benefit level, and you will be responsible for the provider's charges in excess of UHA's payment. Please refer to UHA's "Referrals for Out-of-State Services" policy on UHA's website at uhahealth.com for more information.

Services received beyond the mainland, such as in a foreign country, are not covered except in the event of a travel emergency.

HEALTH CARE SERVICES PROGRAM

To keep your Plan affordable, each claim is reviewed to make sure that the Plan pays for services that are covered benefits and medically necessary.

PAYMENT DETERMINATION CRITERIA

In order for UHA to pay for a covered service, all of the following payment determination criteria must be met:

- The service must be listed as a covered benefit and not be excluded as a benefit under this Plan;
- The service must be medically necessary for the diagnosis or treatment of your illness or injury;
- The service must be provided in an appropriate setting and at an appropriate level of care; and
- When required under this Plan, the service must be prior authorized.

The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets these payment criteria, even if the service or supply is listed as a covered service.

Additional and more clinically specific information about your coverage may be obtained by reviewing **UHA's Medical Payment Policies** with your healthcare provider. They may be found on UHA's website at uhahealth.com.

MEDICAL NECESSITY

It is the responsibility of UHA's Health Care Services Department to determine if a recommended service is medically necessary.

In making the determination of medical necessity, UHA follows the definition established by Hawaii State law, HRS 432E-1.4:

"(a) For contractual purposes, a health intervention shall be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care provider, and determined by the health plan's medical director to be medically necessary as defined in subsection (b). A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. A managed care plan may choose to cover health interventions that do not meet the definition of medical necessity.

(b) A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is:

(1) For the purpose of treating a medical condition;

(2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient;

(3) Known to be effective in improving health outcomes; provided that:

(A) Effectiveness is determined first by scientific evidence;

(B) If no scientific evidence exists, then by professional standards of care; and

(C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and

(4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price."

To assure to the extent possible that a recommended service is medically necessary, UHA utilizes three levels of case review and management: **concurrent review, Prior Authorization,** and **retrospective review**. All Participating Providers agree to cooperate with UHA in its efforts to make these determinations on your behalf. To be successful, UHA needs your cooperation.

PRIOR NOTIFICATION OF ADMISSIONS AND CONCURRENT REVIEW

To work effectively, UHA must be aware of services recommended by your provider that require hospitalization, that are likely to require ongoing care after discharge, and which may require services or supplies to facilitate discharge from the hospital.

Once UHA is made aware of your hospitalization, Health Care Services nurses monitor your care, concurrently assisting with discharge planning and case management. In order for this review process to work for your benefit, UHA requires that you or your physician notify the Health Care Services Department at least **72 hours in advance** of:

- Elective admission to a hospital or rehabilitation facility
- Provision of any substance abuse treatment services

For emergency and non-elective admissions, UHA must be notified within one business day of admission.

If you are under the care of a Non-Participating Provider, you are responsible for providing Prior Notification to UHA.

PRIOR AUTHORIZATION

Prior authorization is a special pre-approval process to ensure that certain treatments, procedures, or supplies are medically necessary covered services.

In determining whether to provide prior authorization, UHA may use guidelines that include clinical standards, protocols, or criteria regarding treatment of specific conditions or providing certain services or supplies. If you are requesting prior authorization and want a copy of the guidelines used for a particular condition or treatment, contact UHA's Health Care Services Department at 532-4006 or 1-800-458-4600, ext. 300 (toll free from the Neighbor Islands).

The services that require prior authorization are listed at the end of this section. If you are under the care of a UHA Participating Provider, the provider should obtain authorization for you and the provider will accept any penalties for failure to obtain authorization. If you are under the care of a Non-Participating Provider, you are responsible for obtaining authorization. **If you do not obtain prior authorization, benefits may be denied.** Penalties for not obtaining prior authorization do not apply toward meeting the Annual Out-of-Pocket Maximum.

How to Obtain Prior Authorization

Prior authorization may be requested by mailing or faxing your request to UHA's Health Care Services Department at:

UHA Health Care Services Department
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813-4100

Phone: (808) 532-4006 (Oahu); 1-800-458-4600, ext. 300 (Toll Free from the Neighbor Islands)
Fax: (866) 572-4384

The Health Care Services Department is open from 8:00 a.m. to 4:00 p.m., Monday through Friday.

Prior Authorization Request forms may be downloaded from the UHA website: uhahealth.com. Your request for prior authorization must include the following information:

- Member name, address, birth date, and UHA Member Number
- Requesting provider's name, specialty, phone and fax numbers
- Information about the member's other health insurance, if any
- Name of the provider of the requested service
- Name of the facility where the requested service will be performed
- Diagnoses, procedures, and supporting medical information
- Information about whether the member's condition is employment or automobile related

- If the prior authorization is for a drug override, the name of the drug and reason for the override
- Provider acknowledgement that the requested service meets the definition of medically necessary

You must provide sufficient information to allow UHA to make a decision regarding your request. If you do not provide the information requested, or if the information you provide does not show entitlement to coverage under this Plan, your request may be denied.

If you want to designate a representative to make a request for prior authorization on your behalf, you may do so by filing an Authorization for Release of Information form with UHA. Contact the Health Care Services Department for an authorization form. If a healthcare provider with knowledge of your condition makes a request for an expedited decision on your behalf, UHA does not require an Authorization for Release of Information from you.

UHA's Decision on Your Request

UHA will make a decision on your request for prior authorization within 15 days of receiving your request.

This period may be extended if you fail to submit information necessary to determine your request, and in that event, UHA will tell you what additional information is needed and will provide you at least 45 days to submit the additional information. UHA may also extend this period one time, for up to 15 days, if the extension is necessary for reasons beyond UHA's control. In that event, UHA will notify you of the circumstances warranting the extension and the date by which a decision will be rendered.

If your request is denied in whole or in part, UHA will provide an explanation, including the specific reason for denial and reference to the health plan terms upon which the denial is based. If you disagree with UHA's denial, you may file an appeal in accordance with the appeal procedures beginning on page 72.

Expedited Review

If your health or ability to regain maximum function could be seriously harmed by waiting 15 days for a decision, you or your physician may request an expedited decision. If UHA finds, or your health care provider states, that your health or ability to regain maximum function could be seriously harmed by waiting 15 days for a decision, UHA will make a decision within 72 hours of receiving your request for an expedited decision and all required information.

You may make your request for an expedited review orally or in writing to the Health Care Services Department. The information required to process your request includes the same information required on the Prior Authorization Request form, as described above. If you qualify for an expedited decision but UHA does

not have sufficient information on which to make an expedited decision, UHA will inform you within 24 hours of receiving your request and will provide you at least 48 hours to submit the required information.

Services Requiring Prior Authorization

The following list summarizes UHA's prior authorization requirements. **These requirements are subject to change upon renewal.** You may contact UHA's Health Care Services Department for the most current list or review the list online at uhahealth.com.

Inpatient and Ambulatory (Outpatient) Surgical Procedures

- All ablative treatment for atrial fibrillation
- Ambulatory surgery proposed to be done in an inpatient setting
- Anesthesia services for gastrointestinal endoscopy
- Arthroscopy, hip, surgical; with removal of loose body or foreign body – with femoroplasty, acetabuloplasty, or labral repair
- Artificial disc insertion in cervical spine (lumbar **NON-COVERED)**
- Autologous chondrocyte implantation (knee)
- Bariatric surgery
- Blepharoplasty and repair of blepharoptosis
- Cardiac catheter ablation procedures
- Electromagnetic navigation bronchoscopy
- Emerging technology (T codes)
- Gender identity reconstructive surgery
- Hepatic resection, radiofrequency ablation and cryotherapy; chemoembolization, and microsphere radiocolloid infusion/embolization
- Hyperbaric oxygen treatment
- Intrastromal corneal ring segments
- In vitro fertilization services
- Kyphoplasty and vertebroplasty
- Lung volume reduction
- Organ, bone marrow, and stem cell transplant services: transplant evaluations, organ donor services, transplant procedures
- Osteochondral allograft
- Panniculectomy and abdominoplasty
- Photodynamic therapy for actinic keratoses and other skin lesions (Limitations and guidelines apply)
- Prophylactic mastectomy

- Radiofrequency ablation of miscellaneous solid tumors (Limitations and guidelines apply)
- Reduction mammaplasty (not related to breast reconstruction following mastectomy for cancer)
- Rhinectomy; partial
- Sleep apnea treatment
- Spinal cord stimulator for pain management
- Spinal injections for pain management
- Stereotactic radiosurgery (SRS) and fractionated stereotactic body radiotherapy (SRBT)
- Thoracic sympathectomy for hyperhidrosis
- Tissue-engineered skin substitutes (Limitations and guidelines apply)
- Transcatheter mitral valve repair
- Transcatheter pulmonary valve implantation
- Transmyocardial laser revascularization
- Treatment of hepatic neoplasms being considered for treatment outside of systemic chemotherapy alone
- Treatment of operable prostate cancer
- Treatment of varicose veins (Limitations and guidelines apply)

COSMETIC PROCEDURES ARE NON-COVERED SERVICES. For the most current list of cosmetic procedures, visit the UHA website at uhahealth.com under "Member Forms". **If a procedure or service could conceivably be considered to be cosmetic or investigational in nature, a Prior Authorization review is required. If a denial for services is issued and complications result in additional medical procedures, you may be financially responsible for those additional proceures.**

Diagnostic Testing and Radiology Procedures

- Charged-particle (Proton or Helium Ion) radiation therapy
- CTCA – Computerized Tomography of the Coronary Arteries (computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium is **NON-COVERED)**
- CTCA – Coronary Computed Tomography Angiography
- Genetic testing
- Oncotype DX
- PET scans
- Psychological testing
- Sleep studies
- Virtual colonoscopy (Limitations and guidelines apply)

Medical Equipment and Appliances and Supplies

- Continuous glucose monitoring system
- Custom fabricated medical items
- External insulin pump
- Home ventilator
- Medical equipment and appliances **purchase** greater than *$500*
- Medical equipment and appliances **rental** greater that *$100/month*
- Negative pressure wound therapy
- Oscillatory device for bronchial drainage
- Oxygen and oxygen equipment for home use
- Positive airway pressure devices for the treatment of obstructive sleep apnea
- Power mobility devices and push-rim activated power assist devices
- Pulse oximeter for home use (children and adult)
- Repair and maintenance of medical equipment and appliances
- Spinal cord stimulators for pain management
- Transcutaneous Electrical Nerve Stimulation
- Wheelchairs: pediatric and adult

Out-of-State Services

- For members living in Hawaii, ALL out-of-state requests (**require at least 2 weeks for processing)**
- For members on the mainland, in addition to all listed services: ALL ambulatory surgery center (ASC) or hospital based elective procedures, ALL advanced imaging

Prosthetics

- Prosthetics with cost greater than *$500*
- Endoskeletal knee-shin system

Rehabilitative Services

- Habilitative Services
- Intensive cardiac rehabilitation (Ornish)
- Physical and Occupational therapy (following **32** units [1 unit = 15 minutes] or **8** sessions; per calendar year). **Payment is limited to 4 units/session.**
- Residential treatment for chemical dependence (only for facility non-participating providers and out-of-state treatments)
- Speech therapy
- Applied behavior analysis for autism spectrum disorders

Home Health Services

- Home health services after the first 12 visits
- Home oxygen therapy (after initial three months)
- Home total parenteral nutrition for adults
- Home IV antibiotic therapy when not ordered and supervised by Infectious Diseases Specialist

Miscellaneous Services

- Cologuard as a choice for colorectal cancer screening ((Limitations and guidelines apply)
- Growth hormone therapy
- Hepatitis C treatment (Limitations and guidelines apply)
- Orthodontic services for orofacial anomalies
- Oral surgery
- Gender identity services
- Experimental and investigational services

Prescription Drugs

- For a list of medications that require prior authorization, please refer to the UHA website at uhahealth.com under "List of Drugs that Require Prior Authorization".

Services Requiring Advance Notification

The following services require advance notification:

- **Elective Hospital Admissions**

  72 hours advance notification is required for elective hospital admissions (including skilled nursing facilities and rehabilitation facilities) when possible. UHA requires notification of emergency and non-elective admissions within one business day of admission.

- **Chemical Dependency/Substance Abuse Residential Treatment**

  72 hours advance notification is required for chemical dependency/ substance abuse treatment.

RETROSPECTIVE REVIEW

All claims for reimbursement are subject to retrospective review to determine if the services provided were:

- Covered benefits,
- Medically necessary,
- Provided in an appropriate setting at an appropriate cost, and
- For a person properly eligible to receive benefits under this Plan.

This includes claims for services provided in an Emergency Department. To determine if these visits are covered, UHA uses the following definition of Emergency Services:

"Emergency Services is defined (1) in accordance with the definition established in Hawaii Revised Statutes (sect. 432E-1) as services provided to an individual when the individual has symptoms of sufficient severity, including severe pain, such that a layperson could reasonable expect, in the absence of medical treatment, to result in placing the individual's health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death; (2) with respect to a pregnant woman, a layperson could reasonably expect the absence of medical treatment to result in serious jeopardy to the health of the woman and her unborn child; or (3) Emergency Services as defined in accordance with federal law (the Patient Protection and Affordable Care Act, 42 U.S.C. Section 300gg-19a)."

If it is determined that an emergency room visit does not meet this standard, payment for these benefits will be denied. In this circumstance, you may be billed by the provider for payment for those services.

IMPORTANT QUESTIONS TO ASK WHEN YOU RECEIVE CARE

The benefits that this Plan pays when you receive medical services depend on the answers to several questions. It is a good idea to keep these in mind when you seek medical care:

1. **Is the service a Covered Service?** To receive benefits, the care you receive must be a covered service. Please refer to the Medical Plan Benefits section (pages 36-61) and Services Not Covered section (pages 62-66) for information on what services are covered and not covered.
2. **Is the provider a Participating Provider?** The amount this Plan pays and the amount you must pay depend on whether the provider of service is a Participating or Non-Participating provider. Please refer to the Choice of Health Care Providers section, (pages 27-28) for more information.
3. **Is the care Medically Necessary and does it meet Payment Determination Criteria?** Please refer to the Health Care Services Program section (page 29) for the definition of medically necessary and UHA's payment determination criteria.
4. **Is the service subject to Prior Authorization requirements?** Some services require prior authorization by UHA before you receive the services. Please refer to the Health Care Services Program section (pages 30-34) for information on prior authorization requirements.
5. **Is the service subject to a Benefit Maximum?** Certain services may have a maximum limit on the dollar amount, the number of visits, or other limitation. Information on benefit maximums for specific services is provided in the Medical Plan Benefits section (pages 36-61).
6. **Is the provider of service qualified and a recognized provider?** To determine if a provider is qualified and recognized, UHA considers the following:
    - Is the provider appropriately licensed?
    - If a facility, is the provider accredited by a recognized accrediting agency?
    - Is the provider qualified under the requirements of the federal Medicare program?
    - Is the provider certified by the appropriate government authority?
    - Are the services rendered within the lawful scope of the provider's licensure, certification, or accreditation?
7. **Did a provider order the care?** To be covered, all services must be ordered by a recognized provider.

MEDICAL PLAN BENEFITS

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

Prior Authorization is required for some services. From time to time it is necessary to change UHA's prior authorization requirements so that benefits remain current with the way therapies are delivered. Please call UHA's Health Care Services Department at 532-4006 (or 1-800-458-4600, ext. 300 toll-free from the Neighbor islands) to see if a service has been added to or deleted from the list on pages 31-34 of this booklet.

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

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

PREVENTIVE CARE SERVICES

PREVENTIVE CARE SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Well Child Care Physician Office Visits	No Copayment	No Copayment
Well Child Immunizations	No Copayment	No Copayment
Well Child Care Laboratory Tests	No Copayment	No Copayment
Preventive Medicine Office Visits	No Copayment	No Copayment
Well Woman Exam	No Copayment	No Copayment

PREVENTIVE CARE SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Screening Laboratory Services - Outpatient	No Copayment	No Copayment
Adult Immunizations	No Copayment	No Copayment
Mammography for Breast Cancer Screening	No Copayment	No Copayment
Cervical Cancer Screening (Pap Smear)	No Copayment	No Copayment
Chlamydia Screening	No Copayment	No Copayment
Osteoporosis Screening	No Copayment	No Copayment
Colorectal Cancer Screening	No Copayment	No Copayment

PREVENTIVE CARE SERVICES SPECIAL NOTES

UHA covers all U.S. Preventive Services Task Force (USPSTF) A and B recommended screening services at 100% as required under the provisions of the Affordable Care Act (ACA). For more information about additional services not listed below, please refer to the "Preventive Health Services" Medical Payment Policies on UHA's website at uhahealth.com.

Well Child Care Physician Office Visits: Covered, including routine sensory screening and developmental/behavioral assessments, according to the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care:

- Birth to one year: seven visits
- Age one year: three visits
- Age two years: two visits
- Ages three years through 21 years: one visit per year

If your child requires medical care for an illness or injury, benefits for Physician Visits, not Well Child Care, apply.

Well Child Immunizations: Covered, in accord with Hawaii law and the guidelines set by the CDC Advisory Committee on Immunization Practices (ACIP).

Well Child Care Laboratory Tests: Covered; UHA clinical preventive services guidelines are derived from the clinical recommendations of the USPSTF and the American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care.

Preventive Medicine Office Visit: Covered; one per calendar year for a preventive health examination for members who are 22 years and older. This benefit is in addition to the Well Woman Exam described below.

Well Woman Exam: Covered, for one annual health assessment per calendar year. The assessment should include screening, evaluation and counseling, and immunizations based on age and risk factors. Please refer to Cervical Cancer Screening (Pap smear) below for specific benefit information.

Screening Laboratory Services: Covered; UHA clinical preventive services guidelines are derived from the clinical recommendations of the USPSTF.

Adult Immunizations: Covered, for standard immunizations and for high risk conditions such as Hepatitis B and other vaccines in accord with the guidelines set by the CDC Advisory Committee on Immunization Practices (ACIP).

Mammography for Breast Cancer Screening: Covered, one per calendar year for women ages 40 and older.

Annual screening for women under 40 is allowed for women with a personal history of breast cancer, a history of chest irradiation, a family history of breast cancer in a first degree relative or a known genetic predisposition to breast cancer.

Each member's frequency of testing should be determined after consultation with her physician to assure that current recommendations and personal risk factors are considered.

Mammograms that are not done for breast cancer screening fall under diagnostic mammography benefits which are included under Diagnostic Testing, Laboratory and Radiology Services.

Cervical Cancer Screening (Pap smear): Covered, one every three years for women ages 21 to 65.

Chlamydia Screening: Covered, one per calendar year.

Osteoporosis Screening: Covered, for initial screening and repeat testing based on age and risk factors per USPSTF and National Osteoporosis Foundation guidelines.

Colorectal Cancer Screening: Covered, based on age and risk factors in compliance with current USPSTF guidelines.

DISEASE MANAGEMENT PROGRAMS

DISEASE MANAGEMENT PROGRAMS	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Smoking Cessation Program	No Copayment	No Copayment
Nutritional Counseling Programs	No Copayment	No Copayment
Asthma Education Program	No Copayment	No Copayment
Diabetes Self-Management Training and Education Program	No Copayment	No Copayment

DISEASE MANAGEMENT PROGRAMS SPECIAL NOTES

Smoking Cessation Program: Covered.

Nutritional Counseling Programs: Covered, but only when counseling is provided:

- By a Registered Dietician (RD), Certified Nutrition Specialist (CNS), or Certified Diabetes Educator (CDE); and
- For the treatment of eating disorders, convulsion/seizures, cardiovascular disease, hypertension, renal disease (chronic kidney disease and end stage renal disease), Crohn's disease, gastrointestinal disorders, gout, obesity in adults (BMI $\geq$ 30 kg/m2), loss of weight, pediatric overweight and obesity (BMI > 95%), pancreatitis, pre- and post-bariatric surgery, pre-natal diet regulation, obstructive sleep apnea, squamous cell – oropharynx, or diabetes.

Asthma Education: Covered, through UHA's Asthma Education Program. Please contact the Health Care Services Department for information about this program.

Diabetes Self-Management Training and Education: Covered, through UHA's Diabetes Education Program, but only through a Certified Diabetes Educator (CDE), Registered Dietician (RD), or Certified Nutrition Specialist (CNS). Please contact the Health Care Services Department for information about this program.

Disease Education Programs: UHA provides Disease Education Programs for members with diabetes and asthma. For information about these programs, please contact the Health Care Services Department. Information is also available on the website at uhahealth.com.

PHYSICIAN SERVICES

PHYSICIAN SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Physician Visits • Office • Hospital (Inpatient or Outpatient)	10% of Eligible Charge	30% of Eligible Charge
Emergency Room Physician Visits	10% of Eligible Charge	10% of Eligible Charge
Second Opinions *Prior Authorization required for opinions rendered by out-of-state providers.*	No Copayment	No Copayment
Consultations	10% of Eligible Charge	30% of Eligible Charge
Anesthesia	10% of Eligible Charge	30% of Eligible Charge

PHYSICIAN SERVICES SPECIAL NOTES

Physician Visits: Covered for the treatment of an illness or injury when you are an inpatient or are seen in a physician's office, clinic, outpatient center, emergency room or your home. Home visits or house calls are covered only when provided within the service area and only when your physician determines that necessary care can best be provided in the home. Services provided by Advanced Practice Registered Nurses and Physician Assistants are covered as Physician Services.

