

# **SUPPLEMENTAL HEALTH PLAN FOR OTS RETIREES**



## **SUMMARY PLAN DESCRIPTION**

**NOVEMBER 2012**

**THIS PLAN IS ADMINSTERED BY**  
**Benefit & Risk Management Services, Inc.**  
(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**

If you have any questions concerning this plan, such as eligibility or benefits, please contact the Hawaii Teamsters Health and Welfare Trust Office at 560 N. 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 modify the plan with regard to eligibility requirements and benefits available, 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 summarizes the eligibility rules and benefits for OTS retirees and spouses only.

# 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. Effective September 1, 2010:
  - a. Federal regulations relating to the use of genetic information in the administration of employee benefit plans apply to the Trust (Genetic Information Nondiscrimination Act of 2008) (page 22).
  - b. Mental Illness and Alcohol or Drug Dependence benefits were revised in accordance with Federal law to provide parity between mental health or substance abuse disorder benefits and medical/surgical benefits (Mental Health Parity and Addiction Equity Act of 2008) (page 22).
2. Effective September 1, 2011:
  - a. The Kaiser Foundation Health Plan was replaced by the Self-Funded HMO Plan through the Queen's Health System. The medical benefits of the Self-Funded HMO Plan are administered by HMA (page 62). The prescription drug benefits of the Self-Funded HMO Plan are administered by Catamaran (formerly Catalyst Rx) (page 83).
  - b. All participants enrolled in the Kaiser Plan were automatically enrolled in the Self-Funded HMO Plan except for retirees and their spouses under 65 years of age who were enrolled in the Kaiser plan prior to September 1, 2011. New retirees and their spouses under age 65 must enroll in either the Self-Funded Comprehensive Medical Plan or the Self-Funded HMO Plan.
3. **SELF-FUNDED COMPREHENSIVE MEDICAL PLAN**
  - a. Effective September 1, 2010:
    - 1) Mental Illness and Alcohol or Drug Dependence benefits were revised in accordance with the Mental Health Parity and Addiction Equity Act of 2008 as follows (pages 45-46):
      - a) The annual maximum benefit limitation on inpatient hospital and facility services no longer applies (formerly 30 days per calendar year).

- b) The annual maximum benefit limitation on inpatient and outpatient visits for services provided by psychiatrists, psychologists, clinical social workers, licensed mental health counselors, and marriage and family therapists no longer applies (formerly 30 inpatient visits and 12 outpatient visits per calendar year).
      - c) The lifetime maximum benefit limitation of two treatment episodes per lifetime for alcohol or drug dependence no longer applies.
    - 2) Prior authorization is no longer required for outpatient Mental Health/Substance Abuse services.
  - b. Effective March 1, 2011:
    - 1) The Eligible Charge for out-of-state services shall not exceed 150% of the Eligible Charge for the same or comparable service rendered in the State of Hawaii (page 54).
    - 2) Prior authorization is required for all non-emergency out-of-state services. For emergency or maternity admissions, you must notify the HMA Health Services Department within 48 hours or by the next working day (pages 30 and 54).
  - c. Effective September 1, 2011:
    - 1) In accordance with the Patient Protection and Affordable Care Act of 2010:
      - a) The Lifetime Maximum limit on the dollar value of essential health benefits payable under the Self-Funded Comprehensive Medical Plan no longer applies (page 24).
      - b) The Annual Maximum benefit amount available under the Self-Funded Comprehensive Medical Plan increased to \$750,000 per person per plan year.
    - 2) The Annual Copayment Maximum will be based on plan year from September 1 to August 31 of the following year rather than calendar year (page 25).
    - 3) The Annual Deductible will be based on plan year from September 1 to August 31 of the following year rather than calendar year (page 25).
  - d. Effective January 1, 2012, the Plan will reimburse Neighbor Island beneficiaries for qualified inter-island travel expenses related to obtaining non-emergency medically necessary services which are not available on the island where the beneficiary resides (page 50).
  - e. Effective September 1, 2012, the Annual Maximum benefit amount available under the Self-Funded Comprehensive Medical Plan increased to \$1,250,000 per person per plan year (page 24).
- 4. INDEMNITY PRESCRIPTION DRUG PLAN**
  - a) Effective July 1, 2009, Prilosec OTC (Over the Counter) may be obtained with no copayment through Point of Service Program participating pharmacies. A physician's prescription is required (page 57).

- b) Effective August 1, 2009, the CVS Longs Mail Order Program is available for beneficiaries who reside in the State of Hawaii in addition to the Walgreens Mail Order Program.
- c) Effective February 1, 2011, Foodland pharmacies were added as Central Fill and Point of Service Program pharmacies.
- d) Effective October 1, 2011:
  - 1) A Step Therapy Program for Cholesterol Medications was implemented (page 57).
  - 2) The Diabetic Sense Program was implemented (page 57).
- e. Effective March 1, 2012:
  - 1) You may obtain up to a 90-day supply under the Mail Order Program at the following copayments (page 60):
    - a) Generic Drugs, Insulin, and Diabetes Supplies - \$8.00 copayment
    - b) Brand Name Drugs - \$24.00 copayment
  - 2) The Mail Order Program is also available through Mina Pharmacy and Pharmacare, in addition to CVS Longs Mail Order and Walgreens Mail Order.
- f. Effective April 1, 2012, when you obtain a brand name medication which has a generic equivalent, you will pay the applicable copayment plus the cost difference between the brand name and generic equivalent medication. If you require a brand name medication in place of the generic equivalent, prior authorization must be obtained from the Pharmacy Benefits Manager (page 58).
- g. Effective June 1, 2012, quantity limits will be placed on certain medications as recommended by the Food and Drug Administration. If you require more than the recommended quantity per valid prescription, prior authorization must be obtained from the Pharmacy Benefits Manager (page 58).

## 5. KAISER FOUNDATION HEALTH PLAN

- a. Effective January 1, 2010, the prescription drug copayment increased to \$12.00 per prescription for up to a 30-day supply.
- b. Effective October 1, 2010:
  - 1) The office visit copayment increased to \$15.00 per visit (page 88).
  - 2) The copayment for outpatient laboratory, imaging and diagnostic services increased to \$15.00 per department per day (page 88).
  - 3) Internally implanted prosthetics, devices and aids are covered at no charge (page 90).
  - 4) The prescription drug copayment increased to \$15.00 per prescription for up to a 30-day supply (page 100).
- c. Effective September 1, 2011, the Kaiser Permanente Plan was replaced by the Self-Funded HMO Plan through the Queen's Health System. Only those retirees and their spouses under 65 years of age who were enrolled in the Kaiser Permanente Plan prior to September 1, 2011 may continue coverage under the Kaiser Permanente Plan.

This change does not affect Medicare Retirees and spouses (age 65 and older) enrolled in the Kaiser Senior Advantage Plan.

**6. VISION CARE PROGRAM**

- a. Effective March 1, 2011, the Indemnity Vision Care benefit program administered by HMA was replaced by the VSP Advantage Plan (page 103).

Sincerely,  
BOARD OF TRUSTEES

*THIS BOOKLET PROVIDES A SUMMARY OF BENEFITS FOR INFORMATION PURPOSES ONLY. THE TRUST AGREEMENT, POLICIES, CONTRACTS, AND RULES AND REGULATIONS ADOPTED BY THE 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 NATURE AND EXTENT OF BENEFITS AND RULES GOVERNING ELIGIBILITY ARE DETERMINED SOLELY AND EXCLUSIVELY BY THE TRUSTEES. THE TRUSTEES SHALL ALSO 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.*

**SUPPLEMENTAL HEALTH PLAN  
FOR OTS RETIREES**

**TRUST OFFICE**

Benefit & Risk Management Services, Inc.  
(Gentry Pacific Design Center)  
560 N. Nimitz Highway, Suite 209  
Honolulu, Hawaii 96817  
Telephone: (808) 523-0199  
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**SATELLITE OFFICE**

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**BOARD OF TRUSTEES**

**EMPLOYER TRUSTEES**

Darrel Tajima  
Robert Yu

**UNION TRUSTEES**

Ronan Kozuma  
Millie Downey  
Mike Costa (Alternate)

**CONTRACT ADMINISTRATOR**

Benefit & Risk Management Services, Inc.

**PLAN CONSULTANT**

Benefit Plan Solutions, Inc.

**LEGAL COUNSEL**

Kawashima Law Group LLLC

**TRUST AUDITOR**

Lemke, Chinen & Tanaka, CPA, Inc.

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

## **PLAN SPONSOR AND ADMINISTRATOR**

Board of Trustees  
Hawaii Teamsters Health & Welfare Trust  
560 N. 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 502

## **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 N. 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**

Darrel Tajima  
Director of Human Resources  
Meadow Gold Dairies – Hawaii  
925 Cedar Street  
Honolulu, Hawaii 96814

Robert Yu  
Vice President  
Finance & Administration  
Oahu Transit Services, Inc.  
811 Middle Street  
Honolulu, Hawaii 96819

**UNION TRUSTEES**

Ronan Kozuma  
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Teamsters Union Local 996  
1817 Hart Street  
Honolulu, Hawaii 96819

Millie Downey  
Secretary/Treasurer  
Teamsters Union Local 996  
1817 Hart Street  
Honolulu, Hawaii 96819

Mike Costa (Alternate Trustee)  
Assistant Business Agent  
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 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-Funded Comprehensive Medical Plan and Self-Funded HMO Medical Plan benefits are paid for by the Trust through Hawaii-Mainland Administrators, LLC which handles the claims administration services for these plans. Indemnity Prescription Drug and Self-Funded

HMO Prescription Drug benefits are paid for by the Trust through Catamaran, the Pharmacy Benefits Manager which handles the claims administration services for these programs. 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

## **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 the 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 the Hawaii Teamsters Health and Welfare Trust 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 will be provided to participants and beneficiaries who have satisfied the eligibility requirements established by the Board of Trustees only as long as funds are available. Benefits under the Trust 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 Trust, should contact the insurance carrier of your choice for information on conversion to an individual plan offered by the respective carrier.

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

# 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 Trust, or with respect to any particular benefit under the Trust, 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 16. 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. A qualified beneficiary is any retiree or the spouse of a retiree who is covered by the Plan on the day before a qualifying event occurs.