Physician Visits – Emergency Room: Covered, but only if the services provided are: (1) Emergency Services as defined in accordance with Hawaii Revised Statutes (sect. 432E-1) as services provided to an individual when the individual has symptoms of sufficient severity, including severe pain, such that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the individual's health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death; (2) with respect to a pregnant woman, a layperson could reasonably expect the absence of medical treatment to result in serious jeopardy to the health of the woman and her unborn

child; or (3) Emergency Services as defined in accordance with federal law (the Patient Protection and Affordable Care Act, 42 U.S.C. sect. 300gg-19a).

Examples of an emergency include:

- Chest pain or other signs of a heart attack
- Shortness of breath and/or difficulty breathing
- Loss of consciousness, convulsions or seizures
- Sudden onset of a severe and unexplained headache
- Sudden weakness on one side of your body
- Poisoning
- Broken back, neck or other bones
- Drug overdose
- Significant loss of blood
- Severe allergic reaction
- Severe burn

Examples of non-emergencies are colds, flu, sore throat, medication refills, and using the emergency room for your convenience for medical conditions that could be treated in your doctor's office.

Second Opinions: Covered. Second opinions on the necessity of surgery or other treatment are fully covered without copayment. Prior Authorization is required for opinions rendered by out-of-state providers.

Consultations: Covered, when requested by your attending physician. If you are hospitalized, the Plan will only pay for one consultation for each specialty for each confinement. Follow-up visits by consultants are covered if UHA determines that additional visits are medically necessary.

Anesthesia: Covered, as required by the attending physician and when appropriate for your condition. Covered services include general and regional anesthesia and conscious sedation.

SURGICAL SERVICES

SURGICAL SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Assistant Surgeon	10% of Eligible Charge	30% of Eligible Charge
Cutting and Non-Cutting Surgery – Inpatient *Certain surgical procedures require Prior Authorization.*	10% of Eligible Charge	30% of Eligible Charge
Cutting and Non-Cutting Surgery – Outpatient *Certain surgical procedures require Prior Authorization.*	10% of Eligible Charge	30% of Eligible Charge
Surgical Supplies	10% of Eligible Charge	30% of Eligible Charge

SURGICAL SERVICES SPECIAL NOTES

Covered surgical services include operating room, surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics, and blood transfusion services in an inpatient or outpatient facility.

Assistant Surgeon: Covered, but only when:

- Assistance is medically necessary based on the complexity of the surgery; and
- The facility does not have a residency or training program; or
- The facility has a residency or training program, but a resident or intern on staff is not available to assist the surgeon.

Cutting Surgery: Covered, including pre- and post-operative care. Pre-operative and post-operative care provided in connection with surgical procedures is included in the Eligible Charge for the surgery. If a physician charges separately for the preoperative and postoperative care in excess of this single Eligible Charge, the Plan will not pay the excess charges.

Non-Cutting Surgery: Covered. Examples of non-cutting surgical procedures include: diagnostic and endoscopic procedures; diagnostic and therapeutic injections; orthopedic castings; destruction of localized lesions by chemotherapy (excluding silver nitrate); cryotherapy or electrosurgery; and acne treatment.

Reconstructive Surgery: Covered, but only for corrective surgery required to restore or correct any bodily function that was lost, impaired or damaged as a result of an illness or injury. Reconstructive surgery to correct congenital anomalies (defects present from birth) is covered only if the anomaly severely impairs or impedes normal, essential bodily functions.

Reconstructive or plastic surgery that is primarily intended to improve your natural appearance and does not restore or materially improve a physical function is considered cosmetic and is not covered. Services related to complications of non-covered reconstructive surgery are also not covered.

Women's Health and Cancer Rights Act of 1998: Following a mastectomy, reconstruction of the breast on which the mastectomy is performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and the patient, **are covered** as provided for in the Women's Health and Cancer Rights Act of 1998 **and do not require Prior Authorization**. Such coverage is subject to copayments that are consistent with those established for other benefits under this Plan.

Prior Authorization Requirements: Certain surgical procedures must receive Prior Authorization before they are performed.

Multiple Surgical Services: When multiple surgical services are performed at the same time, UHA will pay full benefits for the primary surgical service. Benefits for the secondary surgical service will be paid only when UHA determines that the secondary surgical service was necessitated by the complexity and risk of the primary surgical service. If benefits are determined to be payable, allowances for the secondary surgical services will be based on the additional complexity and risk.

Oral Surgery: Covered, but only for certain oral surgical services provided by a physician or a dentist. Services of a dentist (DDS or DMD) are covered services only when:

- The dentist is performing emergency service (for an accidental injury) or surgical services, and
- These covered services could also be performed by physicians (MD or DO).

Coverage is limited to: the removal of tumors and cysts; surgery to correct injuries; cutting and draining of cellulitis; cutting of sinuses, salivary glands, or ducts; and reduction of dislocations. These services, including those anticipated to require hospitalization if you have a serious medical problem, require Prior Authorization.

Payment Based on Appropriate Place for Surgery: If you choose to have surgery as an inpatient in a hospital or other facility when it could have been done safely and effectively in a physician's office or in an outpatient surgical center, the benefits paid will not exceed those for surgery in a physician's office or surgical center, whichever is most appropriate. Similarly, if you choose to have surgery in a surgical center when it could have been done safely and effectively in a physician's office, the benefits paid will not exceed those for surgery in a physician's office.

"Stand By" Time: The services of another physician may be necessary during a surgery so that the physician must "stand by" at the hospital. In this case, benefits will be paid for covered services that this physician actually provides, but no payment will be made for the waiting or "stand by" time.

HOSPITAL SERVICES

HOSPITAL SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Ambulatory Surgery Center (ASC)	10% of Eligible Charge	30% of Eligible Charge
Hospital Room and Board	No Copayment	30% of Eligible Charge
Special Care Units (Coronary care, intensive care, telemetry, or isolation)	No Copayment	30% of Eligible Charge
Hospital Ancillary Services – Inpatient	No Copayment	30% of Eligible Charge
Hospital Ancillary Services – Outpatient	10% of Eligible Charge	30% of Eligible Charge
Emergency Room (For emergencies only)	10% of Eligible Charge	10% of Eligible Charge

HOSPITAL SERVICES SPECIAL NOTES

Inpatient hospital services are covered up to 365 days per calendar year. The hospital facility must hold current national accreditation with either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF) for any level of care including acute inpatient, residential, partial hospitalization, or intensive outpatient programs.

Prior Notification: When and if you require hospital care, the hospital facility and your participating physician have a responsibility to notify UHA of your admission. This is important as UHA's Health Care Services Department reviews all hospital admissions concurrently on your behalf to determine if the level of care being provided is appropriate, the quality of care you are receiving meets predetermined standards and to participate in discharge planning.

If you have elected to receive care from a Non-Participating provider, you become primarily responsible for this prior notification to UHA.

Hospital Room and Board: Covered, including:

- Room and Board based on the participating facility's semi-private medical/surgical room rate, unless a private room is authorized by UHA. If the facility does not have semi-private rooms, or is a Non-Participating facility, benefits will be paid based on UHA's maximum allowable Eligible Charge for semi-private rooms. You will be responsible for your coinsurance on the Eligible Charge and any difference between the Eligible Charge for the semi-private room rate and the facility's room rate.
- Special care units, such as intensive care, coronary care, isolation or intermediate telemetry unit.
- Operating room, labor room, delivery room and recovery room.
- General nursing care.

Hospital Ancillary Services: Covered, including surgical supplies, hospital anesthesia services and supplies, diagnostic and therapy services, drugs, dressings, oxygen, antibiotics, and hospital blood transfusion services.

Emergency Room: Covered, but only if the services provided are: (1) Emergency Services as defined in accordance with Hawaii Revised Statutes (sect. 432E-1) as services provided to an individual when the individual has symptoms of sufficient severity, including severe pain, such that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the individual's health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death; (2) with respect to a pregnant woman, a layperson could reasonably expect the absence of medical treatment to result in serious jeopardy to the health of the woman and her unborn child; or (3) Emergency Services as defined in accordance with federal law (the Patient Protection and Affordable Care Act, 42 U.S.C. sect. 300gg-19a).

Examples of an emergency include:

- Chest pain or other signs of a heart attack
- Shortness of breath and/or difficulty breathing
- Loss of consciousness, convulsions or seizures
- Sudden onset of a severe and unexplained headache
- Sudden weakness on one side of your body
- Poisoning
- Broken back, neck or other bones
- Drug overdose
- Significant loss of blood
- Severe allergic reaction
- Severe burn

Examples of non-emergencies are colds, flu, sore throat, medication refills, and using the emergency room for your convenience for medical conditions that could be treated in your doctor's office.

If you require emergency services, call 911 or go to the nearest emergency room. Prior notification is not required.

If you are admitted to the hospital as an inpatient following a visit to the emergency room, hospital inpatient benefits apply, not emergency room benefits.

SKILLED NURSING FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Room and Board (Up to 120 days per calendar year)	No Copayment	30% of Eligible Charge
Ancillary Services	No Copayment	30% of Eligible Charge

SKILLED NURSING FACILITY SERVICES SPECIAL NOTES

Skilled Nursing Facility services are covered up to 120 days per calendar year.

Notification of Admission: If either a Participating or a Non-Participating physician recommends that you be admitted to a skilled nursing facility, you or your physician must notify UHA's Health Care Services Department within 72 hours of your admission.

Room and Board: Covered, but only at the Eligible Charge for a semi-private room.

Ancillary Services: Covered, including routine surgical supplies, drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy services.

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

- You meet Medicare skilled nursing criteria.
- The facility meets Medicare standards.
- The admission is ordered by a physician.
- You need skilled nursing services and are under the care of a physician during the admission.
- UHA approves the admission.
- The admission is not primarily for comfort, convenience, a rest cure, or domiciliary care.
- If the stay exceeds 30 days, the attending physician submits a report showing the need for skilled nursing care at the end of each 30-day period.
- The confinement is not for custodial care.

HOME HEALTH CARE AND HOSPICE SERVICES

HOME HEALTH CARE AND HOSPICE SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Home Health Care (Up to 150 visits per calendar year) *Prior Authorization required after first 12 visits.*	No Copayment	30% of Eligible Charge
Hospice Services	No Copayment	No Copayment

HOME HEALTH CARE AND HOSPICE SERVICES SPECIAL NOTES

Home Health Care: Covered, but only when all of the following statements are true:

- Home care services are prescribed in writing by a physician for the treatment of an illness or injury when you are homebound. Homebound means that due to an illness or an injury, you are unable to leave home unless you use devices or have assistance from another person and you meet homebound standards defined by the federal Medicare program.
- Part-time skilled health care services are required.
- Home health care services are not more costly than other covered services that would be effective for the treatment of your condition.
- Without home care, you would require inpatient hospital or skilled nursing facility care.
- If you need home health care services for more than 30 days, a physician certifies that there is further need for the services and provides a continuing plan of treatment at the end of each 30-day period of care.
- Services do not exceed 150 visits per calendar year.
- Services are provided by a qualified home care agency that meets Medicare requirements.
- UHA authorizes home health care services.

Prior Authorization is required for home health care services after the first 12 visits.

Hospice Services: Covered, but only if services are received from a Medicare-approved Hospice program. Covered services include:

- Residential hospice room and board expenses directly related to the hospice care being provided.
- Hospice referral visits during which a patient is advised of hospice care options, regardless of whether the referred person is eventually admitted to hospice care.

UHA endorses an “open access” model of hospice care in which palliative care and coordination can be undertaken while members continue or initiate medical, surgical, radiologic and other treatments for both life limiting and other medical conditions. Open access/concurrent hospice care services are covered when the following criteria are met:

- Services are prescribed in writing by the prescribing physician.
- Hospice services are provided by a Medicare-certified hospice under contract with UHA.
- The patient carries the diagnosis of a disease which is active, progressive and irreversible and which has resulted in a greatly reduced life expectancy.

- Interdisciplinary hospice care management is ongoing and documented.

Please refer to the specific benefits for more information on those services.

A certification/attestation of a life expectancy of less than or equal to six months is NOT required.

DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES

DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Allergy Testing	20% of Eligible Charge	30% of Eligible Charge
Diagnostic Mammography	No Copayment	30% of Eligible Charge
Diagnostic Testing – Inpatient	No Copayment	30% of Eligible Charge
Diagnostic Testing – Outpatient	20% of Eligible Charge	30% of Eligible Charge
Genetic Testing and Counseling *Prior Authorization required for testing.*	20% of Eligible Charge	30% of Eligible Charge
Genetic Testing and Counseling related to Breast Cancer (BRCA) screening *Prior Authorization required.*	No Copayment	No Copayment
Laboratory and Pathology – Inpatient	No Copayment	30% of Eligible Charge
Laboratory and Pathology – Outpatient	20% of Eligible Charge	30% of Eligible Charge

DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Radiology – Inpatient	No Copayment	30% of Eligible Charge
Radiology – Outpatient *Prior Authorization required for PET scans and CTCA.*	20% of Eligible Charge	30% of Eligible Charge
Tuberculin Test	No Copayment	No Copayment

DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SPECIAL NOTES

Allergy Testing and Treatment Materials: Covered.

Diagnostic Testing: Covered, when related to an injury, illness, or maternity care. Examples of diagnostic testing include:

- Electroencephalograms (EEG)
- Electrocardiograms (ECG or EKG)
- Holter monitoring
- Stress tests

Genetic Testing and Counseling: Covered, but genetic testing requires Prior Authorization.

Laboratory and Pathology: Covered, when related to an injury, illness or maternity care. Additional benefits for routine and preventive laboratory tests are described in the "Specific Benefits" categories.

Radiology: Covered, when related to an injury, illness, or maternity care. Additional benefits for routine and preventive radiology services are described in the "Specific Benefits" categories. Examples of radiology services are:

- Computerized tomography scans (CT scans)
- Diagnostic mammography
- Nuclear medicine procedures
- Ultrasound
- X-rays

Some Radiology services such as PET scans and CTCA require Prior Authorization.

Tuberculin Test: Covered, for one tuberculin (TB) test per calendar year.

CHEMOTHERAPY AND RADIATION THERAPY SERVICES

CHEMOTHERAPY AND RADIATION THERAPY SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Chemotherapy *Prior Authorization required for certain treatments.*	20% of Eligible Charge	30% of Eligible Charge
Oral Chemotherapy *Benefits are available for these drugs under this Plan only if you do not have a drug plan which provides coverage for oral chemotherapy. Prior Authorization required for certain drugs.*	No Copayment	Not Covered
Oral Chemotherapy by Mail Order (limited to a 30-day supply) *Benefits are available for these drugs under this Plan only if you do not have a drug plan which provides coverage for oral chemotherapy. Prior Authorization required for certain drugs.*	No Copayment	Not Covered
Radiation Therapy – Inpatient	No Copayment	30% of Eligible Charge

CHEMOTHERAPY AND RADIATION THERAPY SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Radiation Therapy – Outpatient *Prior Authorization required for certain treatments.*	20% of Eligible Charge	30% of Eligible Charge

CHEMOTHERAPY AND RADIATION THERAPY SPECIAL NOTES

Chemotherapy: Covered. Prior authorization is not required unless the recommended treatment plan does not conform to one of the nationally recognized oncology compendia.

Oral chemotherapy drugs are covered, but only when you do not have a prescription drug plan which provides coverage for oral chemotherapy. If you have coverage for oral chemotherapy drugs under a drug plan, there shall be no duplication of benefits between this Plan and your drug plan and this Plan will pay secondary to the more specific coverage afforded by your drug plan.

Radiation Therapy: Covered. Prior authorization is required for certain treatments.

ORGAN TRANSPLANT SERVICES

ORGAN TRANSPLANT SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Transplant Evaluation *Prior Authorization required.*	No Copayment	Not Covered
Corneal Transplants	10% of Eligible Charge	30% of Eligible Charge

ORGAN TRANSPLANT SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
All Other Organ Transplants *Prior Authorization required.*	No Copayment	Not Covered
Organ Donor Services *Prior Authorization required.*	20% of Eligible Charge	30% of Eligible Charge

ORGAN TRANSPLANT SERVICES SPECIAL NOTES

Organ and Tissue Transplants: Covered, but only as described in this Organ Transplant Services section. Prior authorization is required for all transplants, except corneal.

Transplant services must be provided by a facility that is under contract with UHA for that type of transplant and that facility must accept you as a candidate.

Benefits are not available for any of the following:

- Artificial (mechanical) organs, except for artificial hearts when used as a bridge to a permanent heart transplant
- Non-human organs
- The purchase of organs
- Organ or tissue transplants not listed in this Organ Transplant Services section

Transplant Evaluations: Covered, for transplants listed in this section but only with Prior Authorization. Transplant evaluation means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations that a facility uses in evaluating a potential transplant candidate.

Corneal Transplants: Covered

Bone Marrow Transplants: Coverage is available only for treatment prescribed in accord with UHA's medical payment policies and requires Prior Authorization.

Heart Transplants: Covered, but only if you meet UHA's criteria and obtain Prior Authorization.

Heart and Lung Transplants: Covered, but only if you meet UHA's criteria and obtain Prior Authorization.

Kidney Transplants: Covered, but only if you meet UHA's criteria and obtain Prior Authorization.

Liver Transplants: Covered, but only if you meet UHA's criteria and obtain Prior Authorization.

Lung Transplants: Covered, but only if you meet UHA's criteria and obtain Prior Authorization.

Simultaneous Kidney/Pancreas Transplants: Covered, but only if you meet UHA's criteria and obtain Prior Authorization.

Small Bowel and Multivisceral Transplants: Covered, but only if you meet UHA's criteria and obtain Prior Authorization.

Organ Donor Services: Covered, but only with Prior Authorization and when you are the recipient of the organ. If you are donating an organ to someone else, then no benefits are available under this Plan.

If you are the recipient of an organ from a living donor and the donor's health coverage provides benefits for organ(s) donated by a living donor, then this Plan's coverage is secondary and the living donor's coverage is primary. No benefits are available under this Plan to the living donor for post-transplant donor services.

Benefits for the screening of donors are limited to the expenses of the actual donor. No benefits are available for screening expenses of candidates who do not become the actual donor.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Mental Health and Substance Abuse Facility Services – Inpatient	No Copayment	30% of Eligible Charge
Mental Health and Substance Abuse Facility Services – Outpatient	10% of Eligible Charge	30% of Eligible Charge
Mental Health and Substance Abuse Professional Services – Inpatient	10% of Eligible Charge	30% of Eligible Charge

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Mental Health and Substance Abuse Professional Services – Outpatient	10% of Eligible Charge	30% of Eligible Charge
Psychological Testing – Inpatient	10% of Eligible Charge	30% of Eligible Charge
Psychological Testing – Outpatient *Prior Authorization required.*	20% of Eligible Charge	30% of Eligible Charge

MENTAL HEALTH AND SUBSTANCE ABUSE SPECIAL NOTES

Mental health and substance abuse services are covered if all of the following are true:

- You are diagnosed with a condition listed within the current version of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- The services are provided under an individualized treatment plan subject to review and approval by UHA or its designee.
- The services are provided by a licensed physician, psychiatrist, psychologist, clinical social worker, mental health counselor, marriage and family therapist, or advanced practice registered nurse. Nutritional counseling services for the treatment of eating disorders is covered, but only when the services are provided by a Registered Dietician (RD) or Certified Nutrition Specialist (CNS).
- Except for telehealth interactions as defined by Hawaii law and family psychotherapy sessions as discussed below, you are physically present with the provider when the services are provided. Standard telephone contacts, facsimile transmissions, or email text, in combination or by itself, do not constitute a telehealth service.
- Each family psychotherapy session may only be billed to one family member, even if the provider is seeing multiple members of the same family. Coverage will be provided for family psychotherapy without the patient present.
- The services are certified as medically or psychologically necessary at the least restrictive appropriate level of care in accordance with Hawaii law.

Conditions such as epilepsy, senility, intellectual disability, or other developmental disabilities, and addiction to and use of intoxicating substances do not, in and of themselves, constitute a mental disorder. You are not covered for educational programs or other services performed by mutual self-help groups, even if you are referred to such groups by your provider or the judicial system.

You are not covered when someone else, including but not limited to any federal, state, territorial, municipal, or other government instrumentality or agency, has the legal obligation to pay for your care, and when, in the absence of this Plan, you would not be charged.

You are covered for treatment provided by a marriage and family therapist but only for treatment of mental illness or substance or drug abuse. You are not otherwise covered for services rendered by a marriage and family therapist.

Outpatient Services: Covered, as follows:

- Outpatient visits by a licensed physician, psychiatrist, psychologist, licensed clinical social worker, licensed mental health counselor, marriage and family therapist, or advanced practice registered nurse for mental health or substance abuse conditions. Nutritional counseling services for the treatment of eating disorders is covered, but only when the services are provided by a Registered Dietician (RD) or Certified Nutrition Specialist (CNS).
- Outpatient psychological testing requires Prior Authorization.
- Residential substance abuse services require 72 hours Prior Notification.

Inpatient Services: Covered, as follows:

- Facility days for mental health or substance abuse conditions. Inpatient care is limited to room, medically necessary care, and ancillary inpatient services.
- Inpatient visits by a licensed physician, psychiatrist, psychologist, licensed clinical social worker, licensed mental health counselor, marriage and family therapist, or advanced practice registered nurse for mental health or substance abuse conditions. Nutritional counseling services for the treatment of eating disorders is covered, but only when the services are provided by a Registered Dietician (RD) or Certified Nutrition Specialist (CNS).
- Substance abuse services require 72 hours Prior Notification.

SPECIFIC BENEFITS FOR CHILDREN

SPECIFIC BENEFITS FOR CHILDREN	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Newborn Circumcision	10% of Eligible Charge	30% of Eligible Charge
Newborn Nursery Care	No Copayment	30% of Eligible Charge
Well Child Care Physician Office Visits	No Copayment	No Copayment

SPECIFIC BENEFITS FOR CHILDREN SPECIAL NOTES

Newborn Circumcision: Covered.

Newborn Nursery Care: Newborn nursery length of stay, covered for up to:

- 48 hours from the time of delivery for normal labor and delivery, or
- 96 hours from the time of delivery for a cesarean birth

Benefits for newborn care, nursery, circumcision, premature child care, and care for illness or injury are only available if you add your child to your coverage within 31 days of birth.

Newborns with congenital defects and birth abnormalities are covered for the first 31 days of birth to the extent required by Hawaii law. These newborns are covered after 31 days of birth only if added to your coverage within 31 days of birth.

Well Child Care Physician Office Visits: Please refer to Preventive Care Services for more information.

SPECIFIC BENEFITS FOR WOMEN

SPECIFIC BENEFITS FOR WOMEN	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Birthing Room	No Copayment	20% of Eligible Charge
Cervical Cancer Screening (Pap smear)	No Copayment	No Copayment
Family Planning	10% of Eligible Charge	30% of Eligible Charge
Mammography for Breast Cancer Screening	No Copayment	No Copayment
Maternity Care	10% of Eligible Charge	30% of Eligible Charge
Tubal Ligation	10% of Eligible Charge	30% of Eligible Charge
Termination of Pregnancy	10% of Eligible Charge	30% of Eligible Charge
Well Woman Exam	No Copayment	No Copayment
Oral Contraceptives from Pharmacy (30-day supply) *Benefits are available for these contraceptives under this Plan only if you do not have a drug plan which provides coverage for contraceptives.*	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)

SPECIFIC BENEFITS FOR WOMEN	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Oral Contraceptives by Mail Order & Maintenance Retail (60-day supply for Brand 90-day supply for Generic) *Benefits are available for these contraceptives under this Plan only if you do not have a drug plan which provides coverage for contraceptives.*	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)	Not Covered
Over-the-Counter (OTC) Contraceptives from Pharmacy *Benefits are available for these contraceptives under this Plan only if you do not have a drug plan which provides coverage for contraceptives.*	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)
Contraceptive Implants, Injections, IUDs	No Copayment	No Copayment

SPECIFIC BENEFITS FOR WOMEN SPECIAL NOTES

Birthing Room: Covered, but only for labor and delivery.

Cervical Cancer Screening (Pap smear): Please refer to Preventive Care Services for more information.

Family Planning Services: Covered, including abortion counseling and information on birth control.

Mammography for Breast Cancer Screening: Please refer to Preventive Care Services for more information.

Maternity Care: Covered, including prenatal, false labor, delivery, and postnatal services provided by your physician or certified nurse midwife. Maternity care does not include related services such as nursery care, labor room, hospital room and board, diagnostic testing, and other lab work and radiology. Please refer to the specific benefits for more information on those services.

The Eligible Charge is a global fee related to a bundle of maternity care, which includes prenatal and postnatal care. If payments for prenatal care are made separately prior to delivery, such payments will be considered advance payments and will be deducted from the maximum allowance for delivery. If a physician provides all or part of the antepartum and/or postpartum patient care but does not perform delivery, separate copayments may apply.

Maternity length of stay, covered for up to:

- 48 hours from the time of delivery for normal labor and delivery, or
- 96 hours from the time of delivery for a cesarean birth

Prenatal Program: UHA may contract with vendors to reduce complications of pregnancy and improve quality of care for expectant mothers with diabetes. Please call the Health Care Services Department for information about current programs.

Tubal Ligation: Covered for only the initial surgery for tubal ligation. Reversal of a tubal ligation is not covered.

Termination of Pregnancy: Covered.

Well Woman Exam: Please refer to Preventive Care Services for more information.

Contraceptive Services and Supplies: Covered, for selected brands and generics determined by UHA in accordance with Hawaii law, but only when:

- Prescribed by your physician (except for emergency contraceptives);
- Approved by the Food and Drug Administration; and
- You do not have a prescription drug plan which provides coverage for contraceptives.

You may obtain a copy of UHA's Preferred Drug Listing by calling Customer Services. The Listing also appears on the website at uhahealth.com.

Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. If you have coverage for contraceptives under a drug plan, there shall be no duplication of benefits between this Plan and your drug plan and this Plan will pay secondary to the more specific coverage afforded by your drug plan.

You are not covered for contraceptive foams, creams, condoms, or other non-prescription substances or supplies used individually or in conjunction with any prescribed drug or device.

Over-the-Counter (OTC) Contraceptives: Covered, for selected brands and generics determined by UHA in accordance with Hawaii law, but only when you receive a written prescription and when obtained from a licensed pharmacist.

SPECIFIC BENEFITS FOR MEN

SPECIFIC BENEFITS FOR MEN	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Prostate Specific Antigen (PSA) Test	20% of Eligible Charge	30% of Eligible Charge
Vasectomy	No Copayment	No Copayment
Erectile Dysfunction	10% of Eligible Charge	30% of Eligible Charge

SPECIFIC BENEFITS FOR MEN SPECIAL NOTES

Prostate Specific Antigen (PSA) Test: Covered; for one prostate specific antigen test per calendar year for men age 50 or older.

Vasectomy: Covered, for only the initial surgery for a vasectomy. Reversal of a vasectomy is not covered.

Erectile Dysfunction: Covered, for services, supplies, prosthetic devices, and injectables to treat erectile dysfunction due to organic cause as defined by UHA or as described under Gender Identity Services (page 59).

SPECIFIC BENEFITS FOR MEMBER AND COVERED SPOUSE

SPECIFIC BENEFITS FOR MEMBER AND COVERED SPOUSE	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
In Vitro Fertilization *Prior Authorization required.*	10% of Eligible Charge	30% of Eligible Charge

IN VITRO FERTILIZATION SPECIAL NOTES

In Vitro Fertilization: Covered, to the extent required by Hawaii law if the in vitro fertilization is for you and your spouse. Coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are a UHA member. If you receive benefits for in vitro fertilization services under a UHA plan, you will not be eligible for in vitro fertilization benefits under any other UHA plan.

One complete in vitro procedure is covered. Payment of benefits for an incomplete in vitro procedure counts as meeting the one-time only benefit limitation. In vitro fertilization services require Prior Authorization.

In vitro fertilization services are not covered when a surrogate is used. The in vitro fertilization procedures must be performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimum standards for programs of in vitro fertilization.

If you have a male spouse, you must meet all the following criteria:

(a) You and your spouse have a five-year history of infertility or infertility is related to one or more of the following medical conditions:

- Endometriosis;
- Exposure in utero to diethylstilbestrol (DES);
- Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
- Abnormal male factors contributing to the infertility.

(b) You and your male spouse have been unable to attain a successful pregnancy through other infertility treatments.

(c) Oocytes are fertilized with your spouse's sperm.

If you do not have a male spouse, you must meet the following criteria:

(a) You are not known to be otherwise infertile, and

(b) You have failed to achieve pregnancy following three cycles of physician-directed, appropriately timed intrauterine insemination.

SPECIFIC BENEFITS FOR DIABETES

SPECIFIC BENEFITS FOR DIABETES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Benefits are available for diabetes drugs, insulin, and diabetes supplies under this Plan only if you do not have a drug plan which provides coverage for diabetes drugs, insulin, and diabetes supplies.		
Diabetes Drugs from Pharmacy (limited to 30-day supply)	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)
Diabetes Drugs by Mail Order & Maintenance Retail (90-day supply)	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)	Not Covered
Insulin from Pharmacy (limited to 30-day supply)	No Copayment (Preferred Brand or Non-Preferred Brand)	No Copayment (Preferred Brand or Non-Preferred Brand)
Insulin by Mail Order & Maintenance Retail (90-day supply)	No Copayment (Preferred Brand or Non-Preferred Brand)	Not Covered
Diabetes Supplies from Pharmacy (limited to 30-day supply)	No Copayment (Preferred Brand or Non-Preferred Brand)	No Copayment (Preferred Brand or Non-Preferred Brand)

SPECIFIC BENEFITS FOR DIABETES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Diabetes Supplies by Mail Order & Maintenance Retail (90-day supply)	No Copayment (Preferred Brand or Non-Preferred Brand)	Not Covered
Diabetes Self-Management Training and Education Program	No Copayment	No Copayment

SPECIFIC BENEFITS FOR DIABETES SPECIAL NOTES

Diabetes Drugs, Insulin, and Supplies: Covered, but only when:

- Prescribed by a health care professional authorized to prescribe the drug, insulin or supply; and
- You do not have a prescription drug plan which provides coverage for diabetes drugs, insulin and supplies.

If you have a drug plan which provides coverage for diabetes drugs, insulin and supplies, there shall be no duplication of benefits between this Plan and your drug plan and this Plan will pay secondary to the more specific coverage afforded by your drug plan.

Diabetes drugs, insulin, and supplies can be Generic, Preferred Brand or Non-Preferred Brand. You may obtain a copy of UHA's Preferred Drug Listing by calling Customer Services. The Listing also appears on the website at uhahealth.com.

Covered diabetic supplies include lancets, syringes and needles, sugar test tablets, test strips, and blood glucose monitors.

Diabetes Self-Management Training and Education: Covered, through UHA's Diabetes Education Program, but only through a Certified Diabetes Educator (CDE), Registered Dietician (RD), or Certified Nutrition Specialist (CNS). Please contact the Health Care Services Department for information about this program.

Prenatal Program: UHA may contract with vendors to reduce complications of pregnancy and improve quality of care for expectant members with diabetes. Contact the Health Care Services Department for information about current programs.

COMPLEMENTARY ALTERNATIVE MEDICINE

COMPLEMENTARY ALTERNATIVE MEDICINE	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Services provided by a chiropractor or acupuncturist for conditions limited to the neuromusculoskeletal system		
Office Visit	$10 Copayment	Plan pays up to $20 per visit; you pay the balance
First set of X-rays	50% of Eligible Charge	Not covered

COMPLEMENTARY ALTERNATIVE MEDICINE SPECIAL NOTES

Services provided by a Chiropractor or Acupuncturist: Covered, subject to the following:

- Benefits are limited to treatment of conditions of the neuromusculoskeletal system, which consists of the nerves, muscles and bones.
- The service is provided by a qualified provider of chiropractic or acupuncture services. A qualified provider is an individual who is licensed appropriately, performs within the scope of his/her licensure and is recognized by UHA.
- The Plan pays 50% of the Eligible Charge for the first set of X-rays ordered by a participating Chiropractor. You are responsible for the balance of the Eligible Charge for the first set of X-rays and the full charge for any subsequent X-rays. The Plan does not cover X-rays ordered by non-participating chiropractors.
- The total maximum benefit paid by the Plan per calendar year is $500 for combined services provided by either participating or non-participating chiropractic and acupuncture providers.

OTHER MEDICAL SERVICES

OTHER MEDICAL SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Ambulance (ground or air) **For emergencies only**	20% of Eligible Charge	30% of Eligible Charge
Applied Behavioral Analysis for Autism Spectrum Disorders *Prior Authorization required.*	10% of Eligible Charge	30% of Eligible Charge
Bariatric Surgery *Prior Authorization required.*	10% of Eligible Charge	30% of Eligible Charge
Blood, Blood Products & Blood Bank Service Charges	20% of Eligible Charge	30% of Eligible Charge
Dialysis and Supplies	20% of Eligible Charge	30% of Eligible Charge
Evaluations for Use of Hearing Aids	20% of Eligible Charge	30% of Eligible Charge
Growth Hormone Therapy *Prior Authorization required.*	20% of Eligible Charge	30% of Eligible Charge
Home Infusion Therapy *Prior Authorization required for Adult Home TPN services*	20% of Eligible Charge	30% of Eligible Charge
Hyperbaric Oxygen Treatment *Prior Authorization required.*	20% of Eligible Charge	30% of Eligible Charge

OTHER MEDICAL SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Implants	20% of Eligible Charge	30% of Eligible Charge
Inhalation Therapy	20% of Eligible Charge	30% of Eligible Charge
Injectable Medications – Outpatient *Prior Authorization required for certain injectables.*	20% of Eligible Charge	30% of Eligible Charge
Medical Equipment and Appliances *Prior Authorization required when purchase is greater than $500 or rental is greater than $100/ month.*	20% of Eligible Charge	30% of Eligible Charge
Medical Foods	20% of Eligible Charge	20% of Eligible Charge
Orthotics	20% of Eligible Charge	30% of Eligible Charge
Physical and Occupational Therapy Services *Prior Authorization required after a total of 32 units (1 unit = 15 minutes).*	20% of Eligible Charge	30% of Eligible Charge
Prosthetics *Prior Authorization required when cost is more than $500*.	20% of Eligible Charge	30% of Eligible Charge

OTHER MEDICAL SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Speech Therapy Services *Prior Authorization required.*	20% of Eligible Charge	30% of Eligible Charge

OTHER MEDICAL SERVICES SPECIAL NOTES

Ambulance: Covered, for ground and intra-island or inter-island air ambulance services to the nearest hospital equipped to treat your illness or injury, when all of the following apply:

- Services to treat your illness or injury are not available in the hospital or skilled nursing facility where you are an inpatient or in the emergency department where you are initially seen.
- Transportation begins at the place where an injury or illness occurred or first required emergency care.
- Transportation ends at the nearest facility equipped to furnish emergency treatment.
- Transportation is for emergency treatment under circumstances where emergency room services would be covered.
- Transportation takes you to the nearest facility equipped to furnish emergency treatment.

Air ambulance benefits are limited to inter-island and intra-island transportation within the State of Hawaii.

Applied Behavioral Analysis for Autism Spectrum Disorders: Treatment and therapeutic care for members with clearly diagnosed autism is covered in accordance with Hawaii law. These services require Prior Authorization with a defined and personalized treatment plan after the diagnosis is made. Services must be provided by licensed or certified providers as defined by the Hawaii Revised Statutes. Medical necessity determinations rest upon complex diagnostic criteria and the early involvement of pediatric psychiatrists and/or psychologists in making diagnoses and originating treatment plans can simplify this process.

Bariatric Surgery: Covered, but requires Prior Authorization.

Blood and Blood Products: Covered, including blood costs, blood bank services, and blood processing.

You are not covered for peripheral stem cell transplants except as described in the Organ Transplants Services section under “Bone Marrow Transplants”.

Dialysis and Dialysis Supplies: Covered

Evaluations for Hearing Aids: Covered, but only when you receive the evaluation for the use of a hearing aid in the office of a physician or audiologist.

Gender Identity Services: Covered, subject to the limitations described in UHA's medical payment policy. Certain services require Prior Authorization; exclusions may apply.

The services listed below are covered, but only when deemed medically necessary to treat gender dysphoria. Your copayments and coinsurance may vary depending on the type of service or supply you receive. Additional benefit information about the service or supply you receive can be found in other areas of the Medical Plan Benefits section.

- Gender reassignment surgery
- Hospital room and board
- Hormone injection therapy
- Laboratory monitoring
- Other gender reassignment surgery related services and supplies which are medically necessary and not excluded. These include but are not limited to sexual identification counseling, pre-surgery consultations and post-surgery follow-up visits.
- Otherwise covered services deemed medically necessary to treat gender dysphoria

Growth Hormone Therapy: Covered, subject to the limitations described in UHA's medical payment policy, but requires Prior Authorization. Benefits for human growth hormone therapy are available for eligible persons based on medical necessity.

Home Infusion Therapy: Covered, for services and supplies for outpatient injections or intravenous administration of medication or nutrient solutions required for primary diet. Home total parenteral nutrition (TPN) for adults requires Prior Authorization.

Hyperbaric Oxygen Treatment: Covered, but only with Prior Authorization.

Implants: Covered, for surgical implants like pacemakers, stents, and screws.

Inhalation Therapy: Covered.

Injectable Medications: Covered, for outpatient services and supplies for the injection or intravenous administration of medication or nutrient solutions required for primary diet, and travel immunizations in accord with the guidelines set by the CDC Advisory Committee on Immunization Practices (ACIP). Some injections require Prior Authorization.

Medical Equipment and Appliances: Covered, up to the Eligible Charge, only when ordered by your physician and subject to the following conditions:

- Prior Authorization is required when the purchase price for the item is greater than $500, or the rental fee for the item is greater than $100 per month. Examples include, but are not limited to CPAP units, BIPAP units, oxygen concentrators, wheelchairs, and hospital-type beds.
- Hearing aids are covered up to the Eligible Charge for one device per ear, every 5 years. You may be responsible for paying the provider the difference between UHA's payment and the total actual charge. You are not covered for the replacement of hearing aids lost or broken within five years from the date of purchase.
- Benefit payment for the rental of appliances and medical equipment is limited to the Eligible Charge to purchase the appliance or equipment.

Replacement appliances and equipment: Covered, only when ordered by your physician and when in the opinion of UHA the original appliance or equipment can no longer be used or repaired. UHA reserves the right to cover repair rather than replacement if it is the more cost-effective option. To "repair" means to fix or mend and put equipment back into good condition after damage or wear, and includes reasonable charges for parts and labor.

Repairs and maintenance of appliances and medical equipment

- Prior Authorization is required.
- You are not covered for routine maintenance of any medical equipment or appliance, including periodic servicing (such as testing, cleaning, adjusting, regulating and checking of equipment) unless you establish that you are unable due to illness, injury or disability to perform the periodic servicing. More extensive maintenance is covered when, based on manufacturer's recommendations, it should be performed by authorized technicians.
- There is no coverage for repair or maintenance to the extent parts and/or labor is covered by a manufacturer's or supplier's warranty or by the rental contract.
- If there is no coverage for the equipment or appliance under this section, then there is no coverage for repair or maintenance of the equipment or appliance.
- You are not covered for battery replacements or recharging related to any appliances or medical equipment.

Medical Foods: Medical foods and low protein modified food products are covered when prescribed for the treatment for an inborn error of metabolism in accord with Hawaii law.

Ophthalmologists: Services provided by ophthalmologists are covered for treatment of medical conditions, such as glaucoma and cataracts. Corrective lenses prescribed as part of the post-operative care following surgery to correct a medical condition are covered under this section.

Services for vision care without a medical diagnosis, such as aniseikonic studies and prescriptions, prescription eyeglasses or contact lenses are not covered by this Plan.

Orthodontic Treatment for Orofacial Anomalies: Covered, for medically necessary orthodontic services for the treatment of orofacial anomalies resulting from birth defects or birth defect syndromes to the extent required by Hawaii law only if you meet UHA's criteria and obtain Prior Authorization.

Benefits are limited to a maximum of $5,500 per treatment phase.

Orthotics: Covered, when prescribed by your physician. Foot orthotics are only covered for diabetic conditions and fractures.

You are not covered for orthotics management and training. Coverage for orthotics fitting and fabrication is included in the reimbursement for the orthotic itself.

Physical and Occupational Therapy: Covered, but only when all of the following are true:

- The therapy is ordered by a provider practicing within the scope of their license under an individual treatment plan.
- The therapy is for restoration of musculoskeletal function that was lost or impaired by injury or illness.
- The therapy can be reasonably expected to improve the patient's condition through short-term care. Long-term maintenance therapy and group exercise programs are not covered.
- The therapy is provided by a qualified provider of physical or occupational therapy services. A qualified provider is an individual who is licensed appropriately, performs within the scope of his/her licensure and is recognized by UHA.

Prior Authorization is required after a combined total of 32 units (1 unit equals 15 minutes) or 8 one-hour sessions per calendar year. Payment is limited to 4 units per session.

Group exercise programs are not covered.

When you receive both occupational and physical therapies, the therapies should provide different treatments and not duplicate the same treatment. Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living. Occupational therapy supplies are not covered.

Prosthetics: Covered, but only when prescribed by your physician. Examples of prosthetics are artificial limbs and eyes. Prosthetics require Prior Authorization when the cost is more than $500.