<b>Qualifying Event</b>	<b>Maximum Period of Continuation Coverage</b>
Employee’s termination of employment (for reasons other than gross misconduct)	18 months
Reduction in hours worked by employee	18 months
Death of retiree	36 months

Qualifying Event	Maximum Period of Continuation Coverage
Divorce or legal separation	36 months
Retiree becomes entitled to Medicare	36 months

If the continuation coverage is for a maximum period of 18 months and during that period another qualifying event occurs which would entitle your spouse to coverage for a maximum period of 36 months, the coverage for your spouse will be extended to 36 months from the date of the first qualifying event.

If the continuation coverage is for a maximum period of 18 months and you or your spouse is determined to be disabled under the Social Security Act at any time during the first 60 days of your COBRA continuation coverage, coverage for both you and your spouse will be extended to 29 months. However, in order to be eligible for this extended coverage, the Hawaii Teamsters Health and Welfare Trust Office must be notified of the qualification for Social Security disability within 60 days after the qualified beneficiary receives the Social Security disability determination letter and before the end of the 18-month COBRA continuation period. In addition, the Trust Office must be notified within 30 days after receipt of the Social Security final determination letter indicating that the qualified beneficiary is no longer disabled.

The Hawaii Teamsters Health and Welfare Trust Office will determine the occurrence of a qualifying event in the event of your termination of employment or reduction in hours. The qualifying event in these cases will be the date of your loss of coverage under the plan. Your employer is responsible for notifying the Trust Office within 30 days in the event of your death, termination of employment, reduction in work hours, or entitlement to Medicare benefits. You or your spouse is responsible for notifying the Trust Office, in writing, within 60 days in the event of divorce, legal separation, or entitlement to Medicare benefits. 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 a notice is not received by the Trust Office within the 60-day period, the qualified beneficiary will not be entitled to choose 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 your 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 and/or your spouse do not elect coverage during the election period, you will lose your right to elect COBRA.

Each qualified beneficiary is entitled to make his or her own independent election to continue coverage under COBRA. A qualified beneficiary who is the covered retiree may elect COBRA on behalf of a spouse who is a qualified

beneficiary. However, if the covered retiree rejects COBRA continuation coverage, the covered retiree's spouse may independently elect COBRA continuation coverage.

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

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

### **COBRA Continuation Coverage**

Under the COBRA Program, if you 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). Continued coverage for life insurance benefits is not available under the COBRA Program. Once a selection is made, coverage cannot be changed except during the annual open enrollment period.

### **Paying for COBRA**

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

The first COBRA payment must be received by the 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 payment period.

### **Addition of New Spouse**

If you (the retired employee) get married while you are enrolled for COBRA continuation coverage, you may enroll your new spouse for coverage for the balance of the period of COBRA continuation coverage, if you do so within 30 days after the date of marriage. Adding a spouse may cause an increase in the amount you must pay for COBRA continuation coverage. Contact the Trust Office to add a spouse.

### **Loss of Other Group Health Plan Coverage**

If while you (the retired employee) are enrolled for COBRA continuation coverage, your spouse loses coverage under another group health plan, you may enroll your spouse for coverage for the balance of the period of COBRA continuation coverage. Your spouse must have been eligible for but not enrolled in coverage under the Supplemental Health Plan for OTS Retirees, and when

enrollment was previously offered under the Plan and declined your spouse must have been covered under another group health plan or had other health insurance coverage. You must enroll your spouse within 30 days after the termination of the other coverage or within 60 days after the termination of coverage under Medicaid in accordance with Federal law. Adding a spouse may cause an increase in the amount you must pay for COBRA continuation coverage.

### **End of COBRA**

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 is terminated;
4. The first day on which the individual becomes covered under Medicare; or
5. The first day on which the individual becomes covered under another employer's group health plan. (Exception - If the group plan contains any exclusion or limitation with respect to any pre-existing condition, COBRA coverage may be continued until the end of the exclusion or limitation period).

If you have any questions about your COBRA rights and obligations, please contact the Trust 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 beneficiary(ies) and 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.

It is important to keep the Trust Office informed of any changes in your personal or family situation, or your contact information. Notify the Trust Office, in writing, and submit the proper documentation if:

- You change your address or telephone number,
- You get married, divorced, or widowed.

## ELIGIBLE DEPENDENTS

Only your legal spouse, regardless of age, is eligible as a dependent. To add a spouse, you must submit the proper documentation, in writing, to the Trust Office within 30 days of your 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.

A former spouse who loses eligibility upon divorce or legal separation may continue coverage by electing and making payments under the COBRA program, or if covered under the Kaiser Plan, may apply in writing or call the Kaiser Foundation Health Plan, Inc. for conversion to an Individual or Family Plan offered directly by this insurance carrier within 30 days of the date the change in eligibility status occurs.

## Restrictions on dual coverage

An eligible person may be covered as either 1) an active employee under the Hawaii Teamsters Health & Welfare Trust or a retired employee under the Supplemental Health Plan for OTS Retirees, or 2) a spouse of an active employee or 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 during a special enrollment period if you qualify under one of the following requirements.

1. If you initially declined enrollment for yourself and/or your spouse because of other health insurance or group health plan coverage, you may enroll yourself and/or your spouse in this Plan if you and/or your spouse lose eligibility for that other coverage or if the employer stops contributing toward your other coverage, provided you 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 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.
3. If you and/or your spouse's Medicaid coverage is terminated due to loss of eligibility, or if you and/or your spouse become eligible for a premium assistance subsidy under Medicaid, you may enroll yourself and/or your spouse in this Plan provided you request enrollment within 60 days of such event.

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 RETIREES OF OAHU TRANSIT SERVICES, INC. (OTS)

## MEDICAL AND PRESCRIPTION DRUG BENEFITS

### **Non-Medicare Retirees and Spouses (Under Age 65)**

- Effective September 1, 2011, new Retirees and spouses under 65 years of age who are not eligible for Medicare will be covered under the Trust's Self-Funded Comprehensive Medical Plan (administered by HMA) described on pages 24-55 or the Trust's Self-Funded HMO Medical Plan (administered by HMA) described on pages 62-82, depending on which plan is selected. The Kaiser Permanente Plan, described on pages 87-102, is only available to Retirees and spouses under age 65 who were enrolled in the plan prior to September 1, 2011.
- If you choose the Trust's Self-Funded Comprehensive Medical Plan, you will be eligible for prescription drug benefits under the Trust's Indemnity Prescription Drug Plan (administered by Catamaran), described on pages 56-61.
- If you choose the Trust's Self-Funded HMO Medical Plan, you will be eligible for the Trust's Self-Funded HMO Prescription Drug benefits (administered by Catamaran), described on pages 83-86.
- If you are enrolled in the Kaiser Permanente Plan, you will be eligible for Kaiser's Prescription Drug Plan, described on pages 100-102.

### **Medicare Retirees and Spouses (Age 65 and Older)**

- Retirees and spouses age 65 years and older who are eligible for and enrolled in Medicare Parts A and B and reside in the State of Hawaii will be covered under their choice of Supplemental Medicare Plan: a) HMSA's Akamai Advantage Plan or b) the Kaiser 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 Senior Advantage Plan, you will be covered under the Kaiser Prescription Drug Plan, described on pages 100-102, which includes Medicare Part D. For a complete description of Kaiser's Senior Advantage Plan, refer to the separate Description of Benefits brochure and Member handbook which is available from Kaiser.

### **Medicare Retirees and Spouses (Age 65 and Older) who reside Out-of-State**

- Retirees and spouses age 65 years and older who are eligible for and enrolled in Medicare Parts A and B and reside outside the State of Hawaii or who are

not eligible to enroll in the HMSA Akamai Advantage Plan or the Kaiser Senior Advantage Plan, will be covered under the Trust's Self-Funded Comprehensive Medical Plan. The Self-Funded Comprehensive Medical Plan will pay benefits that supplement Parts A and B of Medicare. Medicare benefits must be assigned to the Hawaii Teamsters Health and Welfare Trust Self-Funded Comprehensive Medical Plan.

- In order to receive prescription drug benefits through the Trust, 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 quarterly basis, up to the standard Medicare Part D premium adopted by the Trustees. In order to receive this reimbursement, you must submit to the Trust Office:
  1. Confirmation of your enrollment in an approved Medicare Part D plan or Limited Income Subsidy (LIS) plan;
  2. A copy or description of that plan;
  3. Proof of payment for your Medicare Part D Prescription Drug premium; and
  4. A completed "Application for Out-of-State Medicare Part D 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 Drug coverage while enrolled by Medicaid. However, upon termination of your Medicaid coverage, you may request re-enrollment within 60 days after your Medicaid coverage ends (See Special Enrollment Periods on page 16).

## **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 (3) months of any later calendar year. However, you may lose some Medicare benefits during the period that you are not enrolled.

## **VISION CARE BENEFITS**

- OTS Retirees and spouses are eligible for Vision Care benefits provided through the VSP Advantage Plan as described on pages 103-106.

## **LIFE INSURANCE BENEFIT**

- Only those OTS Retirees who were grandfathered as of December 1, 1973 are eligible for a \$1,000 life insurance benefit through Pacific Guardian Life.

# MEDICAL BENEFITS

## CHOICE OF PLANS

### **Non-Medicare Retirees and Spouses (Under Age 65)**

You may choose one (1) of the following self-insured medical – hospital – surgical plans administered by HMA:

1. The Self-Funded Comprehensive Medical Plan which is available on all islands, or
2. The Self-Funded HMO Plan which is available on Oahu, Maui, and Hawaii.

**Note:** Effective September 1, 2011, the Trust's Self-Funded HMO Plan replaced the Kaiser Permanente Plan. Only those Retirees and their spouses under 65 years of age who were enrolled in the Kaiser Permanente Plan **prior to September 1, 2011** may continue coverage under the Kaiser Permanente Plan. The principal benefit provisions of the Kaiser Permanente Plan are summarized in this booklet.

The principal benefit provisions of the Self-Funded Comprehensive Medical Plan and Self-Funded HMO Plan are summarized in this booklet. You and your spouse should compare the benefits of each plan carefully before choosing a plan.