Routine Care Associated with Clinical Trials: Covered, in compliance with the Affordable Care Act. If you are eligible to participate in an approved clinical trial, you are covered for all routine patient costs while enrolled in the trial. Routine patient costs are all items and services that would be covered under your UHA Plan if you were not participating in the clinical trial.

Speech Therapy: Covered, when all of the following are true:

- The therapy is ordered by a provider practicing within the scope of their license under an individual treatment plan.
- The therapy is necessary to restore speech or hearing function which was lost or impaired by illness or injury.
- The therapy is provided by a qualified provider of speech therapy services. A qualified provider is an individual who is licensed appropriately, performs within the scope of his/her licensure and is recognized by UHA.
- The services are reasonably expected to improve the patient's condition through short-term care. (Long-term maintenance programs are not covered.)

Speech therapy services require Prior Authorization.

Telehealth: Health services received via telecommunications (integrated electronic transfer of medical data, including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange) are covered in accord with Hawaii law, if they are for otherwise covered services under this Plan and are provided in accordance with generally accepted health care practices and standards prevailing in the applicable professional community in Hawaii. Covered at the level applicable to the service provided. Standard telephone contacts, facsimile transmissions, or email text, in combination or by itself, do not constitute telehealth services.

SERVICES NOT COVERED

Your medical benefits plan does not provide benefits for those procedures, services, or supplies that are listed in this section. Each of the procedures, services and supplies listed below are excluded from your plan.

Even if a service or supply is not specifically listed as an exclusion, it will **not** be covered unless it is described as a covered benefit in the Medical Plan Benefits section (pages 36-61) and it meets all of the criteria for payment listed in the Health Care Services Program section (page 29). If you have any questions about whether a specific procedure, service or supply is a covered benefit, contact UHA Customer Services for assistance.

Experimental or Investigative Treatment

You are not covered for medical treatments, drugs, devices, or care, and all related services and supplies, which cannot be designated as being reasonably necessary for your care relative to other well established available services or equipment, or when the potential therapeutic benefit of such treatments are judged to be of a degree insufficient to offset the risk to patient safety and cost. The Prior

Authorization process for experimental and investigative treatments is designed to define and address these issues with consideration for each member's individual circumstances.

You are also not covered for the diagnosis and treatment of any complications as a result of previous experimental or investigative services not covered under this Plan, regardless of how long ago such services were performed.

Non-Routine Care Associated with Clinical Trials

You are not covered for any items and services associated with clinical trials except for routine patient costs as stated in the Medical Plan Benefits section. Non-routine patient costs include the investigational item, device, or service itself; items solely for data collection; or services clearly inconsistent with accepted standards of care. These non-covered items and services are usually provided without cost by the clinical trial.

FDA Approval Not Obtained

You are not covered for any service or supply that (i) cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted; or (ii) is the subject of a current new drug or new device application on file with the FDA, that has not yet been approved by the FDA.

Dental Services

You are not covered for dental services except those listed in the Medical Plan Benefits section under "Oral Surgery" and "Orthodontic Treatment for Orofacial Anomalies". The following exclusions apply regardless of the symptoms or illnesses being treated:

- Orthodontia
- Dental splints and other dental appliances
- Dental prostheses
- Maxillary and mandibular implants (osseointegration) and all related services
- Removal of impacted teeth
- Any other dental procedures involving teeth, structures supporting the teeth, or gum tissues
- Any services in connection with the treatment of temporomandibular joint (TMJ) problems or malocclusion of the teeth or jaw, except for limited medical services related to the initial diagnosis of TMJ or malocclusion.

Drugs

You are not covered for prescription drugs except as stated in the Medical Plan Benefits section.

Vision Services, Eyeglasses and Contacts

You are not covered for vision services, including eyeglasses and contacts, except as stated in the Medical Plan Benefits section. You are not covered for:

- Eyeglass and contact lenses
- Sunglasses
- Frames
- Prescription inserts for diving masks or other protective eyewear
- Non-prescription industrial safety goggles
- Exams for a fitting or prescription, including eye refraction
- Refractive eye surgery to correct visual acuity problems
- Vision training
- Aniseikonic studies and prescriptions
- Reading problem studies or other procedures determined to be unusual

Cosmetic or Reconstructive Services, Supplies or Procedures

You are not covered for cosmetic or reconstructive services, supplies or procedures that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function. This exclusion applies to cosmetic or reconstructive services for a psychological or psychiatric reason.

You are not covered for reconstructive surgery or services to correct congenital abnormalities (defects present from birth), unless the anomaly severely impairs or impedes normal, essential bodily functions.

You are not covered for breast implants (except following mastectomy as described in the Medical Plan Benefits section), labioplasty, or rhinoplasty.

You are not covered for excision of superficial benign tumors of the skin and subcutaneous tissue.

UHA maintains a list of procedures which are determined to be cosmetic in most cases. For the most current list of cosmetic procedures, visit the website at uhahealth.com under "Member Forms". The list is not exclusive and UHA will deny coverage for any procedure determined to be cosmetic, whether or not it is on the list.

Counseling Services

Except as described in the Medical Plan Benefits section, you are not covered for any counseling services, including but not limited to the following:

- Bereavement counseling or services of volunteers or clergy
- Marriage, couples, or family counseling
- Sexual orientation counseling
- Parent, or other, training services

You are not covered for nutritional counseling services except as stated in the Medical Plan Benefits section.

Autism Services

You are not covered for autism services except as stated in the Medical Plan Benefits section. You are not covered for:

- Care that is custodial in nature
- Services and supplies that are not clinically appropriate
- Services provided by family or household members
- Treatments considered experimental
- Services provided outside of the State of Hawaii

Fertility/Infertility

You are not covered for services or supplies related to the diagnosis of infertility.

Except as stated in the Medical Plan Benefits section, you are not covered for services and supplies related to the treatment of infertility. This exclusion includes but is not limited to:

- Collection, storage and processing of semen
- Ovum transplants
- Gamete intrafallopian transfer (GIFT)
- Zygote intrafallopian transfer (ZIFT)
- Services related to conception by artificial means (such as intrauterine insemination)
- Hysterosalpingography
- In vitro fertilization when services of a surrogate or gestational carrier are used

Reversal of Sterilization

You are not covered for reversal of sterilization.

Reversal of Vasectomy

You are not covered for reversal of vasectomy.

Growth Hormone Therapy

You are not covered for growth hormone therapy except as stated in the Medical Plan Benefits section.

Transplant and Donor Services

You are not covered for:

- Organ donor services if you are the organ donor
- Any expenses of transporting a living donor
- Mechanical or non-human organs and services related to them except for artificial hearts as a bridge awaiting heart transplant
- The purchase of any organ
- Services rendered to the living donor for post-transplant donor services
- Transplant services or supplies or related services or supplies except as described in the Medical Plan Benefits section under "Organ Transplant Services". Related Transplant Services or Supplies are those that would not meet payment criteria but for your receipt of the transplant.

Exclusion by Type of Provider

You are not covered for services or supplies provided by a provider who is a member of your immediate family, meaning a parent, child, spouse, civil union partner, or yourself.

Emergency Room Visits for Non-Emergencies

You are not covered for any costs of care arising from an emergency room visit if your condition does not meet "emergency" standards as defined in the Medical Plan Benefits section under "Emergency Room".

When Someone Else is Responsible for Payment

You are not covered when someone else, including but not limited to any federal, state, territorial, municipal, or other government instrumentality or agency, has the legal obligation to pay for your care, and when, in the absence of this Plan, you would not be charged.

You are not covered for treatment of illness or injury related to military service when you receive treatment in a facility operated by an agency of the United States government.

You are not covered for services or supplies that are required to treat an illness or injury received while you were on active status in the military service.

You are not covered for services or supplies for an injury or illness for which you are entitled to receive disability benefits or compensation (or forfeit your rights thereto) under any Workers' Compensation or Employer's Liability Law, or entitled to receive Personal Injury Protection payment under a no-fault motor vehicle policy.

You are not covered for services or supplies for an injury or illness that is a Third Party Liability situation, except as stated in the Coordination of Benefits and Third Party Liability section. UHA has the right to deny coverage for any claim in a Third Party Liability situation if you fail to provide UHA with timely notice of the potential claim.

Miscellaneous Exclusions

Airline oxygen: You are not covered for airline oxygen.

Air Ambulance: You are not covered for air ambulance benefits provided outside of the State of Hawaii or between Hawaii and other locations.

Biofeedback: You are not covered for biofeedback or any related diagnostic testing.

Bionic Devices: You are not covered for bionic devices or related services.

Complications of a Non-Covered Treatment or Procedure: You are not covered for the diagnosis and treatment of any complications of a treatment or procedure which is excluded from coverage under this Plan, regardless of how long ago such services were performed and regardless of whether you were eligible for coverage under this Plan at the time the services were performed. This exclusion applies to complications related to every category of excluded services under this Plan.

Complementary and Alternative Medicine: You are not covered for complementary and alternative medicine except as stated in the Medical Plan Benefits section. You are not covered for X-rays ordered by non-participating chiropractors.

Custodial Care: You are not covered for custodial care, sanatorium care, or rest cures provided in a hospital, skilled nursing facility, or other facility. Custodial care consists of training in personal hygiene, routine nursing services, and other forms of personal care, such as help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine. Also excluded are supervising services by a physician or a nurse for a person who is not under specific medical, surgical, or psychiatric treatment to improve that person's condition and to live outside a facility providing this care.

Effective Date: You are not covered for services or supplies that you receive before the effective date of this coverage, or after the effective date of termination of this coverage.

Erectile Dysfunction: You are not covered for services and supplies (including prosthetic devices) related to erectile dysfunction except if due to an organic cause or to treat gender dysphoria as described in the Medical Plan Benefits section under Gender Identity Services. This includes, but is not limited to, penile implants. You are not covered for drug therapies related to erectile dysfunction except certain injectables approved by UHA to treat erectile dysfunction due to an organic cause or to treat gender dysphoria as described in the Medical Plan Benefits section under Gender Identity Services.

False Statements: You are not covered for services or supplies obtained due to a false statement or other misrepresentation made in an application for membership or claim for benefits. If UHA pays such benefits to you or a provider before learning of any false statement or misrepresentation, you are responsible for reimbursing UHA.

Foot Orthotics: You are not covered for foot orthotics except for diabetic conditions and fractures.

Hair Loss and Baldness: You are not covered for services and supplies, including hair transplants and topical medications, for the treatment of male and female pattern hair loss or baldness.

Home Health and Hospice: You are not covered for home health and hospice services except as stated in the Medical Plan Benefits section.

Massage Therapy: You are not covered for massage therapy services except when provided within the course of rehabilitative services as defined in the Medical Plan Benefits section under Physical and Occupational Therapy.

Medical Equipment and Appliances: You are not covered for equipment and appliances that are not primarily medical in nature such as environment control equipment or supplies (e.g. air conditioners, humidifiers, dehumidifiers, air purifiers or sterilizers, water purifiers, vacuum cleaners, supplies such as filters, vacuum cleaner bags and dust mite covers); hygienic equipment; exercise equipment; items primarily for participation in sports or leisure activities; and education equipment, except as stated in the Medical Plan Benefits section.

Medical Foods: You are not covered for medical foods and low protein modified food products except as stated in the Medical Plan Benefits section.

Miscellaneous Supplies: You are not covered for miscellaneous supplies billed separately by your provider. This includes but is not limited to gauze, batteries, surgical trays, diapers and tape.

Motor Vehicle Accident: You are not covered for injuries or illness due to a motor vehicle accident (including arising from operation, maintenance or use of a motor vehicle) except for medical costs exceeding the personal injury protection mandatory coverage amount specified by state law, as described in the Coordination of Benefits and Third Party Liability section.

Motor Vehicles: This Plan does not cover the cost of purchase or rental of motor vehicles, such as cars or vans, or the equipment and costs associated with converting a motor vehicle to accommodate a disability.

Naturopathy: You are not covered for medical treatments, drugs, devices, care, or ancillary services (to include laboratory testing and imaging) that are not the most appropriate delivery or level of service, or are not known to be effective in improving health outcomes.

Orthotics: You are not covered for orthotics management and training.

Personal Convenience Items: You are not covered for treatments, services or supplies that are prescribed, ordered or recommended primarily for your comfort or convenience, or the comfort or convenience of your provider or caregiver. Such items may include home remodeling, hot tubs, ramps, swimming pools, or personal supplies such as surgical stockings and disposable underpads.

Physical examinations: Physical examinations specifically for job-related or sports program-related purposes are not covered.

Physical and Occupational Therapy: You are not covered for physical and occupational therapy except as stated in the Medical Plan Benefits section. You are not covered for occupational therapy supplies.

Preventive Care: You are not covered for preventive care services except as stated in the Medical Plan Benefits section.

Private duty nursing: You are not covered for private duty nursing services.

Repair/Replacement: You are not covered for the replacement of hearing aids lost or broken within five years from the date of purchase. You are not covered for replacement, or repairs and maintenance of medical equipment and appliances except as stated in the Medical Plan Benefits section.

Reversal of Gender Reassignment Surgery: You are not covered for reversal of gender reassignment surgery, except in the case of a serious medical barrier to completing gender reassignment or the development of a serious medical condition requiring a reversal.

Self-Help or Self-Cure: You are not covered for self-help and self-cure programs and equipment. You are not covered for the educational programs or other services performed by mutual self-help groups, even if you are referred to such groups by your provider or the judicial system.

Skilled Nursing: You are not covered for skilled nursing services except as stated in the Medical Plan Benefits section.

Social Work Services: You are not covered for treatment provided by a social worker except as defined in the Medical Plan Benefits section under Mental Health and Substance Abuse Services.

Speech Therapy: You are not covered for speech therapy except as stated in the Medical Plan Benefits section.

Stand-by Time: You are not covered for a provider's waiting or stand-by time.

Third Party Liability: You are not covered for services or supplies for an injury or illness that is a Third Party Liability situation, except as stated in the Coordination of Benefits and Third Party Liability section. UHA has the right to deny coverage for any claim in a Third Party Liability situation if you fail to provide UHA with timely notice of the potential claim.

Travel or lodging costs: You are not covered for the costs of travel or lodging.

Weight Reduction Programs: You are not covered for weight reduction programs and supplies (including dietary supplements, food, equipment, laboratory testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

Wigs: You are not covered for wigs.

FILING CLAIMS FOR PAYMENT

FILING CLAIMS

When you receive services from any provider, be sure to show them your UHA identification card.

When you visit a UHA Participating Provider, the provider will file a claim for payment on your behalf. UHA will send payment to the provider and will send you an Explanation of Benefits (EOB).

When you visit a Non-Participating Provider, the provider may file a claim on your behalf or give you the claim to file with UHA. The provider of service must sign the claim form. UHA will send payment to you along with a Remittance Advice (RA).

In no event will UHA's payment amount to a Non-Participating Provider exceed the amount UHA would pay to a comparable Participating Provider for like services rendered.

If any additional information, such as medical records or reports, is required to process your claim, UHA will request the information from the provider. UHA will not pay the claim unless all necessary information is received.

UHA will not pay claims for services that are not covered benefits or were not actually received.

If you have any questions regarding the filing of claims, please contact UHA Customer Services.

PAYMENT DETERMINATION CRITERIA

In order for UHA to pay for a covered service, all of the following payment determination criteria must be met:

- The service must be listed as a covered benefit and not be excluded as a benefit by this Plan.
- The service must be medically necessary for the diagnosis or treatment of your illness or injury.
- The service must be provided in an appropriate setting and at an appropriate level of care.
- When required under this Plan, the service must be Prior Authorized.

The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets these payment criteria, even if the service or supply is listed as a covered service.

INFORMATION REQUIRED ON A CLAIM

Any claim for services submitted to UHA for payment must include the following information:

- Your subscriber number, which appears on your UHA identification card.
- The provider's full name and address.
- The patient's name.
- The date(s) services were rendered.
- The date of injury or beginning of an illness.
- The charge for each service (in U.S. currency)
- A description of each service (UHA uses nationally accepted CPT-4 and HCPCS procedure codes)*.
- A diagnosis or type of illness or injury (UHA uses the nationally accepted ICD-10 diagnostic codes)*.
- The location where you received the service (office, outpatient center, hospital, etc.)
- If applicable, information about any other health coverage you have.
- The provider's signature must be on the claim.

The claim must be in English. Receipts are not acceptable. UHA has a right to require that you provide sufficient information to allow UHA to make a decision regarding your claim. If you do not provide the information UHA requests, or if the information you provide does not show entitlement to coverage under this Plan, your claim may be denied.

*To be eligible for payment, service codes must conform to nationally-accepted coding standards.

WHERE TO SEND CLAIMS

Claims should be sent to:

UHA
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813

LATE CLAIMS

Claims should be submitted to UHA as soon as possible after the date of service. All claims for payment for services must be filed with UHA within one year of the date of service. UHA will not make payment on any claim received more than one year after the date on which you received the service.

EXPLANATION OF BENEFITS (EOB)

Explanation of Benefits (EOB) are generated after your claim has been processed. You can access your EOB via UHA's member portal which is through the website at uhahealth.com. The EOB tells you how your claim was processed, including the services performed, the amount charged, the Eligible Charge, the amount UHA paid, and the amount, if any, that you owe. If your claim was denied, in whole or in part, the EOB will provide an explanation for the denial.

Be sure to keep your EOB for filing with your secondary insurance carrier when applicable.

If you would like your EOBs mailed to you, have any questions about your EOB, or think that UHA made an error in paying a claim, please call or write to UHA Customer Services. If after contacting Customer Services you are not satisfied and think UHA made an error in determining benefits or paying your claim, you may request a formal review in accordance with the appeal procedures beginning on page 72.

COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

If you have other insurance coverage that provides benefits similar to those of this Plan, UHA will "coordinate" the benefits of the two plans. When benefits are coordinated, the benefits paid under this Plan, when combined with the benefits paid under your other coverage, will not exceed the lesser of:

- 100% of the Eligible Charge; or
- The amount payable by your other coverage plus any deductible and copayment you would owe if the other coverage were your only coverage.

Any copayment you owe under this Plan will first be subtracted from the benefit payment. You remain responsible for the copayment owed under this Plan, if any.

When you receive services, please be sure to inform the provider of any other insurance you may have. This may include automobile insurance or other insurance if you are being treated as a result of an injury.

UHA may send you a letter asking about other insurance coverage before a claim is paid. If you do not respond, your claim may be delayed or denied.

UHA will coordinate benefits for you based on the information you provide.

BENEFIT PAYMENTS UNDER COORDINATION OF BENEFITS RULES

There are certain rules UHA follows to determine which plan pays first when there is similar coverage. Some general rules governing coordination of benefits are:

- Coverage afforded by a specific benefit plan (i.e., drug or specified disease) pays first before the coverage afforded by this Plan.
- The coverage you have as an employee pays first before any coverage you have as a spouse or dependent.
- The coverage you have as an active employee pays before coverage you have as a retiree or under which you are not actively employed.
- When both coverages are employer-sponsored plans and one plan has no coordination of benefits rules and the other does, the plan without coordination of benefits rules pays first.
- When none of these rules apply, the coverage with the earliest continuous effective date pays first.

With respect to children, the following rules apply:

- For a child who is covered by both parents, the "birthday rule" applies; i.e., the coverage of the parent whose birthday occurs first in the calendar year pays first.
- If the child's parents are separated or divorced and a court decree says which parent has health insurance responsibility, that coverage pays first.
- If the child's parents are divorced or separated and there is no court decree stipulating which parent has health insurance responsibility, the coverage of the parent with custody pays first. The payment order for this dependent child is as follows:
    1. Custodial parent
    2. Spouse of custodial parent
    3. Other parent
    4. Spouse of other parent
- When none of these rules apply, the coverage with the earliest continuous effective date pays first.

The coverage that pays first is called "primary" and the coverage that pays second is called "secondary".

When this Plan is determined to be the primary payer, UHA will pay benefits in accordance with the provisions of the Plan.

When this Plan is determined to be the secondary payer, UHA will base its payment on the Eligible Charge and deduct from the payment:

- Any unpaid copayment that you owe under this Plan;
- The benefit amount paid by the primary plan.

UHA will not pay benefits unless the service in question is a covered service. Benefits will not be paid for the difference in cost between a private and a semi-private hospital room, even if such private room is a benefit under the primary plan. Any payment by this Plan as the secondary payer will not exceed the amount that would have been paid for covered services you received had this Plan been your only coverage. Any payment by this Plan as secondary payer will count towards applicable Benefit Maximums of this Plan. Even if no payment is made by this Plan as the secondary payer, the service for which payment is made by the primary plan shall count toward applicable service maximums of this Plan.

MOTOR VEHICLE ACCIDENT COVERAGE

For injuries or illness due to a motor vehicle accident (including arising from operation, maintenance or use of a motor vehicle), any motor vehicle insurance will be considered primary for payment, and those benefits will be applied first before any benefits of this Plan apply. No benefits are payable under this Plan until after the motor vehicle personal injury protection mandatory coverage amount as specified by state law has been exhausted. Only amounts incurred in excess of that mandatory amount are payable as benefits under this Plan (and any other motor vehicle insurance benefits available in excess of the mandatory amount must be applied first before any benefits of this Plan apply). The exhaustion of the mandatory amount may be calculated by UHA in accordance with the fee schedule applicable to Hawaii Revised Statutes Chapter 431, Article 10C.

You are responsible for any cost-sharing payments and/or deductibles required under any motor vehicle insurance coverage. This Plan does not cover any personal injury protection cost sharing arrangements and/or deductibles.

Before Plan benefits for any motor vehicle accident-related injury are paid, you must provide UHA a list of expenses paid by any motor vehicle insurance. This list must include the date the services were provided, the provider of each service, and the amount paid for each service by motor vehicle insurance. Upon verification by UHA that any motor vehicle coverage has been exhausted, covered services you received that exceed the personal injury protection mandatory coverage amount may then be eligible for payment in accord with this coverage.

MEDICARE COORDINATION RULES

If you have both this group coverage and Medicare, federal rules determine which plan pays first. These rules apply to the working aged, the disabled, or patients with end stage renal disease (ESRD). For the working aged and disabled, these rules take into consideration the employment status of the employee covered by the employer group health plan as well as the number of part-time and full-time employees of the employer group plan.

If your employer or group employs 20 or more employees and you are 65 or older and eligible for Medicare only because of your age, this Plan will pay first before Medicare, as long as your coverage is based on your status as a current active employee or the status of your spouse as a current active employee.

If you are under age 65 and eligible for Medicare only because of end stage renal disease (ERSD), coverage under this Plan will pay first before Medicare, but only for the first 30 months of your ERSD coverage. After 30 months, the amount that this Plan pays will be reduced by the amount that Medicare pays for the same services.

If your employer or group employs 100 or more employees and you are under 65 and eligible for Medicare only because of a disability (and not ESRD), this Plan will pay first before Medicare as long as your group coverage is based on your status as a current active employee, or the status of your spouse as a current active employee, or the current active employment status of the person for whom you are a dependent.

When Medicare is allowed by law to be the primary payer, coverage under this Plan will be reduced by the amount paid by Medicare for the same covered services. Benefits under this Plan will be paid up to either the Medicare-approved charge for services by a Medicare-participating provider, or the lesser of UHA's Eligible Charge or the limiting charge (as defined by Medicare) for services rendered by a provider who does not participate with Medicare.

If you are entitled to Medicare benefits, UHA will begin paying benefits after all Medicare benefits, including all lifetime reserve days, are exhausted.

If you have coverage under Medicare Part B only, UHA will pay inpatient benefits based on the Plan's Eligible Charge less any Medicare Part B benefits for inpatient diagnostic, laboratory and radiology services.

When services are rendered by a provider or facility that is not eligible or entitled to receive reimbursement from Medicare, and Medicare is entitled by law to be the primary payer, the Plan will limit payment to the amount that would have been payable by Medicare had the provider been eligible to receive such payments, regardless of whether or not Medicare benefits are paid.

THIRD PARTY LIABILITY RULES

Third party liability situations occur when you are injured or become ill and:

- The injury or illness is caused or alleged to have been caused by someone else and you have or may have the right to recover damages or receive payment in connection with the illness or injury; or
- You have or may have the right to recover damages or receive payment from someone else for your injury or illness without regard to fault.

When third party liability situations occur, UHA's Plan will provide benefits only as set forth in the following Rules.

If you have coverage under Workers' Compensation insurance, such coverage will apply instead of coverage under this Plan. Medical expenses arising from injury or illness covered under Workers' Compensation insurance are excluded from coverage under this Plan.

If you are in a motor vehicle accident, you must exhaust the motor vehicle personal injury protection mandatory coverage amount specified by state law first, before the coverage under this Plan will apply (See Motor Vehicle Accident Coverage beginning on page 69).

In third party liability situations, you must cooperate with UHA by doing the following:

1. Give UHA timely notice of each of the following, no later than 30 calendar days after their occurrence:
    a. Your knowledge of any potential claim or source of recovery related to your injury or illness.
    b. Any written claim or demand (including initiation of legal proceedings) made by you or on your behalf.
    c. Any monetary recovery (including any settlement, judgment, award, insurance proceeds, or other payment) from any source of recovery in connection with your illness or injury, including the amount and source of any recovery.
2. Sign and deliver to UHA all liens, assignments and other documents it requires to secure its rights to recover payments. You have a duty to authorize and direct any person or entity making or receiving any payment on account of such injury or illness to pay to UHA so much of such payment as needed to discharge your reimbursement obligations described above.
3. Provide UHA any information reasonably related to its investigation of liability for coverage and rights to repayment, including medical records and documents related to any legal claims.

4. DO NOT release or otherwise impair UHA's rights to repayment, without UHA's express written consent.

5. Cooperate in protecting UHA's rights under these rules, including giving notice of UHA's rights to repayment as part of any written claim or demand made against any other person or party or other source of recovery.

Any notice required by these Rules must be sent to:

TPL Administrator
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Failure to comply with any of these Rules may result in delay in payment or denial of your claims, and will entitle UHA to reimbursement of its payments to the extent that your actions result in erroneous payment or prejudice UHA's right to repayment. If you know or reasonably should know that you may have a third-party claim for recovery of damages and you fail to provide timely notice to UHA of your potential claim as specified in these Rules, you waive your rights to any benefits under this Plan for the third-party injury or illness, and UHA shall have a right to recover from you any past benefits paid for the injury or illness and to refuse to reimburse any past, present or future medical expenses arising from the third-party injury or illness. If UHA is entitled to reimbursement of payments under these Rules and does not promptly receive full reimbursement pursuant to its request, UHA shall have a right of set-off from any future benefits payable under this Plan.

Subject to the limitations and conditions described above, UHA will pay benefits in accordance with this Plan and these Rules. However, any benefits paid in third party liability situations must be repaid from any recovery received by you, your estate, a family member, special needs trust, or any other person or party, arising from or related to such injury or illness, even if the award does not specifically include medical expenses, or is described as general damages only, or is less than the total actual or alleged loss suffered by you due to the injury or illness, or occurs without any admission or finding of liability or fault, or is paid to some person or entity other than you. UHA shall have a first lien against any such recovery to the extent of its total payment of benefits related to the injury or illness. This lien will attach to and follow any recovery proceeds even if the proceeds are distributed to another person or entity. UHA may file notice of its lien with the court, the other person or party or other source of recovery, or any person or entity receiving the proceeds, including your attorney. You must inform any attorney representing you of these Rules, as your attorney may be subject to professional disciplinary action and liability to UHA if your attorney does not comply with these Rules. You have a duty to authorize and direct any person or entity making or receiving any payment arising from your third-party injury or illness to pay to UHA so much of such payment as is necessary to fulfill your payment duties described in these Rules.

If UHA is not reimbursed for its total payment of benefits in connection with your illness or injury, UHA shall have a right of subrogation (substituting UHA to the

member's rights of recovery) for all causes of action and all rights of recovery you have against such other person or party or other source of recovery, to the extent of UHA's unreimbursed payments on your behalf.

UHA's rights of reimbursement, lien, and subrogation described above are in addition to all other rights of equitable subrogation, constructive trust, equitable lien and/or statutory lien UHA may have for repayment of benefits paid, all of which rights are preserved and may be pursued at UHA's option against you or any other appropriate person or entity.

No reductions for attorneys' fees, costs, or other expenses may be made from the amounts owing to UHA under these Third Party Liability Rules.

For any payment made by UHA under these Rules, you will still be responsible for copayments, timely submission of claims, and other duties under this Plan.

If you comply with the above requirements and if you have made reasonable efforts to obtain recovery for your illness or injury, but receive a final dismissal or denial of all of your legal claims without receiving any recovery for your illness or injury, then no reimbursement is owing to UHA for covered benefits paid for the illness or injury.

GRIEVANCES AND APPEALS

REQUESTING INFORMAL RECONSIDERATION OF AN ADVERSE DECISION

If you are dissatisfied with the services you receive under this Plan or if you believe that UHA incorrectly denied a claim, paid an incorrect amount, incorrectly determined that a service is not a covered benefit, or incorrectly rescinded your coverage under this Plan, you may contact UHA's Customer Services (532-4000 from Oahu or Toll-free 1-800-458-4600 from the Neighbor Islands) and explain your concern. If your concern cannot be resolved on the telephone, the Customer Service representative will refer it for informal reconsideration and inform you of the decision as promptly as possible.

Requests or referrals for an informal reconsideration must be made within one year of the date you were informed of the adverse decision.

If you are dissatisfied with a denial which was based in whole or in part on a medical judgment, including determinations of whether a procedure was experimental or investigational, or whether it was medically necessary or appropriate, your informal reconsideration is limited to a peer-to-peer clinical review (telephonic, in person, or electronically) between UHA and the treating provider. For a peer-to-peer clinical review, you may contact UHA's Health Care Services Department (532-4006 from Oahu or Toll-free 1-800-458-4600, extension 300 from the Neighbor Islands).

Requests for a peer-to-peer clinical review must be made within one month of the date you were informed of the adverse decision.

REQUESTING A FORMAL APPEAL

If you are not satisfied with the response to your concern, or do not wish to request informal reconsideration, you may appeal the decision by writing to:

Appeals Coordinator
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

UHA must receive your written appeal within one year of the date that UHA informed you of the decision you wish to appeal. The appeal should include the following information:

- The date of your request
- Your name and member identification number from your UHA identification card
- The date of the service that you believe was denied or paid in error, or the date of the contested action or decision
- Provider's name
- A description of the facts related to your appeal and why you believe UHA's action or decision was in error
- Any other details about your appeal. This may include written comments, documents and records relating to your appeal that you would like UHA to review.

You should keep a copy of your request for your records. It will not be returned to you.

Upon your written request to UHA at the address above, you will be provided, free of charge:

- A copy of all documents, records, and information relevant to your claims for benefits or rescission of your coverage, as defined by federal ERISA rules
- Any rule, guideline, or protocol UHA relied upon in making the decision at issue

WHO MAY REQUEST AN APPEAL?

You or your authorized representative may request an appeal. Authorized representatives include:

- Any person you authorize to act on your behalf as long as you follow UHA's procedures. This includes filing a form with UHA. To request a form, please call UHA's Customer Services (532-4000 from Oahu or Toll-free 1-800-458-4600 from the Neighbor Islands). Requests for appeal

from an authorized representative who is a provider must be in writing unless you are asking for an expedited appeal.

- A court-appointed guardian or agent under a health care proxy.
- A person authorized by law to provide substituted consent for you or to make health care decisions on your behalf.
- A family member or your treating health care professional if you are unable to provide consent.

DECISION MAKING ON APPEALS

If your appeal concerns a UHA denial which was based in whole or in part on a medical judgment, including determinations of whether a procedure was experimental or investigational, or whether it was medically necessary or appropriate, UHA will respond within 30 days of receipt of your appeal. For all other appeals, UHA will respond within 60 days of receiving your appeal.

Unless you qualify for expedited external review of UHA's initial decision, before requesting external review, you must have exhausted UHA's internal appeals process or show that UHA violated federal rules related to claims and appeals unless the violation was 1) de minimis; 2) non-prejudicial; 3) attributable to good cause or matters beyond UHA's control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of non-compliance.

EXPEDITED APPEALS

You may request an expedited appeal if the standard response time (30 or 60 days, as set forth above) for completing an appeal would:

- Seriously jeopardize your life or health,
- Seriously jeopardize your ability to regain maximum functioning, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment requested.

Expedited appeals are only appropriate when a denial affects care that is in progress or to be initiated. Expedited appeals do not apply to payment denials for services already rendered.

You may make your request for an expedited appeal by calling UHA's Health Care Services Department (532-4006 from Oahu or Toll-free 1-800-458-4600, ext. 300 from the Neighbor Islands).

If a health care provider with knowledge of your condition makes a request for an expedited appeal on your behalf, UHA does not require a written authorization from you.

If UHA determines, or your health care provider states, that the criteria for an expedited appeal are met, UHA will respond to your request for an expedited appeal within 72 hours.

You may request expedited external review of UHA's initial decision if you have requested an expedited internal appeal and the adverse benefit determination involves a medical condition for which the completion of an expedited internal appeal. would meet the conditions stated above

The process for requesting an expedited eternal review is discussed below.

APPEALS COMMITTEE REVIEW

UHA's Appeals Committee will review your appeal request. UHA will notify you in writing of the decision within the timeframes specified above.

Your appeal will be reviewed by staff not involved in the original decision (nor a subordinate to the original decision maker) and will not give deference to the initial decision. If the appeal concerns a matter of medical judgment about an otherwise covered category of service that is not expressly excluded by the Plan, it will be reviewed by an independent licensed practitioner with appropriate expertise and experience in the field of medicine involved in the medical judgment, and who was not previously consulted in connection with the original decision. The review will take into account all comments, documents, records, and other information submitted by you or your authorized representative relating to the claim, or considered as relevant by UHA, without regard to whether such information was submitted or considered in the initial benefit determination.

If UHA considers, relies upon or generates any new or additional evidence in the appeal review, UHA will provide you, free of charge, that evidence as soon as possible and sufficiently in advance of the date the decision on appeal is due to provide you a reasonable opportunity to respond prior to that date.

If UHA intends to base the decision on appeal on a new or additional rationale, UHA will provide you, free of charge, the rationale as soon as possible and sufficiently in advance of the date the decision on appeal is due to provide you a reasonable opportunity to respond prior to that date.

If UHA's appeal decision denies your request or any part of it, UHA will provide an explanation, including an identification of the claim or service denied, the specific reason for denial, reference to the health plan terms on which the decision is based, a statement of your external review rights, and other information regarding the denial. The notice to you of UHA's decision will also include the date of service, the health care provider, and the claim amount. Upon request, UHA will also provide the treatment and diagnosis codes for the claim and their corresponding meanings. You may request this information by contacting Customer Services.

EXTERNAL REVIEW BY INDEPENDENT REVIEW ORGANIZATION

If UHA has denied a request for coverage based on medical necessity, appropriateness, health care setting, level of care or effectiveness, or on the basis that the service requested is experimental or investigational, and you disagree with the decision, you may request external review of the decision by a physician reviewer selected by an independent review organization. The request must be in writing and must be received by the Insurance Commissioner of the State of Hawaii within 130 days from the date of the letter notifying you of UHA's decision. The request should be submitted to:

Hawaii Insurance Division
Attn: Health Insurance Branch – External Appeals
335 Merchant Street, Room 213
Honolulu, HI 96813
Telephone: 808-586-2804

Your request for external review must include: 1) a copy of the adverse benefit determination you wish to have reviewed; 2) a signed authorization for release of your medical records relevant to the review; 3) a disclosure for conflicts of interest; and 4) a filing fee of $15 which will be reimbursed if the decision is reversed on external review. The authorization and disclosure forms are available on UHA's website (uhahealth.com) or by calling Customer Services (532-4000 from Oahu or Toll-free 1-800-458-4600 from the Neighbor Islands). The Commissioner may waive the filing fee if payment of the fee would impose a financial hardship. You are not required to pay more than $60 in any plan year.

UHA will pay for the services of the independent review organization and its physician reviewer if you make a timely request.

If the decision that is the subject of the external review is based on a determination by UHA that the service is experimental or investigational, your request for external review must also include a written certification from your treating physician that standard health care services or treatments have not been effective in improving your medical condition or are not medically appropriate for you, or that there is no available standard health care service or treatment covered by UHA that is more beneficial than the service or treatment that is the subject of the external review. Your treating physician must certify in writing that the service recommended is likely to be more beneficial to you, in the physician's opinion, than any available standard health care service or treatment, or that scientifically valid studies using accepted protocols demonstrate that the service is likely to be more beneficial to you than any available standard health care service or treatment.

You will be notified by the Insurance Division when an independent review organization (IRO) is assigned your external review. You may submit additional written information to the IRO at the address provided in the notice. The IRO will consider any additional information submitted within five business days after you receive the notice, and may consider additional information received after that

date. If any additional information is submitted, it will be shared with UHA in order to give UHA an opportunity to reconsider its denial.

The IRO will be provided all information considered by UHA (including any prior submissions by you) in making the decision that is the subject of the external review, your request for external appeal and any accompanying documentation you provided with your request, and any other pertinent documentation. The IRO will render a decision within 45 days of its receipt of the request for external review.

EXPEDITED EXTERNAL REVIEW BY THE IRO

You may request expedited external review by the IRO of a final adverse determination involving issues of medical necessity:

1. If you have a medical condition for which the completion of a standard external review would seriously jeopardize your life, health or ability to regain maximum functioning, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the external review; or
2. If the final adverse determination concerns an admission, availability of care, continued stay, or health care services for which you received emergency services, provided you have not been discharged from a facility for health care services related to the emergency services.

If the decision that is the subject of the external review is based on a determination by UHA that the service is experimental or investigational, you may request expedited external review if your treating physician certifies, in writing, that the health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated. You may make your request orally, but it must be followed promptly by your treating physician's written certification.

Immediately upon being notified of a request for expedited external review, UHA and the Commissioner will review the request and determine whether you are eligible for expedited external review. If you are not eligible for expedited external review, the Commissioner will notify you and UHA as soon as possible. If the external review is accepted as an expedited review, UHA will provide the IRO with all documents and information it considered in making the decision that is the subject of the expedited external review. The IRO will provide notice of the final external review decision as soon as the medical circumstances require but not more than 72 hours after the external reviewer receives the request for expedited external review of a medical necessity determination or not more than 7 days for a decision regarding experimental or investigational services. The notice of the external review decision may initially be provided orally but must be confirmed in writing by the reviewer within 48 hours of the oral notice.

The IRO's decision regarding the issue in the external review shall be binding on you and UHA except to the extent that other remedies may be available to either you or UHA under applicable State or Federal law. If you elect to have a review by an IRO, then the parties waive their right to an arbitration for the services in question.

OTHER PROCEDURES FOR EXTERNAL REVIEW

If UHA's decision was based on a determination other than one of medical necessity, appropriateness, health care setting, level of care or effectiveness, or on the basis that the service requested is experimental or investigational, and you disagree with the decision, or if the UHA's decision was based on medical necessity or on the basis that the service is experimental or investigational but you elected not to request review by an IRO, you may either:

1. Request binding arbitration before a mutually selected arbitrator, or
2. File a lawsuit against UHA under section 502(a) of ERISA.

ARBITRATION

If you select arbitration, you must submit a written request for arbitration to:

Appeals Coordinator
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Your request for binding arbitration will not affect your rights to any other benefits under this Plan. You must have complied with UHA's appeals procedures as described above and UHA must receive your request for arbitration within one year of the date of the letter notifying you of UHA's decision. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the disagreement. The arbitration is binding and the parties waive their right to a court trial and jury.

Before arbitration actually starts, both parties (you and UHA) must agree on the person to be the arbitrator. The arbitration will be administered by Dispute Prevention and Resolution, and the arbitrator will be selected from its panel of neutrals. If the parties cannot agree within 30 days of your request for arbitration, either party may ask a court of appropriate jurisdiction to appoint an arbitrator. There shall be no consolidation of parties in arbitration.

The arbitration hearing shall be in Hawaii. The questions for the arbitrator shall be whether UHA was in violation of the law, or acted arbitrarily, capriciously, or in abuse of its discretion. The arbitration shall be conducted in accord with the Hawaii Arbitration Act, HRS Chapter 658A, and the arbitration rules of Dispute Prevention and Resolution, to the extent not inconsistent with that Act or this Plan.

The arbitrator will make a decision and will give both parties a copy of this decision. The decision of the arbitrator is final and binding and no further appeal or court action can be taken except as provided under the Hawaii Arbitration Act.

The arbitrator's fees and costs will be shared, with UHA to pay two-thirds and member to pay one third. Each party must pay its own attorney's and witness fees. The arbitrator will decide who will pay all other costs of the arbitration.

UHA waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.

The preceding medical benefits are insured under a contract of insurance issued by University Health Alliance (UHA), 700 Bishop Street, Suite 300, Honolulu, Hawaii 96813. The services provided by UHA include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes and is only a summary of coverage. Its contents are subject to provisions of the Group Contract and UHA 600 Medical Benefits Guide, which contain all the terms and conditions of membership and benefits. These documents are on file with the Hawaii Teamsters Health and Welfare Trust Office. Please refer to these documents for specific questions about coverage.

INDEMNITY PRESCRIPTION DRUG PLAN (Self-Insured)

Retirees and spouses who meet the following requirements are eligible for Indemnity Prescription Drug Plan benefits:

1. Your medical benefits are provided through the Supplemental Health Plan for OTS Retirees;
2. You have selected the UHA 600 Medical Plan for your medical coverage; and
3. You are under age 65 and not eligible for Medicare.