To enroll in the Self-Funded HMO Plan, you must reside within the Plan service area which includes the islands of Oahu, Maui, and Hawaii. If you reside outside the Plan service area, you are not eligible to enroll in the Self-Funded HMO Plan. If you are enrolled in the Self-Funded HMO Plan and subsequently move outside of the Plan service area for more than 60 consecutive days, you will not be allowed to continue coverage under the Self-Funded HMO Plan and must enroll in the Self-Funded Comprehensive Medical Plan.

### **Medicare Retirees and Spouses (Age 65 and Older)**

You may choose one (1) of the following Supplemental Medicare insurance plans:

1. The HMSA Akamai Advantage Plan which is available on all islands, or
2. The Kaiser Senior Advantage Plan which is available on Oahu, Maui, and Hawaii.

For a complete description of HMSA's Akamai Advantage Plan, refer to the separate Description of Benefits brochure and Member handbook or contact HMSA's Customer Service Department at (808) 948-6000. For a complete description of the Kaiser Senior Advantage Plan, please refer to the separate Description of Benefits brochure and Member Handbook or contact Kaiser's Customer Service Department at (808) 432-5955 (Oahu) or 1 (800) 966-5955 (toll free). You and your spouse should compare the benefits of each plan carefully before choosing a plan.

To enroll in the Kaiser Senior Advantage Plan, you must reside within the Plan service area which includes the islands of Oahu, Maui, and Hawaii. If you are enrolled in the Kaiser Senior Advantage Plan and subsequently move to an island where the Senior Advantage Plan is not available, you will not be allowed to continue coverage under the Kaiser Senior Advantage Plan and must enroll in the HMSA Akamai Advantage Plan.

### **Medicare Retirees and Spouses (Age 65 and Older) who reside Out of State**

If you reside outside the State of Hawaii or are not eligible to enroll in the HMSA Akamai Advantage Plan or the Kaiser Senior Advantage Plan, you will be covered under the Trust's Self-Funded Comprehensive Medical Plan. **You must be enrolled in Medicare Parts A and B.** The Trust's Self-Funded Comprehensive Medical Plan will pay benefits that supplement Medicare Parts A and B. Your Medicare benefits will be primary and the Trust's Self-Funded Comprehensive Medical Plan will be secondary to Medicare.

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](http://www.mymedicare.gov).

### **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 Self-Funded HMO Plan and subsequently move outside the Plan service area for more than 60 consecutive days; or
2. You are enrolled in the Kaiser Permanente Plan, Kaiser Senior Advantage Plan, or HMSA Akamai Advantage Plan and subsequently move outside the Plan service area for more than 90 consecutive days, or
3. You meet one of the requirements specified in the "Special Enrollment Periods" section.

### **HOW TO SECURE BENEFITS**

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

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

If you are a Kaiser Permanente or Kaiser Senior Advantage Plan member, show your Kaiser membership card when you go to the Kaiser Hospital or Clinic for services. If you do not have your membership card when you are scheduling medical care, be sure to tell the appointment clerk that you are a Kaiser member and you belong to the Hawaii Teamsters Health and Welfare Trust.

HMSA Akamai Advantage Plan members should show the doctor, hospital, laboratory, or pharmacy their membership card issued by HMSA. If you do not have your membership card available, be sure to tell the provider in advance that you are an HMSA Akamai Advantage Plan member and you belong to the Hawaii Teamsters Health and Welfare Trust.

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

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

You will 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, you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request a certificate within 24 months after losing coverage.

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

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

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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, health plans and insurers may not, under Federal law, require that a provider obtain authorization from the health plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact the Claims Administrator.

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

In compliance with the Women's Health and Cancer Rights Act, benefits for the following services are provided in connection with a covered mastectomy by group health plans offered through the Trust:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery or reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and

- Treatment of physical complications in all stages of the mastectomy, including lymphedemas.

Under the Women’s Health and Cancer Rights Act, coverage of mastectomies and breast reconstruction benefits are subject to deductibles, copayments and coinsurance limitations consistent with those established for other benefits under these plans.

**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, the provisions of this Federal law, which requires parity in financial requirements and treatment limitations between mental health or substance abuse disorder benefits and medical/surgical benefits, apply to group health plans offered through the Trust.

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

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

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



# **SELF-FUNDED COMPREHENSIVE MEDICAL PLAN (Self-Insured)**

The Hawaii Teamsters Health and Welfare Trust has contracted with Hawaii-Mainland Administrators, LLC (HMA) to handle the claims administration for the Self-Funded Comprehensive Medical Plan. This means that if you choose the Self-Funded Comprehensive Medical Plan, your physician, hospital, or you will file claims directly with HMA. If you have any questions about payments made by HMA, or any other aspect of your coverage, you should call HMA.

**Hawaii Mainland-Administrators, LLC (HMA)**

1440 Kapiolani Boulevard, Suite 1020

Honolulu, Hawaii 96814

**(808) 951-4621** (Oahu) or

**Toll free 1 (866) 377-3977** (Neighbor Islands)

Website: [www.teamsters-hma.com](http://www.teamsters-hma.com)

E-mail: [teamsters@hmatpa.com](mailto:teamsters@hmatpa.com)

## **IMPORTANT FACTS**

### **UNDERSTANDING YOUR MEDICAL PLAN**

Your plan pays benefits based on Eligible Charges (see the Eligible Charges section for an explanation) and by the use of some copayments. A copayment is a percentage of the Eligible Charge that you owe when you receive certain medical services covered by this Plan.

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

### **ANNUAL MAXIMUM**

Effective September 1, 2012, in accordance with the Patient Protection and Affordable Care Act of 2010, the total dollar value of essential health benefits available under this Plan, on an incurred basis, is \$1,250,000 per person per plan year.

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

### **LIFETIME MAXIMUM**

Effective September 1, 2011, in accordance with the Patient Protection and Affordable Care Act of 2010, there is no Lifetime Maximum limit on the dollar value of essential health benefits paid or provided under this Plan on your behalf.

## **ANNUAL DEDUCTIBLE**

For certain services shown in the Benefits section, you must pay an Annual Deductible before the Plan begins paying benefits. The Annual Deductible is the first \$100 of Eligible Charges that you paid for covered services or supplies that you received during a plan year which are subject to the Annual Deductible.

The following payments do not count toward the Annual Deductible:

- Your payments for prescription drug services,
- Your payments for those covered services or supplies not subject to the Annual Deductible, and
- Additional expenses which you incur because of any benefit reduction as a result of not obtaining the required pre-approval under the Care Management Program.

You are solely responsible for payment of the Annual Deductible. If you did not meet the Annual Deductible for the previous plan year, any portion of the deductible that you paid during the last three months of the previous plan year (i.e. June, July, and August) may be carried over to meet the Annual Deductible for the current plan year. This carryover provision does not apply if you had met the Annual Deductible and received plan benefits during the previous plan year for services or supplies that were subject to the Annual Deductible.

## **MAXIMUM ANNUAL COPAYMENT**

There is a Maximum Annual Copayment of \$2,500 per person or \$7,500 per family, including the Annual Deductible, in any plan year. If one of these Maximums is reached, you owe no copayment for covered services for the rest of that plan year. The following payments do not count toward the Maximum Annual Copayment and you are responsible for these amounts even after you have met the Maximum Annual Copayment:

- Your payments for prescription drug services,
- Any benefit reduction as a result of not obtaining the required pre-approval under the Care Management Program,
- Any amounts that exceed the maximum for a service subject to the maximum,
- Any difference between the actual charge and the Eligible Charge for services you receive from a nonparticipating provider,
- Payments for non-covered services, and
- Any amounts that you owe in addition to your copayments for covered services.

## **CHOICE OF HEALTH CARE PROVIDERS**

You are free to go to any licensed physician or service provider of your choice and receive coverage under this Plan. For purposes of this Plan, a physician is a properly licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.). Benefits are available for services rendered by other providers as shown in specific areas of this booklet.

The Trust suggests that you choose a physician who can help you obtain the health care you need at a reasonable cost. Your choice of physician or other health care provider can make a difference in how much you will owe after your Plan benefit payments have been made.

### **Participating Providers**

The Trust, through HMA, has contracted with physicians, hospitals, laboratories, and other health care providers throughout Hawaii to provide you the medical services covered by this Plan. When you go to one of these participating providers, HMA sends the provider the benefit payment for the service and you owe only the copayment and the tax, if any (see example on page 27).

### **Nonparticipating Providers**

When you go to a nonparticipating provider, the Trust has no contract with the provider to guarantee limited copayments. HMA bases the benefit payment on Eligible Charges (see below) and sends the payment directly to you. You will then owe the provider the total charge and any tax for the service (see example on page 27).

## **ELIGIBLE CHARGES**

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

### **Participating Providers**

Eligible Charges for covered services of participating providers are part of the contract between the Trust's Claims Administrator (HMA) and each participating provider to guarantee you limited out-of-pocket payments.

### **Nonparticipating Providers**

The Eligible Charge for physician and most medical services of nonparticipating providers is the lesser of the following two (2) charges:

- The Eligible Charge approved by the Trust, or
- The actual charge to you.

### **Infrequent Services**

There may be times when a service is performed for the first time in Hawaii or so infrequently that an Eligible Charge as described above has not been established. In such cases, HMA's Medical Consultants, who are qualified practicing physicians, will recommend an Eligible Charge by comparing the complexity of the infrequent service with similar, frequent services and the Trust will make the final determination on the Eligible Charge. The approved Eligible Charge will become the maximum allowed for this new or infrequent service for the purpose of future updates.

## HOW TO USE THIS PLAN

This is an example of benefits and copayments for a covered physician's office visit:

<b>If You Go To A Participating Provider</b>	<b>If You Go To A Nonparticipating Provider</b>
<b>Plan pays Provider:</b> <ul style="list-style-type: none"><li>• 90% of the Eligible Charge</li></ul>	<b>Plan pays You:</b> <ul style="list-style-type: none"><li>• 80% of the Eligible Charge</li></ul>
<b>You owe Provider:</b> <ul style="list-style-type: none"><li>• Your copayment (10% of the Eligible Charge)</li><li>• Tax</li></ul> You do not owe any amount above the Eligible Charge.	<b>You owe Provider the Total Charge:</b> <ul style="list-style-type: none"><li>• Plan payment (80% of the Eligible Charge)</li><li>• Your copayment (20% of the Eligible Charge)</li><li>• Any amount of the Provider's charge above the Eligible Charge</li><li>• Tax</li></ul>

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

You should ask your physician or call HMA to find out if your physician is a participating provider. You will receive a Participating Physician and Health Care Provider Directory when you join this Plan. Updated directories are available upon request from HMA.