Benefits provided under the Indemnity Prescription Drug Plan are self-insured by the Hawaii Teamsters Health and Welfare Trust. The Trust has contracted OptumRx (formerly Catamaran) 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:

OptumRx

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

ANNUAL COPAYMENT MAXIMUM

Effective June 1, 2016, there is an Annual Copayment Maximum of $2,000 per individual and $4,000 per family of three or more in any plan year. Once the Annual Copayment Maximum is met, you are no longer responsible for copayment amounts for covered prescription drug services for the rest of that plan year. Each family member must meet the individual Annual Copayment Maximum until the family Annual Copayment Maximum is met. The following payments do not count toward the Annual Copayment Maximum and you are responsible for these amounts even after you have met the Annual Copayment Maximum:

- Payments for medical services,
- Copayments and/or additional expenses you incur as a result of failure to satisfy a prior authorization requirement,
- Payments for non-covered drugs or items, and
- Any amounts that you owe in addition to your copayments for covered services.

COVERED DRUGS

The Indemnity Prescription Drug Plan covers **medically necessary prescription drugs which are federally controlled and prescribed by a physician**. Although a physician may prescribe, order, recommend, or approve a particular prescription drug, this will not guarantee coverage under this Plan.

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

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

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

Preventive Health Care Medications

The Affordable Care Act (ACA) requires pharmacy benefit plans to cover certain Preventive Health Care Medications at 100% of the cost. Plan members are not charged a copayment, co-insurance or deductible for these medications. These products include:

- U.S. Preventive Services Task Force (USPSTF) A & B Recommendation medications and supplements
- Food and Drug Administration (FDA) approved prescription and Over-the-Counter (OTC) contraception for women. (Male forms of birth control are not currently considered Preventive Care Medications under the Affordable Care Act).

To comply with ACA, the Plan is offering Preventive Health Care Medications at no cost to you if they are:

- Prescribed by a health care professional
- Age and condition appropriate
- Filled at a participating pharmacy

If these items are obtained from an out-of-network or non-participating pharmacy, you will have to pay the full cost for them and file a claim for reimbursement with the Pharmacy Benefits Manager.

The list of covered Preventive Health Care Medications is updated from time to time when new recommendations or guidelines are issued. Please contact the Pharmacy Benefits Manager for a current listing of covered drugs or if you have

any questions regarding covered medications. You may view this list online by logging on to the website at www.optumrx.com.

Over-the-Counter Drugs

The following drugs, although obtainable without a prescription, are covered if your physician orders them as part of your treatment and sends verification to the Pharmacy Benefits Manager that they are necessary for the treatment of an illness or injury:

- Insulin and diabetic supplies for the treatment of diabetes. Supplies are limited to syringes, needles, lancets, sugar test tablets and tapes, and acetone test tablets, or equivalent.
- Special vitamins prescribed for severe vitamin deficiency conditions. This does not include over-the-counter "multiple" vitamin preparations which may be purchased with or without a physician's prescription.
- Prilosec OTC

COVERAGE LIMITATIONS

Prior Authorization

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

Generic Substitution

For brand name medications with a generic equivalent, the generic equivalent will be substituted for a brand name drug. Plan members who obtain a brand name medication when a generic equivalent is available will pay the applicable copayment plus the cost difference between the brand name and the generic equivalent medication. If you require the brand name medication in place of the generic equivalent, your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager. 33If you obtain a Prior Authorization, you will pay the brand name drug copayment.

If this is your **initial** prescription, you will pay the brand name drug copayment and the Pharmacy Benefits Manager will notify you that a generic equivalent is available. Thereafter, if you do not obtain a Prior Authorization, you will pay the brand name copayment plus the cost difference between the brand name and the generic equivalent medication.

If you transition from a brand name drug to the generic alternative, you will be able to fill up to a 60-day supply for a maintenance prescription drug. You are not required to obtain an initial 15-day supply.

Step Therapy Program

Step Therapy is a program designed especially for members who take prescription drugs regularly for an ongoing medical condition such as arthritis, asthma, high cholesterol, or high blood pressure. For targeted medications, drugs are grouped into specific categories based on cost effectiveness and safety. Step Therapy encourages the use of preferred medications that are cost effective and will work optimally for the vast majority of patients with the least number of side effects.

The first step is typically generic drugs (first tier), followed by lower cost brand drugs (second tier), and then the higher cost brand drugs (third tier). If you are prescribed a brand name medication that has a generic equivalent, you will be required to try the generic medication before obtaining the brand name medication. If you require a second or third tier medication, your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager. This requirement applies to new prescriptions only.

Drug Quantity Management Program

Drug Quantity Management is a program designed to promote the appropriate dispensing of drugs and reduction of drug waste through quantity limits 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 prescription, your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager.

Specialty Medications

Specialty medications are high-cost drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. Specialty medications are dispensed exclusively through the Optum Specialty Pharmacy and limited to a 30-day supply. Your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager for coverage approval when you are prescribed a new or different specialty medication. For further information about obtaining medications through the Specialty Pharmacy, contact the Pharmacy Benefits Manager at 1 (888) 869-4600.

Compounded Medications

A compounded medication is one that requires the pharmacist to combine, mix or alter the ingredients of a medication when filling a prescription. Your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager for coverage approval when you are prescribed a compounded medication costing more than $200.

New FDA Approved Drugs

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

DRUGS NOT COVERED

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

- Prescription drugs and items not approved by the Food and Drug Administration (FDA).
- Injectable drugs dispensed under the UHA 600 Medical Plan.
- Immunization agents.
- Agents used in skin tests for determining sensitivity.
- Fertility agents, other than oral prescription drugs for in vitro fertilization (Prior Authorization is required).
- Appliances and other non-drug items.
- Drugs furnished to hospital or skilled nursing facility inpatients.
- Drugs for treatment of sexual dysfunction or inadequacies.
- Drugs which may be purchased without a prescription, except as specified above.

FILLING A PRESCRIPTION

You have five options for obtaining covered prescription drugs:

1. The Point of Service Program,
2. The Central Fill Program,
3. The Mail Order Program,
4. The Specialty Program, and
5. The Direct Member Reimbursement Program.

To obtain services through the Point of Service and Central Fill Programs, you must use participating or designated pharmacies and present your OptumRx identification card. To obtain prescriptions through the Mail Order Program, you must register with one of the Mail Order providers. For Specialty medications, you must register with and obtain your prescriptions through the Optum Specialty Pharmacy. For the Direct Member Reimbursement Program, you must file claims directly with the Pharmacy Benefits Manager. If you have any questions about how

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

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

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

	Participating Pharmacy
Generic Drugs, Insulin, Diabetic Supplies	$ 5.00 copayment
Brand Name Drugs	$15.00 copayment[1]
Preventive Health Care Medications	No copayment[2]
Days Supply Limit	Up to 15 days[3]

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

[2] There is no copayment for generic Preventive Health Care medications. If a generic equivalent is not available or not medically appropriate for you, a brand name drug will be provided without charge. If a generic equivalent is available but you request brand name only, you will be responsible for the brand name copayment plus the difference between the cost of the brand name drug and its generic equivalent.

[3] For prescription drugs that can only be dispensed in "unbreakable" packages (e.g. creams, ointments, certain inhalers), the day supply limit shall be equivalent to the package size day supply, not to exceed a 30-day supply, with the applicable 15-day copayment charged to the member.

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 for reimbursement under the Direct Member Reimbursement Program.

NOTE: If you were charged the full price for your medication at a participating Point of Service pharmacy, please call the Pharmacy Benefits Manager for assistance.

CENTRAL FILL PROGRAM (through designated Central Fill pharmacies)

If you need to obtain a long-term prescription or maintenance prescription drug that you take daily or regularly, you may fill your prescription through the Central Fill program. Under the Central Fill program, you fill your long-term prescriptions at any designated Central Fill pharmacy by following the steps below. For a current list of Central Fill pharmacies, contact the Pharmacy Benefits Manager at 1 (888) 869-4600.

How to use the Central Fill Program

Step 1: Obtain a prescription from your doctor.

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

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

	(Initial Fill) **15-Day Supply**
Generic Drugs, Insulin, Diabetic Supplies	$ 5.00 copayment
Brand Name Drugs	$15.00 copayment[1]
Preventive Health Care Medications	No copayment[2]

Step 4: If you and your doctor decide to continue to use this drug and dosage, you may obtain a refill for up to a 60-day supply. Call the pharmacy refill phone number listed on your prescription at least three (3) days before your prescription supply runs out and request a refill.

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

	(Refills) 60-Day Supply
Generic Drugs, Insulin, Diabetic Supplies	$ 8.00 copayment
Brand Name Drugs	$24.00 copayment[1]
Preventive Health Care Medications	No copayment[2]

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

[2] There is no copayment for generic Preventive Health Care medications. If a generic equivalent is not available or not medically appropriate for you, a brand name drug will be provided without charge. If a generic equivalent is available but you request brand name only, you will be responsible for the brand name copayment plus the difference between the cost of the brand name drug and its generic equivalent.

MAIL ORDER PROGRAM
(through designated Mail Order providers)

If you prefer to have your long-term prescription drugs delivered to your home or mailing address, you may use the Mail Order Program. Under the Mail Order Program, you may obtain up to a 90-day supply at the copayments listed below:

	90-day Supply Limit[1]
Generic Drugs, Insulin, Diabetic Supplies	$ 8.00 copayment
Brand Name Drugs	$24.00 copayment[2]
Preventive Health Care Drugs	No copayment[3]

[1] 15-day initial fill required.

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

[3] There is no copayment for generic Preventive Health Care medications. If a generic equivalent is not available or not medically appropriate for you, a brand name drug will be provided without charge. If a generic equivalent is available but you request brand name only, you will be responsible for the brand name copayment plus the difference between the cost of the brand name drug and its generic equivalent.

To use the Mail Order Program, contact the Pharmacy Benefits Manager at 1 (888) 869-4600 for registration forms and/or brochures and mailing instructions.

SPECIALTY PROGRAM (through Optum Specialty Pharmacy)

Specialty medications are dispensed exclusively through the Optum Specialty Pharmacy. You may obtain up to a 30-day supply (15-day initial fill required) at the following copayments:

	(Initial Fill) 15-Day Supply
Generic Drugs	$ 5.00 copayment
Brand Name Drugs	$15.00 copayment
	(Refills) 30-Day Supply
Generic Drugs	$ 8.00 copayment
Brand Name Drugs	$24.00 copayment

Prior Authorization is required when you are prescribed a new or different specialty medication. Please contact the Pharmacy Benefits Manager at 1 (888) 869-4600 for assistance.

DIRECT MEMBER REIMBURSEMENT PROGRAM

Under the Direct Member Reimbursement Program, you may obtain prescription drugs from any pharmacy of your choice. You are responsible for paying the entire cost of the prescription and filing a claim with the Pharmacy Benefits Manager. All prescription drugs are limited to a 30-day supply.

When prescriptions are dispensed by a legally licensed provider, the Trust will pay as follows:

	30-day Supply Limit
Generic Drugs, Insulin, Diabetic Supplies	100% of the Eligible Charge or the cost of the prescription, whichever is less
Non-Substitutable Brand Name Drugs	80% of the Eligible Charge or the cost of the prescription, whichever is less
Substitutable Brand Name Drugs	75% of the Eligible Charge or the cost of the prescription, whichever is less
Preventive Health Care Medications	100% of the cost of the prescription[1]

[1] The Plan will pay 100% of the cost of the prescription for generic Preventive Health Care medications. If a generic equivalent is not available or not medically appropriate for you, the Plan will pay 100% of the cost of the prescription for the brand name drug. If a generic equivalent is available but you request brand name only, the Trust will pay 75% of the Eligible Charge or the cost of the prescription, whichever is less.

How to File a Direct Member Reimbursement Program Claim

Claim forms are available from the Pharmacy Benefits Manager. A completed claim form, together with your receipts, must be submitted to the Pharmacy Benefits Manager within 90 days from the date you purchased the drug. Payment will be made directly to you.

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

COORDINATION OF BENEFITS

If you receive prescription drug benefits under this Plan and any other program or plan providing or reimbursing for prescriptions drug benefits, including but not limited to Medicare and any motor vehicle insurance policy, then the benefits of this Plan and each other plan will be coordinated and adjusted so that the total of such benefits will not exceed 100% of the Eligible Charge for covered prescription drugs.

IF YOU DO NOT AGREE WITH A BENEFIT DETERMINATION

Specific information about the Plan's claims and appeals procedures are contained in the CLAIMS AND APPEALS PROCEDURES section of this booklet (see SELF-INSURED CLAIMS beginning on page 113).

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

You must submit your request, in writing, within 180 days of receiving notice of the action or decision you are contesting to:

Board of Trustees
Benefits and Appeals Committee
Hawaii Teamsters Health and Welfare Trust
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817

Or, send a fax to: (808) 537-1074

For urgent care claims, you may ask for an expedited appeal by calling the Trust Administrator at (808) 523-0199 or 1 (866) 772-8989 (toll free).

The Board of Trustees has appointed the Benefits and Appeals Committee to hear all requests for review of denied claims. Please refer to the Appeals section beginning on page 115 of this booklet for further details on appealing a denied claim to the Board of Trustees.

DISCLAIMER

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

The Indemnity Prescription Drug Plan benefits are self-insured by the Hawaii Teamsters Health and Welfare Trust. 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 Hawaii Teamsters Health and Welfare Trust Office. Please refer to this document for specific questions about coverage.

KAISER FOUNDATION HEALTH PLAN INC.

KAISER PERMANENTE PLAN

Note: Effective September 1, 2019, the Kaiser Permanente Plan replaced the Trust's HMO Medical Plan. All eligible participants enrolled in the HMO Medical Plan as of August 31, 2019 were automatically enrolled in the Kaiser Permanente Plan. The Kaiser Permanente Plan changed from "grandfathered" to "non-grandfathered" health plan status under the Affordable Care Act effective September 1, 2019.

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

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

HOW TO USE THE KAISER PERMANENTE PLAN

PERSONAL DOCTOR

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

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

LOCATIONS

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

For your convenience, Kaiser Permanente operates twelve (12) outpatient

facilities on Oahu, five (5) on Maui, three (3) on the Big Island, and one (1) on Kauai. On 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 at the Moanalua Medical Center. Members on Hawaii Island, Maui, Kauai, Molokai and Lanai receive hospital care at a designated hospital on your island.

Hospital Facilities

Hawaii Island

- Hilo Medical Center
- Kona Community Hospital

Kauai

- Samuel Mahelona Memorial Hospital
- West Kauai Medical Center

Maui

- Maui Memorial Medical Center
- Kula Hospital

Lanai

- Lanai Community Hospital

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

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

OFFICE VISITS

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

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

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

- Alcohol and drug treatment
- Allergy
- Audiology
- Bariatric medicine
- Behavioral health services
- Cosmetic dermatology
- Cosmetic plastic surgery
- Eye examinations for glasses and contact lenses

- Family practice
- Health education
- Internal medicine
- Medication counseling
- Obstetrics-gynecology
- Occupational health services
- Pediatrics
- Physical therapy
- Social work
- Sports medicine
- Tobacco telephone counseling
- Travel medicine

EMERGENCY SERVICES

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

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

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

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

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

If you are admitted to a non-Kaiser Permanente facility, you or a family member must notify Kaiser Permanente within 48 hours after care begins (or as soon as reasonably possible) by calling the phone number on the back of your Kaiser Permanente identification card. 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.

SERVICES OUTSIDE THE HAWAII REGION

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

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

Visiting Member Services at Mainland Kaiser Permanente Facilities

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

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

Moving Out of the Service Area

If you are relocating to another Kaiser Permanente service area, you should contact the Trust Office to discuss your plan/coverage options.

If you move outside the Hawaii service area, Kaiser Permanente may terminate your membership. Until that time, you will only be covered for initial emergency care and urgent care in accordance with your Health Plan benefits.

BASIC MEDICAL BENEFITS

The following is a summary of medical benefits available under the Kaiser Permanente Plan and your payment obligations. This summary of benefits is subject to the description of benefits, limitations, and exclusions described elsewhere in this section. For a complete description of benefits, please refer to the Kaiser Permanente Group Agreement, Kaiser Permanente Group Plan Benefit Schedule and applicable riders, which are on file at the Trust Office. Please refer to these documents for specific questions about coverage.

PLAN BENEFITS	MEMBER CHARGES
ANNUAL COPAYMENT MAXIMUM	$2,000 per member $6,000 per family
INPATIENT HOSPITAL CARE	$50 per day for days 1-4 $0 per day for day 5 and after
PHYSICIAN VISITS	$15 per visit
PREVENTIVE CARE	
• Well-child care visits (birth to 5 years)	None
• Annual preventive care visit (physical exam) (6 years and older)	None
• Annual gynecological exam (female members)	None
• Preventive screenings	None
• Routine immunizations	None
• Hearing exam (for correction)	$15 per visit
• Vision exam (for glasses)	$15 per visit

PLAN BENEFITS	MEMBER CHARGES
EMERGENCY CARE	
• Within Hawaii Service Area	$75 per visit
• Outside Hawaii Service Area	$75 per visit
URGENT CARE	
• Within Hawaii Service Area	$15 per visit
• Outside Hawaii Service Area	20% of applicable charges
OUTPATIENT LABORATORY, IMAGING & TESTING SERVICES	$15 per department per day
OUTPATIENT SURGERY AND PROCEDURES	$15 per visit
SKILLED NURSING FACILITY CARE	None
HOME HEALTH CARE	None
HOSPICE CARE	None
FAMILY PLANNING & INFERTILITY SERVICES	
• Family planning visits	$15 per visit
• Infertility consultation	$15 per visit
• Artificial insemination	$15 per visit
• In vitro fertilization	20% of applicable charges
• Contraceptive drugs and devices (FDA approved) to prevent pregnancy	None or 50% of applicable charges
• Interrupted pregnancy	$15 per visit

PLAN BENEFITS	MEMBER CHARGES
MATERNITY CARE (Routine obstetrical care, delivery and hospital stay for mother and newborn)	None
MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES	
• Outpatient services	$15 per visit
• Inpatient services	$50 per day for days 1-4 $0 per day for day 5 and after
OUTPATIENT DRUGS & DRUG THERAPY	
• Skilled administered drugs	None
• Self-administered drugs (See page 102)	$12 per prescription
• Diabetes supplies	50% of applicable charges
• Tobacco cessation drugs and products	None
• Drug therapy services	Applicable charges
OTHER MEDICAL SERVICES	
Ambulance services	20% of applicable charges

PLAN BENEFITS	MEMBER CHARGES
Autism care	$15 per visit
Blood and blood processing	None (Medical office) Included in applicable charge if provided in any other setting (e.g. Hospital, ER, etc.)
Diabetes equipment	50% of applicable charges
Dialysis	10% of applicable charges
Durable medical equipment	20% of applicable charges
External prosthetic devices and braces	20% of applicable charges
Hearing aids	60% of applicable charges
Health education services	$15 per visit
Hyperbaric oxygen therapy	Applicable charges
Internal prosthetics, devices and aids	None (Medical office) Included in applicable charge if provided in any other setting (e.g. Hospital, ER, etc.)
Medical foods	20% of applicable charges
Orthodontic care for treatment of orofacial anomalies from birth	$15 per visit
Physical, Occupational & Speech therapy	$15 per visit
Pulmonary rehabilitation	Applicable charges
Radiation therapy	$15 per visit
Transplant services	Applicable charges

PLAN BENEFITS	MEMBER CHARGES
DEPENDENT CHILD OUTSIDE SERVICE AREA	
Routine primary care	$20 per visit
Basic laboratory and general imaging	$10 per visit
Testing	20% of applicable charges
Self-administered prescription drugs	20% of applicable charges

BENEFIT DESCRIPTION

ANNUAL COPAYMENT MAXIMUM

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

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

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

- Fit Rewards or any fitness programs
- Bariatric surgery program
- Complementary alternative services such as chiropractic, acupuncture, massage therapy, or naturopathy
- Cosmetic plastic surgery
- Cosmetic dermatology
- Dental services
- Dressings and casts

- Health education services, classes or support groups
- Lasik eye surgery
- Medical social services
- Sexual dysfunction drugs
- Payments for services subject to a maximum once you reach the maximum
- Take-home supplies
- Travel immunizations
- Any amounts you owe in addition to your copayments for covered services
- Payments you make for non-covered or excluded services or services for which coverage has been exhausted

INPATIENT HOSPITAL CARE

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

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

Observation: Covered when prescribed by a physician without charge.

PHYSICIAN VISITS

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

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

PREVENTIVE CARE

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

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

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

Preventive Screenings: The following preventive screening services are provided without charge:

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

In addition, you are covered for preventive care as determined by the Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) and for recommended preventive care for women supported by the Health Resources and Services Administration (HRSA). The preventive care services list is subject to change at any time to conform to changes in applicable laws and regulations. This list is available on www.kp.org or may be obtained from Member Services.

Routine Immunizations: Prescribed immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) for disease prevention, including influenza and pneumococcal, and for children 5 years of age and younger are provided without charge. Your office visits for prescribed immunizations are provided without charge.

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

Travel immunizations: Not covered.