### KEEPING YOUR COVERAGE AFFORDABLE

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

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

Most of the claims received are for services that follow standard medical practice and are medically necessary. However, there may be times when HMA and your physician may disagree. When this happens, HMA's Medical Consultants will review the services and decide whether the services follow standard medical practice, are medically necessary, and therefore, are eligible for benefits.

HMA's Medical Consultants are qualified practicing physicians. They consult with other physicians and specialists in Hawaii and use the findings of Federal agencies.

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

If you want to know whether a particular service follows standard medical practice or is medically necessary for an illness or injury, please ask your physician to write to HMA's Health Services Department for an evaluation before the service is performed. HMA's Medical Consultants will review the service and send their written evaluation to your physician.

### **Standard Medical Practice**

To be covered by your Plan, all services must follow standard medical practice. This means that most physicians in the U.S.A. regard the service as safe and effective. If a service is in its trial stages (e.g. "experimental" because it is being used in research or on animals, or "investigative" because it is or has been used on a limited number of people, or where the long-term effectiveness of the treatment has not been scientifically proven, and where applicable, has not been approved by the appropriate government agency), the service is not considered standard medical practice.

### **Medical Necessity**

The Plan pays benefits only for services that are medically necessary for the illness or injury being treated. To be medically necessary, a service or the use of a facility must follow standard medical practice. And, in following standard medical practice, the service must be essential, appropriate and economical for the diagnosis or treatment of an injury or illness.

The following examples will help you understand what is meant by medical necessity.

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

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

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

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

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

## CARE MANAGEMENT PROGRAM

Under the Care Management Program, you (or your physician on your behalf) must call the HMA Health Services Department and obtain prior authorization for certain types of medical services, including surgery, hospitalization, and certain diagnostic tests. If a required review or authorization is not requested and obtained, your benefit payments may be reduced by 10%. For emergency or maternity admissions, you must notify the HMA Health Services Department within 48 hours or by the next business day.

### HMA Health Services Department

Oahu	(808) 951-4621
Toll Free	1 (866) 377-3977
Fax	1 (866) 206-5655

## AUTHORIZATION AND REQUIREMENTS

### Prior Authorization

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

### INPATIENT ADMISSIONS

- All inpatient admissions including acute, skilled and observation days

### OUTPATIENT SERVICES

- Imaging scans (MRI, MRA, or PET scans)
- Gamma knife or X-knife procedures
- Greater than two (2) OB ultrasounds per pregnancy
- In-vitro fertilization
- Plastic and/or reconstructive surgery

### OUTPATIENT REHABILITATION

- Physical Therapy
- Speech Therapy
- Occupational Therapy

### OTHER MEDICAL SERVICES

- Durable Medical Equipment (DME)
- Hospice Care
- Home Health Services
- Infusion Therapy
- Human Growth Hormone Therapy
- Dialysis

**OTHER MEDICAL SERVICES**

- Chemotherapy
- Radiation Therapy
- Orthotics and Prosthetics

**MENTAL HEALTH / SUBSTANCE ABUSE SERVICES**

- Mental Health Services – treatment plan required
- Substance Abuse Services – treatment plan required

**OUT-OF-STATE SERVICES**

- All non-emergency inpatient admissions, services, or procedures

**INTER-ISLAND TRAVEL BENEFIT**

(Available only to beneficiaries who do not reside on Oahu)

- Inter-island travel to obtain non-emergency medically necessary services which are not available on the island where the beneficiary resides

For emergency or maternity admissions, you must notify HMA's Health Services Department within 48 hours or by the next business day.

**Surgical Review**

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

**Second Surgical Opinion**

Upon obtaining the necessary information from you or your physician, HMA's Health Services Department will determine whether or not a second surgical opinion is required. If a second surgical opinion is required and arranged by HMA, the Plan will cover 100% of the Eligible Charges for the services of a participating provider or 80% of the Eligible Charges for the services of a nonparticipating provider for the second surgical opinion office visit. If you choose to obtain a second surgical opinion when it is not required, regular office visit benefits will apply.

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

# MEDICAL BENEFITS

## PHYSICIAN SERVICES

PHYSICIAN SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
<p><b>Physician Visits</b> Home, office, hospital emergency room or office consultation visit. Office visit benefits will be paid for second opinion on the necessity of surgery.</p>	<p>You owe a copayment of 10% of Eligible Charges (You owe no copayment for an office visit for a required second surgical opinion on the necessity of surgery if the second opinion is arranged by HMA)</p>	<p>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</p>
<p><b>Immunizations</b> Cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus, chicken pox, and meningococcal vaccine.</p>	<p>You owe a copayment of 20% of Eligible Charges</p>	<p>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</p>
<p><b>Hospital Visit</b> One per day during an inpatient confinement</p>	<p>You owe a copayment of 10% of Eligible Charges</p>	<p>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</p>
<p><b>Skilled Nursing Facility Visit</b> One per day during an inpatient confinement, up to 120 visits per calendar year</p>	<p>You owe a copayment of 10% of Eligible Charges</p>	<p>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</p>
<p><b>Consultation Visit</b> Medical or surgical, one visit per confinement in a hospital or skilled nursing facility as medically necessary and approved by HMA</p>	<p>You owe a copayment of 10% of Eligible Charges</p>	<p>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</p>



<b>PHYSICIAN SERVICES</b>	<b>PARTICIPATING PROVIDER</b>	<b>NONPARTICIPATING PROVIDER</b>
<b>Surgery</b> Inpatient or outpatient	You owe a copayment of 10% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Anesthesiology Services</b> Services of an anesthesiologist (physician) that are required by a physician. Hospital anesthesia services (i.e., nurse anesthetist services) will be paid in accordance with Hospital Inpatient Services	You owe a copayment of 10% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges

### **PHYSICIAN SERVICES SPECIAL NOTES**

- Visits to or by licensed Nurse Practitioners and licensed Physician Assistants for medical services are covered under Physician Visits.

#### **Immunizations**

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

#### **Surgery**

- The preoperative and postoperative care that most physicians customarily provide in connection with most major surgery is included in the Eligible Charge for surgery. If a physician charges separately for the preoperative and postoperative care in excess of this single Eligible Charge, the excess will not be paid.
- Postoperative care for most minor surgery is not included in the charge for surgery and will be considered a separate physician's visit payable at the applicable physician office visit benefit.
- When the services of another physician may be necessary during a surgery so that the physician must "stand by" at the hospital, the Plan will pay benefits for covered services that the physician actually performs but will not pay for the waiting or "stand by" time.
- The Plan will pay benefits for the services of an assistant surgeon only when the assistance is medically necessary based on the complexity of the surgery and the hospital had no resident or training program in effect so that there was no resident or intern on the staff to assist the surgeon.

## **Reconstructive Surgery**

- The Plan will pay benefits for reconstructive surgery only when it is required to restore, reconstruct, and correct any bodily function that was lost, impaired, or damaged as a result of an illness or injury.
- In compliance with the Women's Health and Cancer Rights Act, the Plan provides coverage for medically necessary services in connection with a covered mastectomy including reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications in all stages of the mastectomy, including lymphedemas. Benefits are subject to deductibles, copayments and coinsurance limitations consistent with other benefits under this Plan.

## **Oral Surgery**

- For the purposes of this Plan, a dentist means a doctor of dentistry (D.M.D.) or dental surgery (D.D.S.) who is appropriately licensed to practice by the proper governmental authority and who renders services within the lawful scope of such license. A dentist is considered a "Physician" under this Plan, but only with respect to surgical services which he or she is legally authorized to perform.
- Physician benefits are available for certain oral surgical services provided by a physician or a dentist. Services of a dentist are covered only when: a) the dentist is performing emergency services or surgical services and b) these services could also be performed by physicians (M.D. or D.O.).
- The Plan does not pay for dental services that are generally done only by dentists and not by physicians. Regardless of the symptoms or illness being treated, services such as orthodontia, dental splints and other dental appliances, dental prostheses, osseointegration and all related services, removal of impacted teeth and any other dental procedures involving the teeth, structures supporting the teeth and gum tissues, and services relating to diagnosis or treatment of temporomandibular joint problems or malocclusion (misalignment of teeth or jaw) are not benefits of the Self-Funded Comprehensive Medical Plan.
- Hospital Benefits are available if you are hospitalized because you have a medical problem, such as hemophilia, that makes hospitalization necessary in order for you to safely receive dental services or when the oral surgery itself requires hospitalization. A physician must certify the need for hospitalization.

## **Transplants**

- The following transplants and transplant evaluations are eligible for benefits: kidney; cornea; bone marrow, excluding high dose chemotherapy with bone marrow transplants or peripheral stem cell infusion for epithelial ovarian cancer, multiple myeloma, and primary intrinsic tumors of the brain; liver, excluding liver transplants for metastatic malignancies to the liver and Hepatitis B e antigen or core antibody positive; heart; heart-lung; and lung. All other transplants, including artificial or animal organ transplants, are not eligible for benefits under this Plan.

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

## HOSPITAL INPATIENT SERVICES

HOSPITAL INPATIENT SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Up to 365 days per calendar year of hospital inpatient services		
<b>Room &amp; Care</b> Based on semiprivate room rate	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Intermediate Care and Isolation Unit</b>	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Intensive Care or Coronary Care Unit</b> Operated according to standards acceptable to the Trust	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Ancillary Inpatient Services</b> Operating room, surgical supplies, drugs, dressings, hospital anesthesia services and supplies, oxygen, antibiotics, blood transfusion services	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges

<b>HOSPITAL INPATIENT SERVICES</b>	<b>PARTICIPATING PROVIDER</b>	<b>NONPARTICIPATING PROVIDER</b>
<b>Laboratory and X-ray Services</b>		
X-ray films for injuries (within 48 hours) and Radiotherapy for treatment of malignancy	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
Laboratory Services and Diagnostic Tests, Other X-Ray films	You owe a copayment of 10% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
Radiotherapy for treatment of non-malignancy	You owe a copayment of 20% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
Complete Blood Count and Urinalysis upon admission to a hospital	You owe a copayment of 10% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges

### **HOSPITAL INPATIENT SERVICES SPECIAL NOTES**

- If a hospital uses a single, all-inclusive daily charge instead of itemized charges for laboratory, X-Ray, radiotherapy, and all other allowable hospital inpatient services and supplies, you owe a copayment of 10% of Eligible Charges for a participating provider or 20% of Eligible Charges and the difference between actual and Eligible Charges for a nonparticipating provider. In no event will the Plan pay more than if the hospital charged separately for these services.
- “Life Bed” electronic monitoring services are covered with prior authorization from the Claims Administrator.
- If you choose to receive inpatient services in a private room, you may be responsible for additional room charges not covered by the Plan.
- Inpatient hospital services relating to the treatment of mental illness are covered under Mental Illness or Alcohol or Drug Dependence Benefits and are subject to limitations specified in that section.

# OUTPATIENT LABORATORY AND X-RAY SERVICES

OUTPATIENT LABORATORY AND X-RAY SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Services ordered by a physician for the diagnosis or treatment of an injury or illness		
<b>X-ray films for injuries (within 48 hours) and Radiotherapy for treatment of malignancy</b>	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Other X-ray films and Radiotherapy for treatment of non-malignancy</b>	You owe a copayment of 20% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Laboratory Services and Diagnostic Tests</b> <ul style="list-style-type: none"> <li>• <b>Routine Pap Smear</b> Limited to one per calendar year</li> <li>• <b>Prostate Specific Antigen Test</b> Limited to one per calendar year for men age 50 and above</li> <li>• <b>Tuberculin Tine Test</b> Limited to one per calendar year</li> </ul>	You owe a copayment of 20% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Screening by Low-Dose Mammography</b>	You owe a copayment of 20% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges

**OUTPATIENT LABORATORY AND X-RAY SERVICES SPECIAL NOTES**

- Screening by low-dose mammography is limited to one baseline mammogram during ages 35 through 39, and one mammogram every 12 months if you are age 40 and above. Women of any age with a history of breast cancer, or at an increased risk of breast cancer, or whose mother or sister has had a history of breast cancer, are eligible for a mammogram upon the recommendation of a physician. When a mammography test cannot be scheduled within a designated benefit period, the mammography test may be covered if rendered within ten (10) days of the benefit period, as long as the total number of mammography tests allowed by the Plan is not exceeded.

## SKILLED NURSING FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Up to 120 days per calendar year of skilled nursing facility services		
<b>Room and Care</b> Based on semi-private room rate	You owe a copayment of 10% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Inpatient Services</b> Routine surgical supplies, drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy services	You owe a copayment of 10% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Laboratory and X-ray Services</b>	For Participating Providers whose laboratory and X-ray services are not included in a single, all-inclusive amount per day, this Plan shall pay laboratory and X-ray services in accordance with Outpatient Laboratory and X-Ray Services	See Outpatient Laboratory and X-ray Services for benefits

### SKILLED NURSING FACILITY SERVICES SPECIAL NOTES

- To be eligible for benefits, the facility must meet Medicare standards and be approved by the Claims Administrator.
- A physician must admit you to the facility. You must need skilled nursing services and be under the care of an attending physician while in the facility. No payment will be made for services furnished primarily for comfort, convenience, rest cure, or domiciliary care.
- If you remain in the facility more than 30 days, the attending physician must submit a report showing the need for skilled nursing care at the end of each 30-day period.
- Custodial care is not covered.

## OUTPATIENT SURGICAL CENTER SERVICES

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

### OUTPATIENT SURGICAL CENTER SERVICES SPECIAL NOTES

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

## HOME HEALTH CARE SERVICES

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

### HOME HEALTH CARE SERVICES SPECIAL NOTES

- To be eligible for benefits, services must be received from a qualified home health agency which meets Medicare standards and is approved by the Claims Administrator.
- Your physician must certify that you are homebound due to an injury or illness, in need of skilled health services, and would require inpatient Hospital or Skilled Nursing Facility care if there were no home health care visits.



Being homebound means that you are unable to leave home, unless you use supportive devices or have assistance from another person, because of an illness or injury. Homebound standards defined by the Federal Medicare program apply.

- If you need home health care services for more than 30 days, a physician must certify that there is further need for the services and provide a continuing plan of treatment at the end of each 30-day period of care.
- No payment will be made for home care services furnished primarily to assist in meeting personal, family, and domestic needs such as general household services, meal preparation, shopping, bathing or dressing.

## **HOSPICE CARE SERVICES**

<b>HOSPICE CARE SERVICES</b>	<b>PARTICIPATING PROVIDER</b>	<b>NONPARTICIPATING PROVIDER</b>
Up to 150 days of care for a terminal illness, based on an all-inclusive daily rate (in lieu of other covered services for such illness)	You owe no copayment	Not a benefit

### **HOSPICE CARE SERVICES SPECIAL NOTES**

- To be eligible for benefits, services must be received from a hospice agency which is under contract with the Claims Administrator to provide hospice care and is operated under generally accepted standards for hospices.
- The hospice and attending physician must certify in writing that you are terminally ill and have a life expectancy of six months or less.
- If you elect hospice benefits, you will not be eligible for any other benefits for the treatment of the terminal illness except for physician services. You may continue to receive benefits for all other illnesses or injuries.
- You may decide to discontinue hospice care and receive other covered services at any time before the end of the 150-day hospice benefit period. However, if you decide to do so, any remaining days of the 150 days of hospice benefits will be lost and will not be available for future use.

## EMERGENCY SERVICES

EMERGENCY SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
<b>Emergency Room Use</b>	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Automobile Ambulance</b>	You owe a copayment of 10% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Air Ambulance</b> Air ambulance services are limited to inter-island transportation within the State of Hawaii	You owe a copayment of 20% of Eligible Charges after you pay the Annual Deductible	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges after you pay the Annual Deductible

### EMERGENCY SERVICES SPECIAL NOTES

- Emergency services are services received in connection with a medical condition that exhibits acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect in the absence of immediate medical attention to result in:
  - Serious jeopardy to the health of the individual, including the health of a pregnant woman or her unborn child;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- Emergency room physician services are covered under physician visits or surgical services.
- No payment will be made for use of emergency room facilities for any treatment which is not an emergency.
- No payment will be made for take-home drugs or supplies such as crutches or braces.

#### **Automobile and Air Ambulance**

- Services must be received from a properly licensed or certified automobile or air ambulance service.

- Transportation must be from the place where an injury occurred or an illness first required emergency care to the nearest facility equipped to furnish emergency treatment.
- The injury or illness must require emergency medical treatment, surgical treatment or hospitalization.

## MATERNITY SERVICES

MATERNITY SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
<b>Physician Services</b> For pregnancy, childbirth or other termination of pregnancy, and related medical conditions; cesarean section and surgery, and routine nursery visits to newborn child	See Physician Services for benefits	See Physician Services for benefits
<b>Surgery for Complications of Pregnancy</b> Including ectopic pregnancy	See Physician Services for benefits	See Physician Services for benefits
<b>Nurse-Midwife Services</b>	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>Hospital Services</b> Hospital Services shall count against the 365-day maximum for hospital benefits	See Hospital Inpatient Services for benefits	See Hospital Inpatient Services for benefits
<b>Birthing Center Services</b>	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges

<b>MATERNITY SERVICES</b>	<b>PARTICIPATING PROVIDER</b>	<b>NONPARTICIPATING PROVIDER</b>
<b>In Vitro Fertilization</b>		
One procedure per lifetime whether successful or not, up to a maximum of \$5,000 for all covered services (including physician services, lab and x-ray services and prescription drugs)		
<b>Inpatient Hospital Services</b>	See Hospital Inpatient Services for benefits	See Hospital Inpatient Services for benefits
<b>Physician Services</b>	See Physician Services for benefits	See Physician Services for benefits
<b>Laboratory and X-ray Services</b>	See Outpatient Laboratory and X-ray Services for benefits	See Outpatient Laboratory and X-ray Services for benefits
<b>Prescription Drugs</b>	See Indemnity Prescription Drug section for benefits	See Indemnity Prescription Drug section for benefits

### **MATERNITY SERVICES SPECIAL NOTES**

- The Eligible Charge for delivery includes prenatal and postnatal care. If payments for prenatal care are made separately prior to delivery, these payments will be considered an advance payment and will be deducted from the maximum allowance for delivery.
- In accordance with the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), hospital stays in connection with childbirth for the mother and newborn child will be provided up to 48 hours following a normal vaginal delivery or up to 96 hours following a cesarean delivery, unless, after consultation with the mother, the attending provider discharges the mother or newborn earlier.

### **Nurse-Midwife Services**

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

## **Birth Center Services**

- When a properly licensed birthing center is used instead of regular hospital facilities, payment will be made under Hospital Inpatient Services for birthing center services. The birthing center must be approved by the Claims Administrator or the Trust Fund.

## **Newborn Child**

- Hospital and physician benefits are available for in-hospital, routine nursery care of a newborn and for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
- Diagnostic tests for an unborn child will be paid only when medically necessary.

## **In Vitro Fertilization**

- Limitations:
  - Only beneficiaries who have been covered under the Self-Funded Comprehensive Medical Plan for twelve (12) consecutive months preceding the in vitro fertilization procedure are eligible for benefits.
  - Beneficiary's oocytes are to be fertilized with beneficiary's spouse's sperm.
  - Beneficiary and beneficiary's spouse have a history of infertility of at least five years duration or infertility associated with a) endometriosis, b) exposure in utero to diethylstilbestrol (des), c) blockage or surgical removal of one or both fallopian tubes, or d) abnormal male factors contributing to the infertility.
  - Beneficiary has been unable to attain a successful pregnancy through other applicable infertility treatments for which coverage is available under this Plan.
  - In vitro fertilization procedures are performed at medical facilities that conform to American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.
  - "Spouse" means the person who is legally married to the beneficiary and is qualified as a spouse in accordance with the Internal Revenue Code.
- Exclusions from coverage:
  - Cost of equipment and of collection, storage and processing of sperm.
  - In vitro fertilization requiring the use of either donor sperm or donor eggs.
  - Artificial insemination requiring the use of donor sperm.
  - Services related to conception by artificial means, other than artificial insemination and in vitro fertilization as specified above.