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

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

EMERGENCY CARE

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

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

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

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

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

URGENT CARE

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

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

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

OUTPATIENT LABORATORY, IMAGING & TESTING SERVICES

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

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

Examples of specialty lab tests include:

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

Imaging: Covered, for prescribed general and specialty imaging including

interpretation of imaging and related materials. Examples of general imaging include:

- X-ray
- Diagnostic mammography

Examples of specialty imaging include:

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

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

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

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

SURGERY

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

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

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

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

Reconstructive Surgery: Covered, if a physician determines that the surgery is medically feasible and (i) will result in significant improvement in physical function (such as bariatric surgery and surgery to correct congenital anomalies); or (ii) will correct significant disfigurement following an injury or medically necessary

surgery; or (iii) is performed incident to a covered mastectomy. Your copayment for the surgery is determined based on whether it is performed as an inpatient or outpatient surgical procedure.

SKILLED NURSING FACILITY CARE

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

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

Medicare guidelines are used to determine when skilled nursing services are covered except that a prior three-day stay in an acute care hospital is not required. Up to 120 days per calendar year of prescribed skilled nursing care are provided without charge.

HOME HEALTH CARE

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

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

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

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

HOSPICE CARE

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

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

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

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

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

FAMILY PLANNING & INFERTILITY SERVICES

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

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

Artificial Insemination: Covered, to determine infertility status.

In vitro fertilization: Covered, when provided or arranged by your Kaiser Permanente physician. Coverage is limited to a one-time only benefit for one out-patient in vitro fertilization procedure while you are a Kaiser Plan member. If you received benefits for in vitro fertilization under any Kaiser Permanente plan, you are not eligible for in vitro fertilization benefits under this plan. In vitro fertilization services are not covered when a surrogate is used.

In vitro fertilization must meet state law requirements and Health Plan requirements

and criteria. The cost of donor sperm, donor eggs, equipment and of collection, storage and processing of sperm or eggs are not covered.

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

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

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

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

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

MATERNITY CARE

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

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

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

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

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

MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES

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

Mental Health - Outpatient services: Care by physicians and mental health

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

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

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

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

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

OUTPATIENT DRUGS

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

Self- administered drugs: Covered under Prescription Drug Rider. See page 102.

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

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

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

DRUG THERAPY SERVICES

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

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

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

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

OTHER MEDICAL SERVICES

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

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

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

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

Diabetes equipment: Covered, when prescribed by a physician, preauthorized in

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

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

Durable medical equipment (DME): Covered, for medically necessary and appropriate DME for use in the home when prescribed by a physician, preauthorized in writing and obtained from sources designated by Health Plan on either a purchase or rental basis. Examples of DME include oxygen equipment, hospital beds, and mobility assistive equipment (wheel chairs, walkers, power mobility devices). Oxygen for use in conjunction with prescribed durable medical equipment and the repair, replacement and adjustment of durable medical equipment other than due to misuse or loss, is also covered. If you receive your DME during a hospital or skilled nursing facility stay, your DME is included in the copayment for INPATIENT HOSPITAL or SKILLED NURSING FACILITY care.

External prosthetic devices and braces: Covered, when prescribed by a physician, preauthorized in writing and obtained from sources designated by Health Plan. Fitting and adjustment of external prosthetic devices and braces, including repairs and replacement other than due to misuse or loss, is also covered. External prosthetic devices and braces received during a hospital or skilled nursing facility stay are included in the copayment for INPATIENT HOSPITAL or SKILLED NURSING FACILITY care.

External prosthetic devices are those which are affixed to the body externally and are required to replace all or part of any body organ or the function of a permanently inoperative or malfunctioning body organ. Examples include artificial limbs and eyes, post-mastectomy or post-lumpectomy breast prostheses, external pacemakers and post-laryngectomy electronic speech aids.

Braces are rigid or semi-rigid devices which are required to support a weak or deformed body member or are required to restrict or eliminate motion in a diseased or injured part of the body.

Coverage is limited to the standard model of external prosthetic device or brace in accord with Medicare guidelines that adequately meet the patient's needs. Convenience and luxury items and features are not covered.

Hearing aids: Covered, for up to two hearing aids, one for each hearing-impaired ear, once every 36 months, when prescribed by a physician or audiologist and obtained from sources designated by Health Plan. Coverage is limited to the lowest priced model hearing aid that adequately meets the patient's medical needs.

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

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

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

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

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

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

- The diagnosis and medical records document the need for therapy.
- The therapy is ordered by a physician under an individual treatment plan.
- In the judgment of a physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy.
- The therapy is provided by or under the supervision of a physician-designated licensed physical, occupational or speech therapist, as appropriate.
- The therapy is skilled and necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury.
- The therapy is to restore neurological and/or musculoskeletal function required to perform normal activities of daily living.
- Occupational therapy is limited to hand rehabilitation and medical care to

achieve improved self-care and other customary activities of daily living.

- Speech-language therapy is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin.
- Speech language therapy is provided on a one-to-one basis.
- The therapy is not for deficits due to developmental delay.
- The therapy does not duplicate services provided by another therapy or available through schools and/or government programs.

Maintenance therapy is not covered.

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

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

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

The following are excluded from coverage: 1) Non-human and artificial organs and their implantation; and 2) bone marrow transplants associated with high-dose chemotherapy for the treatment of solid tumors, except for germ cell tumors and neuroblastoma in children.

Benefits for transplant recipients include transplant evaluations, medical and hospital care, and prescribed post-surgical immunosuppressive drugs required as a result of a covered transplant.
Health Plan will pay for medical services for living organ and tissue donors and prospective donors if the medical services meet the following requirements. Health Plan pays for these medical services as a courtesy to donors and prospective donors, and this document does not give donors or prospective donors any of the rights of Kaiser Permanente members.

- Regardless of whether the donor is a Kaiser Permanente member or not, the terms, conditions, and Member Charges of the transplant-recipient Kaiser Permanente member will apply. Copayments 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 Annual Copayment Maximum.

- 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.

DEPENDENT CHILD CARE OUTSIDE THE SERVICE AREA (up to age 26)

Routine primary care: Covered, up to 10 office visits per year.

Basic laboratory, general imaging and testing: Covered, up to 10 combined outpatient tests per year.

Self-administered prescription drugs: Covered, up to 10 prescriptions per year.

Services must be obtained outside the Hawaii Service Area and all other Kaiser Permanente regional Service Areas from a non-Kaiser Permanente provider. You must pay for services at the time they are received and submit a claim for reimbursement to Health Plan. Payments for Emergency Services, out-of-area Urgent Care, and care authorized under a referral will not be made under this benefit.

COVERAGE EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

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

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

- **Dental care services**, such as dental implants, dental appliances, orthodontia, dental x-rays, care relating to Temporomandibular Joint Dysfunction (TMJ) or Craniomandibular Pain Syndrome (CPS).
- **Employer or Government 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 Administration facility; services required by law to be provided only by, or received only from, a government agency.
- **Experimental or investigational services**.
- **eye exercises**.
- **Eye surgery** solely for the purpose of correcting refractive defects of the eye such as Photo-refractive keratectomy (PRK), lasek eye surgery and lasik eye surgery.
- **Routine foot care**, unless medically necessary.
- **Health Education**: specialized health promotion classes and support groups (such as weight management and bariatric surgery program).
- **Homemaker services**.
- **Infertility services** including services related to conception by artificial means such as ovum transplants, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT); services to reverse voluntary, surgically-induced infertility and stand-alone ovulation induction services.
- **Non-FDA approved drugs and devices**.
- **Certain exams and services**. Certain services and related reports/paperwork in connection with third party requests such as those for: employment, participation in employee programs, sports, camp, insurance, disability, licensing, or on court order or for parole or probation. Physical examinations that are authorized and deemed medically necessary by a Kaiser Permanente physician and are coincidentally needed by a third party are covered according to the member's benefits.
- Long-term **physical therapy, occupational therapy, speech therapy**; maintenance therapies; unskilled therapy and physical, occupational, and speech therapy deficits due to developmental delay.
- **Services not generally and customarily available in the Hawaii service area**.
- **Services and supplies not medically necessary**. A service or item is medically necessary (in accord with medically necessary state law definitions and criteria) only if, 1) recommended by the treating Kaiser

Permanente physician or treating Kaiser Permanente licensed health care practitioner, 2) is approved by Kaiser Permanente's medical director or designee, and 3) is for the purpose of treating a medical condition, is the most appropriate delivery or level of service (considering potential benefits and harms to the patient), and known to be effective in improving health outcomes. Effectiveness is determined first by scientific evidence, then by professional standards of care, then by expert opinion. Coverage is limited to the services which are cost effective and adequately meet the medical needs of the member.

- All services, drugs, injections, equipment, supplies, and prosthetics related to treatment of **sexual dysfunction**, except evaluations and health care practitioners' services for treatment of sexual dysfunction.
- **Take-home supplies** for home use, such as bandages, gauze, tape, antiseptics, ace type bandages, drug and ostomy supplies, catheters and tubing.
- Services for injuries or illness caused or alleged to be caused by **third parties or** in **motor vehicle accidents**.
- **Transportation** (other than covered ambulance services), **lodging and living expenses**.
- **Travel immunizations** (serum).
- **Services for which coverage has been exhausted, services not listed as covered, or excluded services**.

LIMITATIONS

Benefits and services are subject to the following limitations:

- **Unusual circumstances:** Services may be curtailed because of major disaster, epidemic, or other circumstances beyond Kaiser Permanente's control such as a labor dispute or a natural disaster.
- **Refusal to accept treatment:** Coverage is not provided for treatment of conditions for which a member has refused recommended treatment for personal reasons when Kaiser Permanente physicians believe no professionally acceptable alternative treatment exists. Coverage will cease at the point the member stops following the recommended treatment.

- **Third party liability or motor vehicle accidents:** Kaiser Permanente has the right to recover the cost of care for a member's injuries or illness caused by another person or in an auto accident from a judgment, settlement, or other payment paid to the member by an insurance company, individual, or other third party. You must furnish information about the existence and terms of any third party insurance policy or motor vehicle insurance policy covering the injury or illness and complete and submit all claims, releases, and other documents necessary to comply with State or Federal law. It is your responsibility to ensure that charges you incur are paid either by the third party or a motor vehicle insurance carrier.
- **Surrogacy health services:** Kaiser Permanente has the right to recover the cost of care for surrogacy health services. Surrogacy health services are services the member receives related to conception, pregnancy, or delivery in connection with a surrogacy arrangement. The member must reimburse Kaiser Permanente for the cost of surrogacy health services out of the compensation the member or the member's payee are entitled to receive under the surrogacy arrangement.
- **Coordination of benefits:** If members have medical coverage with another health plan or insurance company, Kaiser Permanente will coordinate benefits with the other coverage in accordance with the current rules of the National Association of Insurance Commissioners (NAIC).

PRESCRIPTION DRUG BENEFITS

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

BENEFITS	MEMBER CHARGES
For each prescription or refill, when the quantity does not exceed: • A 30-day consecutive supply of a prescribed drug, or • An amount as determined by the Formulary. Self-administered drugs are covered only when all of the following criteria are met: • Prescribed by a Kaiser Permanente physician or licensed prescriber, or a prescriber Kaiser Permanente designates, • The drug is one for which a prescription is required by law, • On the Kaiser Permanente Hawaii Drug Formulary and used in accordance with Formulary criteria, guidelines, or restrictions, • Obtained at pharmacies in the Hawaii service area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc., or pharmacies designated by Kaiser Permanente, • The drug does not require administration by or observation by medical personnel.	$12.00 per prescription

Insulin	$12.00 per prescription
Mail Order Service Members may request refills of maintenance drugs through the mail order service, in which members are entitled to a 90-day supply for two copayments. (Prescription must have been previously filled at a Kaiser Permanente pharmacy).	Refills (up to a 90-day supply) $24.00 per refill

HOW TO REQUEST MAIL ORDER REFILLS

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

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

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

PRESCRIPTION DRUG PLAN EXCLUSIONS

The following are excluded from coverage:

- Drugs for which a prescription is not required by law (e.g., over-thecounter drugs) including condoms, contraceptive foams and creams, or other non-prescription substances used individually or in conjunction with any other prescribed drug or device. This exclusion does not apply to tobacco cessation drugs and products as described in the prescribed drugs section of the Medical Benefits.

- Drugs in the same therapeutic category as a non-prescription drug, as approved by Kaiser Permanente's Pharmacy & Therapeutics Committee.
- Drugs obtained from a non-Kaiser Permanente pharmacy.
- Non-prescription vitamins.
- Drugs when used primarily for cosmetic purposes.
- Medical supplies such as dressings and antiseptics.
- Reusable devices such as blood glucose monitors and lancet cartridges (covered under Medical Benefits).
- Diabetes supplies such as blood glucose test strips, lancets, syringes and needles (covered under Medical Benefits).
- Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente physician or licensed prescriber, or a prescriber Kaiser Permanente designates.
- Brand name drugs requested by a member when there is a generic equivalent.
- Prescribed drugs that are necessary for or associated with excluded or non-covered services.
- Drugs related to sexual dysfunction.
- Drugs to shorten the duration of the common cold.
- Drugs related to enhancing athletic performance (such as weight training or bodybuilding).
- Any packaging other than the dispensing pharmacy's standard packaging.
- Immunizations, including travel immunizations.
- Contraceptive drugs and devices to prevent unwanted pregnancies (covered under Medical Benefits).
- Abortion drugs such as RU-486 (covered under Medical Benefits).
- Replacement of lost, stolen, or damaged drugs.

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

FIT REWARDS PROGRAM BENEFITS

The Fit Rewards Program is provided through American Specialty Health, Inc. (ASH). Eligible members, age 16 and older, can enroll online at kp.org/activeandfit or by calling the American Specialty Health Network toll-free member services hotline at 1-877-750-2746, from 5:00 a.m. to 3:00 p.m. (Hawaii Time), Monday through Friday.

Members must pay the annual $200 gym membership fee or $10 home fitness program fee directly to ASH. Fees will not be prorated or refunded except as provided below[1]. Fees do not count toward your Annual Copayment Maximum.

BENEFITS	MEMBER PAYMENT
FITNESS CLUB & EXERCISE CENTER MEMBERSHIP PROGRAM • Eligible members may enroll with an ASH contracted network fitness club • Program enrollment includes standard fitness club services and features (Members should verify services and features with the ASH contracted fitness club)	$200 per calendar year[1] [1] You can get back your $200 annual membership fee after working out at least 45 days (30 minutes per session), each calendar year.
OR	
HOME FITNESS PROGRAM • Eligible members may select up to two of the available ASH home fitness kits per calendar year	$10 per calendar year
ACTIVE & FIT WEBSITE • All eligible members have access to web-based services such as facility provider search, enrollment functions, educational content and fitness tools and trackers	

ACTIVE & FIT PROGRAM EXCLUSIONS

- Instructor-led classes for which a separate fee is charged and which are not routinely included in the general membership fee
- Personal trainers, classes, and club services, amenities and products or supplies for which an additional fee is charged
- Access to fitness or exercise clubs that are not part of ASH's contracted network
- Home fitness kits not provided through ASH's Active & Fit Program
- Enrollment for members under the age of 16

DISPUTE RESOLUTION

ERISA CLAIMS

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

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

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

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

Internal Review

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

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

External Review

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

External reviews are limited to situations where:

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

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

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

Or by facsimile to 808-587-5379

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

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

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

Binding Arbitration

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

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

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

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

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

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

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

ADDITIONAL KAISER PERMANENTE INFORMATION

MEMBER SERVICES

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

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

Phone line hours:

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

Member Services can assist you with questions about:

- Your benefits
- Claims and billing
- Filing an appeal
- Updating your address and contact information
- Replacing your ID card

Kaiser Permanente provides:

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

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

IDENTIFICATION CARDS

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

YOUR CURRENT ADDRESS

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

CLAIMS FOR BENEFITS

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

CONTINUING COVERAGE

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

IMPORTANT KAISER PERMANENTE PHONE NUMBERS

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

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

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

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

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

Maui: **808-243-6000**

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

Kauai: **808-246-5600**

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

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

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

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

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

VISION CARE BENEFITS

Retirees and spouses are eligible for vision care benefits provided through the VSP Advantage Plan. You may select from VSP's 275+ Hawaii doctor locations or go to an out-of-network provider for your vision services. If you have any questions regarding your vision care benefits, please contact VSP's Customer Care Division.

VSP CUSTOMER CARE	
Oahu:	(808) 532-1600
Neighbor Islands:	1 (800) 522-5162 Toll Free
Nationwide (24/7):	1 (800) 877-7195 Toll Free

WHAT ARE THE VISION CARE BENEFITS?

Standard Eye Examinations and Prescription Glasses

Eye Examinations:	Once every 12 months*
Lenses:	Once every 24 months*
Frames:	Once every 24 months*

**From the date of your last service. Interim benefits for lenses are available after 12 months if the new prescription differs from the original prescription by a) at least (+) or (-) 0.50 diopter sphere or cylinder, or b) an axis change of 15 degrees or more, or c) a 0.5 prism diopter change in at least one eye.*

	PLAN PAYS	
BENEFIT	**VSP MEMBER DOCTOR**	**OUT-OF-NETWORK PROVIDER**
EYE EXAMINATION		
Optometrist (O.D.) or Ophthalmologist (M.D.)	100% after copayment	Up to $ 45.00
SPECTACLE LENSES		
Single Vision Lenses	100% after copayment	Up to $ 50.00
Lined Bifocal Lenses	100% after copayment	Up to $ 70.00
Lined Trifocal Lenses	100% after copayment	Up to $ 70.00
FRAMES	Up to $ 90.00 after copayment	Up to $ 40.00
CONTACT LENSES (in lieu of glasses)	Up to $110.00 (no copayment)	Up to $110.00

Copayment

Your copayment is $10.00 (total) for the exam, lenses and frame.

Elective Contact Lenses

Contact lenses may be chosen instead of glasses. Contact lens frequency is the same as spectacle lenses. If you elect contact lenses, you will not be eligible for lenses again for 24 months (interim benefits are available after 12 months as noted above), and frames for 24 months, after the last date you received contact lenses.

An allowance of $110 is provided for contact lenses and the contact lens exam (evaluation and fitting). Any costs exceeding the allowance are the responsibility of the patient. If you use a VSP Member Doctor, a 15% discount will be applied toward the doctor's professional fees for the contact lens exam. This discount is applicable for the 12 months following the covered exam from VSP doctors.

Medically Necessary Contact Lenses

Coverage for medically necessary contact lenses is subject to review and approval by VSP. When medically necessary contact lenses are prescribed by a VSP Member Doctor, they are covered in full with prior approval from VSP. Medically necessary contact lenses obtained from an Out-of-Network Provider are covered up to $110 when approved by VSP. This benefit is subject to the copayment.

Extra Discounts and Savings from VSP Member Doctors

- 20% off any frame overage in excess of the frame benefit.
- 20% off non-covered lens options such as tints, progressive lenses and anti-scratch coatings.
- 20% off additional pairs of prescription glasses and sunglasses, including lens options, within 12 months of your covered vision exam from a VSP Member Doctor.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan benefits or may be subject to additional limitations. Details regarding frame brand availability may be obtained from your VSP Member Doctor or by calling VSP's Customer Care Division at 1-800-877-7195.

There is no benefit for professional services or materials connected with:

- Eye examinations or corrective eyewear required by an employer as a condition of employment
- Orthoptics or vision training and any associated supplemental testing
- Corneal Refractive Therapy (CRT)
- Orthokeratology
- Refitting of contact lenses after the initial (90-day) fitting period
- Plano lenses (lenses with refractive correction of less than $\pm$ .50 diopter)
- Two (2) pairs of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision treatment of an experimental nature
- Contact lens modification, polishing or cleaning

- Additional office visits associated with contact lens pathology
- Contact lens insurance policies or service agreements
- Services and/or materials not indicated as covered plan benefits

The Plan will not pay Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to a patient by a VSP Member Doctor or an out-of-network provider.

HOW DO I USE THE PLAN?

When you receive services from a VSP Member Doctor, you pay the doctor your copayment for the examination and materials. The VSP Member Doctor will submit the claim to VSP for payment, so there is no paperwork for you. If you select any non-covered extras (e.g., designer frames, lens tinting, scratch resistant coatings, etc.) you will be charged according to discounted usual and customary charges.

VSP Member Doctor

Step 1: Call a VSP Member Doctor of your choice to make an appointment and identify yourself as a VSP member.

Step 2: The doctor will collect a $10.00 copayment for the examination and materials.

Step 3: Ask your VSP Member Doctor to itemize the charges so you will know exactly what portion of the bill is covered under your VSP plan.

How Do I Receive Out-of-Network Reimbursement?

If you have received services from an Out-of-Network Provider:

Step 1: Pay the full amount of your bill to the Out-of-Network Provider at the time you receive services.

Step 2: Submit a claim to VSP for reimbursement. Be sure to include itemized receipts with your claim.

Step 3: VSP will reimburse you up to the scheduled amounts for covered services.

For faster reimbursement, you may submit a claim on-line.

- Log in to your vsp.com account.
- Complete the vsp.com online claim form following the prompts.