# MENTAL ILLNESS AND ALCOHOL OR DRUG DEPENDENCE SERVICES

MENTAL ILLNESS AND ALCOHOL OR DRUG DEPENDENCE SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
<b>INPATIENT</b>		
<b>Hospital and Facility Services</b> Services received as a registered bed patient in a Hospital or Qualified Treatment Facility which shall count against the 365-day maximum for Hospital Inpatient Services benefits	See Hospital Inpatient Services for benefits	See Hospital Inpatient Services for benefits
<b>Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor and Marriage and Family Therapist Services</b> Up to one visit per day during an inpatient confinement in a Hospital or Qualified Treatment Facility.	See Physician Services for benefits	See Physician Services for benefits
<b>OUTPATIENT</b>		
<b>Outpatient Facility, Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor and Marriage and Family Therapist Services</b>	You owe a copayment of 10% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
<b>PSYCHOLOGICAL TESTING</b>	You owe a copayment of 10% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges

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

### **Hospital and Facility Services**

- A Qualified Treatment Facility is a facility which has been specifically accredited and licensed to render mental illness or alcohol or drug dependence services by the proper authority.
- For inpatient hospital or facility services, you or your physician must notify the Claims Administrator and obtain a Preadmission Review.

### **Mental Illness Limitations**

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

### **Alcohol and Drug Dependence Limitations**

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

## OTHER MEDICAL SERVICES

OTHER MEDICAL SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
<p><b>Allergy Testing and Treatment Materials</b> One testing series per calendar year</p>	<p>You owe a copayment of 20% of Eligible Charges after you pay the Annual Deductible</p>	<p>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges after you pay the Annual Deductible</p>
<p><b>Appliances and Durable Medical Equipment</b></p>	<p>You owe a copayment of 20% of Eligible Charges after you pay the Annual Deductible</p>	<p>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges after you pay the Annual Deductible</p>
<p><b>Blood, Blood Products and Blood Bank Service Charges</b> Cost of blood and blood products except when donated, and blood bank service charges. Any additional charges for autologous blood (reserved for the person who donated the blood) are excluded as a benefit</p>	<p>You owe a copayment of 20% of Eligible Charges after you pay the Annual Deductible</p>	<p>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges after you pay the Annual Deductible</p>
<p><b>Chemotherapy</b> Chemical agents and their administration (other than oral) for treatment of malignancy</p>	<p>You owe a copayment of 20% of Eligible Charges after you pay the Annual Deductible</p>	<p>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges after you pay the Annual Deductible</p>
<p><b>Dialysis and Supplies</b></p>	<p>You owe a copayment of 20% of Eligible Charges after you pay the Annual Deductible</p>	<p>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges after you pay the Annual Deductible</p>



<b>OTHER MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER</b>	<b>NONPARTICIPATING PROVIDER</b>
<b>Evaluations for the Use of Hearing Aids</b>	You owe a copayment of 20% of Eligible Charges after you pay the Annual Deductible	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges after you pay the Annual Deductible
<b>Outpatient Injections</b> Outpatient services and supplies for the injection or intravenous administration of medication or of nutrient solutions required for primary diet	You owe a copayment of 20% of Eligible Charges after you pay the Annual Deductible	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges after you pay the Annual Deductible
<b>Physical Therapy</b> Physical therapy from a registered physical therapist (R.P.T.) or registered occupational therapist (O.T.R.)	You owe a copayment of 20% of Eligible Charges after you pay the Annual Deductible	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges after you pay the Annual Deductible
<b>Speech Therapy</b> Speech therapy from a certified speech therapist	You owe a copayment of 20% of Eligible Charges after you pay the Annual Deductible	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges after you pay the Annual Deductible
<b>Transplant Donor Services</b> Services related to the donor or organ bank	You owe a copayment of 20% of Eligible Charges after you pay the Annual Deductible	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges after you pay the Annual Deductible

## OTHER MEDICAL SERVICES SPECIAL NOTES

### **Appliances and Durable Medical Equipment**

- The Plan pays benefits for the initial provision and replacement of appliances and durable medical equipment listed below:
  - Hearing aids (one device per ear every five years);
  - Cardiac pacemakers;
  - Artificial limbs, eyes, and hips, and similar non-experimental appliances;
  - Casts, splints, trusses, braces, and crutches;
  - Oxygen and rental of equipment for its administration;
  - Rental or purchase of wheelchair and hospital-type bed;
  - Charges for use of an iron lung, artificial kidney machine, pulmonary resuscitator and similar special medical equipment.
- **Limitations:** The Plan will pay only for the appliances and durable medical equipment listed above. All appliances and durable medical equipment must be for services covered under this Plan and must be ordered by the attending physician. However, the Trust Fund must agree that the ordered item is medically necessary for the treatment of your illness or injury. The Plan will not pay for any convenience items.

### **Physical and Speech Therapy**

- Services must be ordered by a physician under an individual treatment plan. Physical therapy services must be medically necessary for restoration of a musculoskeletal function that was lost or impaired by injury or illness. Speech therapy services must be medically necessary for restoration of speech or hearing function that was lost or impaired by injury or illness.
- Services must be reasonably expected to improve the patient's condition through short-term care. (Long-term maintenance therapy is not covered).
- For physical therapy, group exercise programs are not covered.
- Prior authorization is required for outpatient physical, occupational, or speech therapy visits. Your physician must submit a treatment plan to HMA's Health Services Department.
- Speech therapy for children with developmental learning disabilities (developmental delay) is not a covered benefit.

### **Transplant Donor Services**

- Services related to the donor or organ bank (for bones, corneas, etc.) are covered only if a beneficiary is the recipient.
- If the donor is covered under another medical plan, that plan will be the primary plan and its benefits will be applied first before benefits under this Plan apply.
- Covered expenses for screening of donors are limited to expenses of the actual donor. Screening expenses of other donor candidates who do not become the actual donor are not eligible for benefits.

## **NON-EMERGENCY INTER-ISLAND TRAVEL BENEFITS**

Effective January 1, 2012, a beneficiary who resides in the State of Hawaii but does not reside on the island of Oahu may seek reimbursement for qualified travel expenses related to obtaining non-emergency medically necessary services for the diagnosis or treatment of an illness or injury when the required medical services are not available on the island where the beneficiary resides. The following benefit will be provided subject to prior review and authorization by the Claims Administrator under the Care Management Program:

- Reimbursement for roundtrip airfare, not to exceed \$200.00.
- Reimbursement for taxi fare to and from the airport on the island of Oahu, not to exceed \$50.00.
- For beneficiaries residing on the island of Lanai, the benefits under this section will be limited to travel by ferry for all authorized inter-island travel to the island of Maui, unless the beneficiary's medical condition prohibits this mode of travel. Reimbursement for travel by ferry to the island of Maui shall not exceed \$50.00.

## **EXCLUSIONS AND LIMITATIONS**

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

- Cosmetic services (services, supplies, or drugs that may improve physical appearance but do not restore or materially improve a body function)
- Treatment of baldness, including hair transplants and topical medications
- Treatment with non-ionizing radiation
- Eye refractions, eyeglasses or contact lenses, and refractive eye surgery to correct visual problems
- Dental services generally done only by dentists and not physicians. These exclusions include: orthodontia; dental splints and other dental appliances; dental prostheses; osseointegration and all related services; removal of impacted teeth; and any other procedures involving the teeth, gums, and structures supporting the teeth. In addition, any services in connection with the diagnosis or treatment of temporomandibular joint problems or malocclusion (misalignment of the teeth or jaws) are not eligible for benefits under this Plan
- Rest cures
- Routine physical examinations, screens or checkups, except for the screening services provided under Outpatient Laboratory and X-ray Services
- Services which are or may be covered by Workers' Compensation or any other employer's liability insurance
- Services provided without charge by any federal, state, municipal, territorial, or other government agency
- Services for which no charge or collection would be made if you or your dependents had no health plan coverage

- Services by a member of your immediate family or household
- Services or expenses connected with confinement which is primarily for custodial or domiciliary care
- Services for the treatment of an illness or injury resulting from acts of war (whether or not a state of war legally exists) or required during a period of active duty that exceeds 30 days in any armed forces
- Reversal of sterilization
- Fertilization by artificial means and all services and drugs related to the diagnosis or treatment of infertility (except for one in vitro fertilization program per qualified married couple per lifetime)
- Services and prosthetic devices related to sexual transformation or treatment of sexual dysfunction or inadequacies, regardless of cause
- Biofeedback and other forms of self-care or self-help training and any related diagnostic testing
- Human growth hormone therapy, except replacement therapy services to treat hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy
- Weight loss or weight control programs
- A physician's waiting or stand-by time
- Private duty nursing
- Foot orthotics, except for specific diabetic conditions
- Services not medically necessary and charges which exceed the Eligible Charge
- Services that do not follow or are not standard medical practice (e.g. experimental or investigative services)
- General excise or other taxes
- Services not described as covered in this booklet or in the Self-Funded Comprehensive Medical Plan document

## **IF YOU ARE HOSPITALIZED ON YOUR EFFECTIVE DATE**

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

## **INCORRECT OR FALSE INFORMATION**

The Plan will not pay any benefits to the extent that such benefits are payable by reason of any false statement made on the enrollment form or in any claim for benefits. If the Plan pays such benefits before learning of any false statement, you agree to reimburse the Plan for 100% of such payment, without any

deduction for legal fees or costs which you incurred or paid. In addition, you agree to reimburse the Plan for any legal fees and costs incurred or paid by the Plan to secure reimbursement. If reimbursement is not made as specified, the Plan, at its sole option, may:

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

## **COORDINATION OF BENEFITS (DUAL COVERAGE)**

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

In order to coordinate benefits, it is necessary to determine which plan is primary (pays first) and which plan is secondary (pays second) for each beneficiary. The Plan's determination is based on guidelines provided by the National Association of Insurance Commissioners (NAIC).

For those beneficiaries with Medicare, this Plan will be a supplement to the federal Medicare program. For Medicare eligible beneficiaries who have not enrolled in Medicare, the Plan will pay only up to those amounts that would have been paid had Medicare coverage been in place. Where a spouse is actively employed and covered under an employer group health plan, applicable federal statutes will determine which plan is primary for the spouse and Retiree.

For motor vehicle insurance cases, motor vehicle insurance will be considered primary for payment, and those benefits will be applied first before any medical benefits of this Plan apply. You must provide the Claims Administrator with a list of the medical expenses that the motor vehicle insurance covered. The list of expenses will be reviewed and upon verification that benefit maximums were met, this Plan will then begin paying benefits. If another person caused the motor vehicle accident, refer to the "Third Party Liability" section.

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

## **SPECIAL PROVISIONS RELATING TO MEDICAID**

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

## **WORKERS' COMPENSATION**

If you are entitled to receive disability benefits or compensation for an injury or illness under any Workers' Compensation or Employer's Liability Law, the Plan will not pay benefits for any services rendered in connection with such injury or illness. In the event that you formally appeal the denial of a Workers' Compensation claim, you must notify the Trust of such appeal. Upon the execution and delivery to the Trust of all documents it requires to secure its rights of reimbursement, the Plan may pay such benefits. However, such payment shall be considered only as an advance or loan to you. If your claim is declared eligible for benefits under Workers' Compensation or Employer's Liability Law, or if you reach a compromise settlement of the Workers' Compensation claim, you agree to repay 100% of the advance or loan, without any deduction for legal fees or costs which you incurred or paid, within 10 calendar days of receiving payment. If reimbursement is not made as specified, the Trust, at its sole option, may:

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

## **THIRD PARTY LIABILITY**

If your injury or illness is, or may have been caused by, a third party and you have a right or assert a right to recover damages from that third party or your own insurance company, the Plan is not liable for benefits in connection with services rendered for such injury or illness. However, upon the execution and delivery to the Trust of all documents it requires to secure its rights of reimbursement, the Plan may pay such benefits. Such payments shall be considered only as an advance or loan to you and you agree to repay 100% of the advance or loan, without any deduction for legal fees and costs which you incurred or paid, from any recovery received, however classified or allocated, and you promise not to waive or impair any rights of the Trust without its written consent.

If the Plan makes payments for such injury or illness, the Trust shall have reimbursement rights and shall have a lien against any recovery you or a covered dependent obtain from the third party or your insurance company (whether by lawsuit, settlement, or otherwise) to the extent of the Plan payments (i.e.. that portion of the total recovery which is due the Trust for benefits paid), even if you or a covered dependent is not made whole by such recovery. Such lien may be filed with the third party, his or her agent or insurance company, your insurance company, or the court. If you do not repay the loan as specified, the Trust, at its sole option, may:

1. take legal action to collect 100% of any payments made plus any legal fees and costs incurred or paid by the Plan to secure reimbursement, or to seek equitable relief (e.g., constructive trust) or injunctive relief; or
2. offset future benefit payments by the amount of such reimbursement plus any legal fees and costs incurred or paid by the Plan to secure reimbursement.

## CLAIMS FILING AND PAYMENT

### HOW TO FILE A MEDICAL CLAIM

When you obtain the services of a physician or hospital:

- Present your HMA membership identification card to the provider. (NOTE: The membership identification card is for identification only and does not guarantee eligibility).
- Be sure that the physician, hospital and HMA have your correct mailing address.
- Ask your physician or the hospital to file a claim directly on your behalf.

<p><b>All claims must be filed within one (1) year after the date of service.</b></p>
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### PAYMENT OF MEDICAL BENEFITS

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

### OUT-OF-STATE MEDICAL SERVICES

When you need covered services outside the State of Hawaii:

- Prior authorization is required for all non-emergency out-of-state services. You or your physician must call the HMA Health Services Department for out-of-state Hospital admissions, services, or procedures before the services are received. For emergency or maternity admissions, you must notify HMA within 48 hours or by the next business day (see Care Management Program section).
- Send HMA a completed claim form signed by the provider and attach a copy of the itemized bill or receipt. (Claim forms are available from HMA to take with you on your trip.)
- For covered services received outside the State of Hawaii, the Plan's reimbursement will be made as though such services had been rendered in Hawaii; however, the Eligible Charge for out-of-state services shall not exceed 150% of the Hawaii Eligible Charge for the same service. This limitation applies to both participating and non-participating providers.

## **DISCLAIMER**

None of the Self-Funded Comprehensive Medical 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 Self-Funded Comprehensive Medical Plan benefits are self-insured by the Hawaii Teamsters Health and Welfare Trust. The preceding is for informational purposes and is only a summary of coverage. Its contents are subject to the provisions of the Self-Funded Comprehensive Medical Plan Document and all amendments thereto. This document is on file with the Hawaii Teamsters Health and Welfare Trust Office. Please refer to this document for specific questions about coverage.



# INDEMNITY PRESCRIPTION DRUG BENEFITS

The Hawaii Teamsters Health and Welfare Trust has contracted Catamaran (formerly Catalyst Rx) as the Pharmacy Benefits Manager to administer and process Indemnity Prescription Drug claims. To obtain services through the Point of Service or Central Fill Program, you must use participating or designated pharmacies and present your HMA/Catalyst Rx identification card. To obtain prescriptions through the Mail Order Program, you must register with one of the Mail Order providers. For the Direct Member Reimbursement Program, you must file claims directly with the Pharmacy Benefits Manager. You may obtain claim forms and Mail Order registration forms and/or brochures from the Pharmacy Benefits Manager.

If you have any questions regarding your prescription drug benefits or would like to request a current list of participating pharmacies in your area, please contact the Pharmacy Benefits Manager at:

**CATAMARAN**  
**National Help Desk**  
**Toll Free: 1 (888) 869-4600**  
*(available 24 hours a day, seven days a week)*

## ELIGIBILITY

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

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

## DRUGS COVERED

The Indemnity Prescription Drug Plan will cover **only 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 Physicians in the United States; and
3. Is the most appropriate and economical prescription drug available.

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:

- Ointments and lotions for the skin which are prepared by a pharmacist.
- 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.
- 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.
- Smoking deterrents.
- Anti-obesity drugs.
- Prilosec OTC (You pay no copayment. Coverage is available only through the Point of Service program with a physician’s prescription).

### **Oral Contraceptives**

Oral contraceptives prescribed for contraceptive purposes or hormonal disorders are available through either the Point of Service Program or the Mail Order Program. However, only the following three (3) brand name oral contraceptives and their generic equivalents are covered under the Point of Service Program:

- Tri-levlen
- Desogen
- Ortho Tri-Cyclen

Under the Mail Order Program, all brand name and generic oral contraceptives are covered.

### **Step Therapy Program**

Effective October 1, 2011, the Step Therapy Program was implemented for cholesterol medications. A step therapy uses treatment guidelines to recommend drug therapy for medications that will work for the vast majority of patients with the least number of side effects and at the right economic price.

If you are prescribed a brand name cholesterol medication that has a generic equivalent, you will be required to try the generic medication prior to obtaining the brand name medication. The Plan will cover the brand name medication only if your physician deems the brand name medication medically necessary and Prior Authorization has been obtained from the Pharmacy Benefits Manager. This requirement applies to new prescriptions only.

### **Diabetic Sense Program**

Effective October 1, 2011, the Diabetic Sense Program is open to Plan members who are diabetic. Program enrollees receive diabetic testing supplies, a glucometer (limited to one per year), home delivery of diabetic testing supplies, and outreach services from a Certified Diabetic Educator, free of charge.

## **Brand Name Medication with a Generic Equivalent**

Effective April 1, 2012, Plan members who obtain a brand name medication with a generic equivalent will pay the applicable copayment plus the cost difference between the brand name and the generic equivalent medication. If you require the brand name medication in place of the generic equivalent, your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager.

## **Quantity Duration Management Program**

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

## **BENEFIT PROGRAMS**

You may obtain your covered prescription drugs through the following programs:

1. Point of Service Program (through participating pharmacies),
2. Central Fill Program (through designated Central Fill pharmacies),
3. Mail Order Program (through designated Mail Order providers), and
4. Direct Member Reimbursement Program.

A brief description of each program is outlined below.

### **POINT OF SERVICE 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 Trust Office or the Pharmacy Benefits Manager at 1 (888) 869-4600.

#### **Participating Pharmacy**

<b>Generic Drugs, Insulin, Diabetic Supplies</b>	\$ 5.00 copayment
<b>Brand Name Drugs</b>	\$15.00 copayment*
<b>Days Supply Limit**</b>	Up to 15 days

\* A generic drug is one which is prescribed or dispensed under its commonly used generic (chemical) name and is no longer protected under patent laws. If you request brand name only and a generic equivalent is available, you will be responsible for the brand name copayment plus the difference between the cost of the brand name drug and its generic equivalent.

\*\* For prepackaged prescription drugs that can only be dispensed in “unbreakable” packages (e.g. creams, ointments, certain inhalers), the days supply limit shall be equivalent to the package size days supply, not to exceed a 30-day supply, with 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: Claim forms submitted for prescription drugs purchased from a participating Point of Service pharmacy will not be accepted or paid under the Direct Member Reimbursement Program.

### **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 Trust Office or the Pharmacy Benefits Manager at 1 (888) 869-4600.

#### **To use the Central Fill Program:**

- Step 1: Obtain a prescription from your doctor.
- Step 2: Go to the nearest Central Fill pharmacy and present your prescription and HMA/Catalyst Rx identification card.
- Step 3: If this is the first time you are taking this drug or dosage of this drug, the pharmacist will fill your prescription for 15 days and you pay the following copayment:

**(Initial Fill)**

**15-Day Supply**

<b>Generic Drugs, Insulin, Diabetic Supplies</b>	\$ 5.00 copayment
<b>Brand Name Drugs</b>	\$15.00 copayment

- Step 4: If you and your doctor decide to continue to use this drug and dosage, you may obtain a refill for up to a 60-day supply. Call the 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**

<b>Generic Drugs, Insulin, Diabetic Supplies</b>	\$ 8.00 copayment
<b>Brand Name Drugs</b>	\$24.00 copayment

## **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 following copayments:

### **90-day Supply Limit\***

<b>Generic Drugs, Insulin, Diabetic Supplies</b>	\$ 8.00 copayment
<b>Brand Name Drugs</b>	\$24.00 copayment**

\* 15-day initial fill required.