- Submit your itemized receipt(s) along with the claim form. You can either upload your receipts or print the claim form and submit with your receipts by mail to:

  VSP
  Attention: Claims Services
  P.O. Box 385018
  Birmingham, Alabama 35238-5018

Mobile users can simply snap a photo and attach their receipts.

After submitting your claim, you can track the status of your claim online.

- Log in to your vsp.com account.
- Click on “Claims and Reimbursement” and select “Previous Doctor Visits & Services” to see the status of your claim.

Please allow up to ten (10) business days for VSP to process your reimbursement.

If you need assistance in filing a claim, you may call VSP Customer Care at (808) 532-1600 (Oahu) or 1-800-522-5162 (Neighbor Islands Toll Free) or 1-800-877-7195 (Nationwide Toll Free).

IMPORTANT: Out-of-network claims for reimbursement must be submitted to VSP within 12 months of the date of service.

CLAIMS APPEAL PROCESS

If your claim is denied in whole or in part, a copy of the specific rule, guideline, or protocol relied upon in making the benefit determination will be provided free of charge upon request by you or your authorized representative. A copy of VSP's claims appeal process may also be obtained from Customer Care.

If you are not satisfied with the explanation of why a service was not covered, a request for review may be sent within 180 days following denial of the claim to:

Vision Service Plan
Attn. Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741

Your request should include:

- Your name and telephone number.
- Member Identification Number.
- The name and birthdate of the covered person for whom the claim was denied.
- The date of the service denied or date of the contested action or decision.
- The provider's name and the claim number.
- A description of the facts related to your request and why you believe the claims administrator's action or decision was in error.
- Any other details about your appeal. This may include written comments, documents, and records you would like the claims administrator to review.

VSP will respond to your appeal within 30 calendar days following receipt of your request.

In some cases, you have a right to a faster, 24-hour appeal. You can get a fast appeal if your health or ability to function could be seriously harmed by waiting 30 days for a standard appeal. If you ask for a fast appeal, VSP will decide if you get a 24-hour/fast appeal. If not, your appeal will be processed in 30 days. If any doctor asks VSP to give you a fast appeal, or supports your request for a fast appeal, it must be given to you.

If you want to file a fast appeal, which will be processed within 24 hours, do the following:

- File an oral or written request for a 24-hour appeal and specifically state "I am requesting an: expedited appeal, fast appeal or 24-hour appeal." Or "I believe that my health could be seriously harmed by waiting 30 days for a normal appeal."
- To file a request orally, call **1 (800) 877-7195.** VSP will document the oral request in writing.

If you disagree with VSP's response to your appeal, you have the right to a second level appeal. You may submit a second appeal to VSP along with any pertinent documentation within 60 calendar days following receipt of VSP's response to the initial appeal. VSP will communicate its final determination on your appeal within 30 calendar days.

If, after completing the appeals process, your claim was not approved in whole or in part and you disagree with the outcome, you have the right to bring a civil action under Section 502(a) of ERISA.

The preceding vision care benefits are insured under an insurance contract issued by Vision Service Plan (VSP), 3333 Quality Drive, Rancho Cordova, California 95670. The services provided by VSP include the payment of claims and the handling of claims appeals.

The preceding information is only a summary of coverage. Its contents are subject to the provisions of the Group Vision Care Agreement which contains the terms and conditions of membership and benefits. This document is on file with the Hawaii Teamsters Health and Welfare Trust Office. Please refer to this document for specific questions about coverage.

CLAIMS AND APPEALS PROCEDURES

SELF-INSURED CLAIMS
(Indemnity Prescription Drug Plan)

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

If your claim is wholly or partially denied by the Claims Administrator, you will be provided with a written determination explaining the reasons for denial.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

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

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

INITIAL CLAIMS

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

Urgent Care Claims: 72 Hours

You will be notified within 72 hours from the receipt of your claim whether your claim is approved or denied. If you fail to follow the Plan's claims filing procedure or submit an incomplete urgent care claim, you will receive oral notification (or written notification, if you request) within 24 hours of the day the claim was received. The notification will indicate what the proper procedures are for filing claims, or what additional information is needed to complete your claim. You will be given 48 hours from the date you are notified to complete your claim.

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

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

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

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

You will be notified within 15 calendar days from the receipt of your claim whether your claim is approved or denied. A pre-service claim is any claim involving a requirement or request for approval before care is rendered. Pre-service claims include prior authorization and utilization review decisions. For specific procedures on obtaining prior approvals for benefits, pre-authorizations, or utilization reviews, refer to the specific sections of the self-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. The five day deadline will apply only if your claim is received by the Claims Administrator and is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

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

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

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

The Plan may extend the time to respond to a pre-service or post-service claim by 15 calendar days if there are circumstances beyond the Plan's control that interfere with a timely claim determination. The Plan must provide you with advance notice of the extension, identifying the circumstances which provide the basis for the extension and the date that the Plan is expected to make its decision, prior to the extension period taking effect. If the extension is necessary due to

insufficient information to decide the claim, the notice of extension will indicate what additional information is needed to complete your claim. You will be given 45 days from the date you are notified to provide additional information to complete your claim.

Concurrent Care Claims: 24 Hours

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

INITIAL BENEFIT DETERMINATION

Upon approval of a pre-service or urgent care claim by the Claims Administrator, you will receive a notice informing you of the approval. No approval notice will be provided for post-service claims.

If your claim is denied by the Claims Administrator, you will be provided written notice of the denial at no cost to you. Examples of a denied claim include a determination to reduce or terminate a benefit or a failure to make whole or partial payment of a benefit by the Plan. In the case of urgent care claims, the Plan may first notify you orally, with a written notice to follow in three days. The notice of denial, whether oral or written, will contain the following information:

a. Identification of the claim involved including the date of service, the provider's name, and the claim amount, if applicable, and a statement that you may request, free of charge, the diagnosis code and the treatment code and their corresponding meanings.

b. The specific reason(s) for the denial, with reference(s) to the specific Plan provisions, the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.

c. A description of any additional material or information necessary to complete your claim and why the information is needed.

d. 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.

e. 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.

f. A description of the Plan's internal appeals and external review procedures, the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

g. A description of the expedited review process applicable to the claim, if the denial involved a claim for urgent care.

APPEALS

If you wish to appeal the denial of any claim for benefits by the Claims Administrator or a rescission of coverage, you have 180 days following your receipt of an adverse benefit determination to file an appeal with the Board of Trustees. The Board of Trustees has appointed the Benefits and Appeals Committee to hear all appeals.

An appeal may be initiated by you or your authorized representative (such as your physician). Appeals must be submitted in writing to the Board of Trustees at the following address:

Board of Trustees
Benefits and Appeals Committee
Hawaii Teamsters Health & Welfare Trust
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817

Or, send a fax to: (808) 537-1074

You may ask for an expedited appeal by calling the Trust Administrator at (808) 523-0199 or 1 (866) 772-8989 (toll free).

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 that 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:

a. Reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits; and

b. 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.

Before the Benefits and Appeals Committee can issue an adverse benefit determination on your appeal based on a new or additional rationale, the Plan must provide you with the rationale, free of charge, and give you a reasonable opportunity to respond.

Appeal of an Urgent Care Claim

If you are appealing a denial that is considered an urgent care claim, you have the option of submitting your appeal orally or in writing. All necessary information will be communicated to you through the quickest method available, such as telephone or fax. The Benefits and Appeals Committee must issue its decision as soon as possible, but no later than 72 hours from the time the appeal is received.

Appeal of a Pre-Service Claim

If you are appealing a denial that is considered a pre-service claim, you must submit a written request for review of the initial denial. The Benefits and Appeals Committee must issue its decision no later than 30 days from the time the appeal is received.

Appeal of a Post-Service Claim

If you are appealing a denial that is considered a post-service claim, you must submit a written request for review of the initial denial. The Benefits and Appeals Committee must issue its decision no later than 60 days from the time the appeal is received.

Appeal of a Rescission of Coverage

If you are appealing a rescission of coverage, you must submit a written request for review. 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. If your claim is denied, the notice of denial will contain the following information:

a. Identification of the claim involved including the date of service, the provider's name, and the claim amount, if applicable, and a statement that you may request, free of charge, the diagnosis code and the treatment code and their corresponding meanings.

b. The specific reason(s) for the denial, with reference(s) to the specific Plan provisions and a description of the Plan's standard, if any, that was used in denying the claim.

c. A statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim.

d. 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.

e. 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.

f. A description of the Plan's external review procedures and the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA.

Continued Coverage pending the Outcome of an Appeal

Pending the outcome of an appeal, benefits for an ongoing course of treatment will not be reduced or terminated without advance notice and an opportunity for review.

Right to Bring Civil Action

Following receipt of an adverse benefit determination on your appeal, you have the right to bring a civil action under section 502(a) of ERISA within two years after receipt of the written notice of Initial Benefit Determination.

EXTERNAL REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)

Following receipt of an adverse benefit determination on an appeal involving medical judgment or a rescission of coverage, you may request an external review by an Independent Review Organization (IRO). You must submit your request to the Plan, in writing, within 130 days after notice of the adverse benefit determination is received. Within six business days following receipt of your request, the Plan will notify you in writing whether your appeal is eligible for external review. Upon determination that the criteria for external review has been met, the Plan will assign an IRO at random from a panel of three IROs to review your appeal. The IRO will notify you of its decision within 45 days after it receives the assignment from the Plan.

Expedited External Review by an IRO

You may request an expedited external review if:

a. You have filed an expedited internal appeal and the timeframe for completion of an expedited internal appeal would seriously jeopardize your life, health, or ability to regain maximum functioning; or

b. The timeframe for completion of a standard external review would seriously jeopardize your life, health, or ability to regain maximum functioning; or

c. The internal appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services and you have not been discharged from a facility.

Upon determination that you meet the above criteria, the Plan will assign an IRO at random from a panel of three IROs to review your appeal. The IRO will notify you of its decision as expeditiously as your condition or circumstances require but in no event more than 72 hours after it receives the assignment from the Plan.

INSURED CLAIMS

Participants may obtain information concerning claims and appeals procedures for the following insured benefits by referring to the applicable benefit section of this booklet or by contacting the insurance carrier at the address listed below:

Medical Benefits:

UHA
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813
Attn: Appeals Coordinator

KAISER FOUNDATION HEALTH PLAN, INC.
711 Kapiolani Boulevard, Suite 400
Honolulu, Hawaii 96813
ATTN: Customer Service

HAWAII MEDICAL SERVICE ASSOCIATION
P.O. Box 860
Honolulu. Hawaii 96808-0860
Attn: Customer Service

Vision Care Benefits:

VISION SERVICE PLAN
P.O. Box 2350
Rancho Cordova, California 95741
ATTN: Member Appeals

DISABILITY CLAIMS

A disability claim is any claim for which the Plan must make a determination of disability in order for the beneficiary to receive the benefit. Examples include the continuation of your benefits when you become disabled and unable to work, and the continuation of benefits for a disabled dependent child beyond age 26.

Effective on and after April 1, 2018, any claim for a disability benefit shall be subject to the following claims and appeal procedures. **Exception:** When the Plan provides a benefit that is conditioned on a finding of a disability made by a party other than the Plan (e.g., the Social Security Administration), then a claim for such benefits is **not** treated as a disability claim under this section.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

You can designate another person to act on your behalf in the handling of your benefit claims. In order to do so, you must complete and file a form with the Administrator of the Hawaii Teamsters Health and Welfare Trust 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.

INITIAL CLAIMS

Upon the filing of a claim for disability benefits with the Administrator, and all necessary information required to make a determination on your claim, a decision will be made within 45 days. This period may be extended by the Plan for up to 30 days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you prior to expiration of the initial 45-day period of the circumstances requiring the extension and the date by which the Plan expects to make a decision. If, prior to the end of the first extension period, the Administrator determines that due to matters beyond the control of the Plan a decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Plan notifies you prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date by which the Plan expects to make a decision.

In the case of any extension, the notice of extension shall explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You will be given 45 days from the date you are notified to provide the specified information to complete your claim.

INITIAL BENEFIT DETERMINATION

If your claim is approved by the Administrator, you will receive a notice informing you of the approval.

If your claim is denied by the 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. The notice of denial will contain the following information:

a. The specific reason(s) for the denial, with reference(s) to the specific Plan provisions on which the determination is based.

b. A description of any additional material or information necessary to complete your claim and why the information is needed.

c. A description of the Plan's review procedures, the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal. The statement of your right to bring an action under section 502(a) of ERISA shall also describe any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

d. Identification of any internal rule, guideline, protocol, or other criteria the Plan relied upon in making the determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

e. 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.

f. A discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following: (a) the views of health care professionals who treated you or vocational professionals who evaluated you; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan without regard to whether the advice was relied upon in making the benefit determination; (c) a disability determination made by the Social Security Administration.

g. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

h. A statement that if you are not proficient in English and have questions about the claim denial, you should contact the Trust Office to find out if language assistance is available.

APPEAL OF A DENIED CLAIM

If your disability claim is denied in whole or in part or you disagree with the decision made on a claim, you may ask for a review (appeal the decision).

An appeal may be initiated by you or your authorized representative. Appeals must be submitted in writing to the Board of Trustees at the following address:

Board of Trustees
Hawaii Teamsters Health & Welfare Trust
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817

Or, send a fax to: (808) 537-1074

If you wish to appeal the denial of any disability claim by the Administrator, you have 180 days following your receipt of an adverse benefit determination to file an appeal with the Board of Trustees.

The appeal will be conducted by the Board of Trustees (or a subcommittee thereof) 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 Board of Trustees 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 Board of Trustees 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 that was involved in the initial determination of the claim, nor a subordinate of that individual.

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

a. Reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits; and

b. 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.

Before the Plan can issue an adverse benefit determination on your appeal or before the Plan can issue an adverse benefit determination based on a new or additional rationale, you will be provided, free of charge, any new or additional rationale or evidence considered, relied upon, or generated by the Plan in connection with your claim for benefits. Such rationale or evidence will be provided in advance of the date on which the notice of determination on appeal is required and you will be given a reasonable opportunity to respond prior to that date.

The Board of Trustees meets quarterly. The Board of Trustees (or a subcommittee thereof) will review your appeal and make its benefit determination no later than the date of the Board meeting that immediately follows the Plan's receipt of your request for an appeal. However, if your request for appeal is filed within 30 calendar days preceding the date of the next Board meeting, the Board's benefit determination may be made no later than the date of the second meeting following the Plan's receipt of your request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered no later than the third meeting of the Board following the Plan's receipt of your request for an appeal. If such an extension is necessary, the Plan will provide you with a Notice of Extension describing the special circumstances and date by which the benefit determination will be made. The Administrator will notify you of the benefit determination no later than five days after the benefit determination is made at the Board meeting.

OTHER APPEALS

The Trust Office serves as the Administrator of the Hawaii Teamsters Health and Welfare Trust and maintains the records regarding your eligibility for benefits. Questions concerning enrollment, change of employee status, or change in dependent coverage should be directed to the Trust Office. Any disagreement regarding your eligibility status or the status of your dependent that cannot be resolved by the Administrator may be submitted to the Board of Trustees for review.

You have the right to appeal any decision of the Administrator based on Plan rules adopted by the Board of Trustees (e.g. denial of eligibility or loss of eligibility) by filing a written request for review with the Board of Trustees. Your written request must be filed within 60 days after notification by the Administrator and should describe your version of the facts and reasons why you feel the Administrator's decision was not proper. You should also submit any documents, records, and other information in support of your claim not already furnished to the Plan. If you wish, you (or your authorized representative) may review and obtain copies of all Plan documents, records, and other information relevant to your claim, free of charge.

Upon receipt of your written request for review, the Board of Trustees (or a sub-committee thereof) will review your case and take into account all evidence submitted by you (or your authorized representative), without regard to whether such evidence was submitted or considered in the initial benefit determination. The Board of Trustees (or sub-committee thereof) will determine whether or not a hearing will be held on your case. If a hearing is to be held, you will be notified of the time and place of the hearing at least two weeks in advance, unless you agree in writing to a shorter notification period. You and/or your authorized representative may appear at the hearing.

The Board of Trustees (or subcommittee thereof) will render its decision in writing, within 60 days after receipt of your written request for review, unless special circumstances require an extension of time for processing your request, in which case the decision shall be rendered as soon as possible, but not later than 120 days after receipt of your written request for review. If an extension is required, the Board of Trustees (or subcommittee thereof) must notify you, in writing, prior to the end of the initial 60-day review period and indicate the special circumstances that make the extension necessary and the date by which a decision is expected.

The decision of the Board of Trustees (or sub-committee thereof) will be written in clear, easily understood language and provide the reasons why the decision was made and the specific Plan provisions that support it. If you disagree with the decision on review, you may file suit in federal or state court. If your suit is successful, the court may award you legal costs, including attorneys' fees.

GENERAL PROVISIONS

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator (the Board of Trustees) or its delegate, other Plan fiduciaries, and the insurers or administrators of each program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ELIMINATION OF CONFLICT OF INTEREST

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

FACILITY OF PAYMENT

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, nor the Board of Trustees, appropriate claims administrator, or any other designee of the Plan Administrator will be required to see to the application of the money so paid.

EXHAUSTION OF ADMINISTRATIVE REMEDIES / LIMITATION ON TIME TO FILE A LAWSUIT

You or any other claimant may not file a lawsuit to claim Plan benefits until all administrative remedies have been exhausted including this Plan's claim appeal review procedures. In the event your claim is denied, you must commence any lawsuit under Section 502(a) of ERISA respecting such claim not later than two years after receipt of the written notice of Initial Benefit Determination denying such claim.

For disability claims filed on or after April 1, 2018, the foregoing appeals procedures will not be deemed exhausted if the Plan's violation was de minimis and did not cause, and is not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and that the violation occurred in the context of an ongoing, good faith exchange of information with the claimant. This exception is not available if the violation is part of a pattern or practice of violations. The Plan must provide a written explanation of the violation within ten days of receipt of a request.

The preceding is for informational purposes only and is a summary of the Trust's claims and appeals procedures. This summary is subject to the provisions of the Plan Documents, certificates of insurance, and all amendments made thereto, which are on file with the Hawaii Teamsters Health and Welfare Trust Office. In the event of a conflict between the information contained in this booklet and the Plan Documents or certificates of insurance, the Plan Documents or applicable insurance certificate will control. Please refer to these documents for specific questions about claims and appeals procedure.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The Hawaii Teamsters Health and Welfare Trust 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 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 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;
- Request a list of certain disclosures by the Trust of your health information; and
- Request communications of your health information by alternative means or at alternative locations.

You also have the right to make complaints to the Trust as well as to 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 should be made in writing to: *Privacy Officer, Hawaii Teamsters Health and Welfare Trust Office, 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii* 96817. You will not be retaliated against, in any way, for filing a complaint.

The Trust has designated Benefit & Risk Management Services, Inc. as the Trust's Privacy Officer and 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's Privacy Officer at *560 North Nimitz Highway, Suite 209, Honolulu, Hawaii* 96817, *phone: (808) 523-0199 (Oahu) and* 1 (866) 722-8989 *(neighbor islands), Monday through Friday, 8:00 a.m. to 4:30 p.m.*

For questions or complaints regarding your health information and privacy rights related to the benefits provided through the plans listed below, contact the following:

UHA Medical Plan

Privacy Officer
UHA
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813
Phone: 532-4000 (Member Services)

Indemnity Prescription Drug Plan

Privacy Office
OptumRx
17900 Von Karman Avenue
M/S: CA016-0203
Irvine, California 92614
Phone: 1 (877) 598-3646
Fax: 1 (888) 905-9490

Kaiser Permanente Plan / Kaiser Permanente Senior Advantage Medicare Plan

Privacy Officer
Kaiser Foundation Health Plan, Inc.
711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Phone: (808) 432-5090

HMSA Akamai Advantage Medicare Plan

Privacy Officer
Hawaii Medical Services Association
P.O. Box 860
Honolulu, Hawaii 96808-0860
Phone: (808) 948-6111

Vision Care Plan

Privacy Specialist
Vision Service Plan
3333 Quality Drive
MS-163
Rancho Cordova, California 95670
Phone: 1 (916) 858-7432

STATEMENT OF ERISA RIGHTS

As a participant in the Supplemental Health Plan for OTS Retirees, 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 or your spouse if there is a loss of coverage under the Plan as a result of a qualifying event. You or your spouse may have to pay for such coverage. Review this summary plan description and the documents governing the Plan or 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, or when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request a certificate before losing coverage, or within 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 individuals who are responsible for the operation of the employee benefit plan. The individuals 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 receive a written explanation, 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.

NOTE

This booklet provides a summary of the benefits available to eligible retired OTS employees and their spouses. The actual Trust Agreement, Plan Documents, policies, contracts, and rules and regulations adopted by the Board of Trustees are the final authorities in all matters related to the Supplemental Health Plan for OTS Retirees and the Hawaii Teamsters Health and Welfare Trust. Copies of these documents are available for inspection at the Trust Office during regular business hours.