\*\* 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.

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.

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

### **30-day Supply Limit**

<b>Generic Drugs, Insulin, Diabetic Supplies</b>	100% of the Eligible Charge or the cost of the prescription, whichever is less
<b>Non-Substitutable Brand Name Drugs</b>	80% of the Eligible Charge or the cost of the prescription, whichever is less
<b>Substitutable Brand Name Drugs</b>	75% of the Eligible Charge or the cost of the prescription, whichever is less

Refills will be paid for up to one (1) year from the date the original prescription was written.

### **Limitations:**

All prescription drugs are limited to a 30-day supply or a standard size package of 100 units when 100 units would be charged even if it is more than a 30-day supply.

### **How to file a Direct Member Reimbursement Claim:**

- Step 1: Complete a claim form. (To request a claim form, contact the Pharmacy Benefits Manager.)
- Step 2: Submit your completed claim form and receipts to the Pharmacy Benefits Manager within 90 days after the date of purchase.
- Step 3: Payment will be made directly to you.

**All claims must be submitted to the Pharmacy Benefits Manager within 90 days after the date of purchase. Claims received after the 90-day period will be denied.**

### **DRUGS NOT COVERED**

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

- Injectable drugs, including injectable drugs administered by a physician or physician's nurse, except insulin.
- Immunization agents.
- Agents used in skin tests for determining allergic sensitivity.
- Contraceptives, *except* oral contraceptives prescribed for specific hormonal disorders and oral contraceptives available through the Point of Service Program or Mail Order Program as previously described.
- 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.

### **DISCLAIMER**

None of the Indemnity Prescription Drug benefits described in this booklet is insured by any contract of insurance and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Trust 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 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.

## SELF-FUNDED HMO MEDICAL PLAN (Self-Insured)

Effective September 1, 2011, the Kaiser Permanente Plan was replaced by the Trust's Self-Funded HMO Medical Plan through the Queen's Health System. The benefits of the Self-Funded HMO Medical Plan are administered by Hawaii-Mainland Administrators, LLC (HMA). If you have any questions about any aspect of your coverage, you should call HMA.

**Hawaii-Mainland Administrators, LLC (HMA)**

1440 Kapiolani Boulevard, Suite 1020  
Honolulu, Hawaii 96814

**HMA Connection Line**

Phone: 951-4641

Toll Free: 1-877-384-2875

Website: [www.teamsters-hma.com](http://www.teamsters-hma.com)

E-mail: [teamsters@hmatpa.com](mailto:teamsters@hmatpa.com)

The Self-Funded HMO Medical Plan is designed to provide quality medical care at a reasonable cost. The Self-Funded HMO Medical Plan provides pre-paid medical and hospital services for members, as well as preventive health benefits like health evaluations.

When you join, you and other enrolled members of your family are encouraged to follow a health maintenance program with covered benefits such as periodic health evaluations and pediatric checkups. When an illness does occur, your benefit coverage enables your Primary Care Physician to provide necessary services.

### HOW TO USE THE SELF-FUNDED HMO MEDICAL PLAN

You obtain your medical care through the Queen's network of facilities and contracted physicians. **There is no coverage if you obtain services from a non-contracted provider.**

### PERSONAL DOCTOR

You and each enrolled member of your family may choose a Primary Care Physician from a network of highly qualified physicians engaged in family practice, general practice, obstetrics and gynecology, internal medicine, or pediatrics. **All care and services, except for emergency services and routine gynecological care, must be received from or arranged by your Primary Care Physician.**

Your Primary Care Physician will act as your health manager and is the first point of contact whenever you require medical assistance. He or she will do all of the following:

- Advise you on personal health issues.
- Diagnose and treat medical problems.
- Coordinate and monitor any care you may require from appropriate specialists.
- Keep your medical records up-to-date.

Maintaining an ongoing relationship with your Primary Care Physician will help ensure that you are receiving optimum care.

**Please note:** To provide you with the best care possible, the total number of patients that a Primary Care Physician can care for is limited. If the Primary Care Physician you select cannot accept new patients without adversely affecting the availability or quality of services provided, you will need to select another Primary Care Physician.

For assistance in finding a Primary Care Physician, please contact HMA. A Provider Directory by island will be provided to you, free of charge, upon request. You may also view the directory online by logging on to the website at [www.teamsters-hma.com](http://www.teamsters-hma.com).

### **Changing your Primary Care Physician**

If you need to change your Primary Care Physician, please contact HMA. The requested change will become effective on the first day of the following month.

### **SERVICE AREA**

The Self-Funded HMO Medical Plan provides services on the islands of Hawaii, Maui, and Oahu. Coverage for services rendered outside this Service Area is limited to Emergency Care, Urgent Care for unforeseen illness or injury while you are temporarily traveling outside the Service Area, and authorized referrals to providers outside the Service Area.

### **HOSPITAL LOCATIONS**

Members on Oahu receive hospital care in semi-private rooms at the Queen's Medical Center. Members on Maui receive hospital care at the Maui Memorial Medical Center. Members on the Big Island receive hospital care at the Kona Hospital, Hilo Medical Center, or North Hawaii Community Hospital.

### **ACCESSING CARE**

You must present your HMA member identification card whenever you obtain services. Visits to your Primary Care Physician may be scheduled by calling in advance to arrange appointments. Referrals to specialist physicians or facilities must be arranged by your Primary Care Physician. **Exception:** You do not need a referral from your Primary Care Physician to receive an annual gynecological exam from a contracted Plan provider who specializes in obstetrics or gynecology.



## **PAYMENT INFORMATION**

### **PAYMENT DETERMINATION CRITERIA**

To receive Plan benefits, the care you receive must be a covered service that is *medically necessary*. The fact that a physician may prescribe, order, recommend, or approve a service does not in itself constitute medical necessity or make a charge an allowable expense under this Plan. Your physician may write to HMA for a determination regarding the medical necessity of a service before it is performed.

To be considered medically necessary, a service must meet the following criteria:

- The service must follow standard medical practice and be essential and appropriate for the diagnosis or treatment of an illness or injury. Standard medical practice, with respect to a particular illness or injury, means that the service was given in accordance with generally accepted principles of medical practice in the United States at the time furnished.
- The service or treatment must not be “experimental” (e.g., used in research or on animals) or “investigative” (e.g., used only on a limited number of people or where the long term effectiveness of the treatment has not been proven in scientific, controlled settings, and where applicable, has not been approved by the appropriate government agency).
- If there is more than one medically appropriate method of treatment, the Plan’s coverage is limited to the most cost effective method.
- The service or treatment is covered by Federal government health plans.

### **ELIGIBLE CHARGE**

The Plan’s benefit payments for covered services are based on the Trust’s determination of an Eligible Charge for the covered service. The Plan will not pay the portion of any charge that exceeds the Eligible Charge.

### **COPAYMENT**

A copayment applies to most covered services. It is either a fixed percentage of the Eligible Charge or a fixed dollar amount. If you get services from more than one provider on the same day, more than one copayment may apply. You are responsible for paying the copayment at the time services are received.

### **ANNUAL COPAYMENT MAXIMUM**

There is an Annual Copayment Maximum of \$2,000 per person or \$6,000 per family (three or more persons) per plan year. Once the Annual Copayment Maximum is met, you are no longer responsible for copayment amounts for covered services for the rest of that plan year. The following payments do not count toward the Annual Copayment Maximum:

- Your copayments for prescription drug services.
- Payments for services subject to a maximum once you reach the maximum.
- Payments for services which are not covered.

- Copayments or additional payments you owe due to a benefit denial resulting from failure to satisfy a Managed Care Program review or Plan notice requirement.

## MANAGED CARE PROGRAM

A prior review must be obtained from HMA for certain types of medical services before the services are received. Your Primary Care Physician or specialty provider, upon a referral by your Primary Care Physician, is responsible for initiating and submitting all requests and documentation necessary for obtaining a required Managed Care review or prior authorization review on your behalf.

### SERVICES REQUIRING PRIOR REVIEW AND AUTHORIZATION

The following benefits and services require prior review and authorization by HMA before benefits or services are received:

- Referrals to specialists for consultations and office visits, including all out-of-state services
- All inpatient admissions including acute, skilled, and observation stays
- Outpatient services to include Imaging scans (MRI, MRA, or PET), Gamma knife or X-knife procedures, greater than three (3) OB ultrasounds per pregnancy, and In vitro fertilization
- Outpatient rehabilitation services including Physical Therapy, Speech Therapy, or Occupational Therapy
- Other medical services to include Appliances and Durable Medical Equipment, Hospice Care, Home Health Care, Human Growth Hormone Therapy, Dialysis, Chemotherapy, Radiation Therapy, Reconstructive Surgery, Transplants, intravenous administration of medication or nutrient solutions, Orthotics and Prosthetics
- Mental Illness and Alcohol or Drug Dependence services (requires a treatment plan)
- Inter-island Travel benefits

### SURGICAL REVIEW FOR CERTAIN SURGICAL PROCEDURES

A surgical review is required for certain surgical procedures identified by the Plan which are sometimes performed even though non-surgical treatment may be equally effective. The list of procedures changes periodically and is available from HMA. Before scheduling any of these listed surgical procedures, your physician must notify HMA and request a Surgical Review. **If a surgical review is required but not obtained, the Plan may deny payment of benefits.** Where the surgery cannot be scheduled in advance, e.g., in cases of emergency or maternity, HMA must be notified as soon as practical after the surgery, but no later than 48 hours or one (1) business day after the surgery.

HMA will notify you and your physician of the results of the surgical review. HMA may approve or deny payment of benefits for the surgery, or may condi-

tion the payment of benefits on your receiving a second opinion on the necessity of surgery. If a second opinion is required and arranged by HMA for a listed surgery, you may obtain the second opinion at no cost to you.

The second opinion does not need to confirm the recommended surgery. After receiving a second opinion, you and your physician may still decide whether to proceed with the surgery. **However, remember that you are responsible for all charges related to any listed surgical services for which the Plan has indicated it will not pay benefits.**

## **PREADMISSION REVIEW**

Before admission to a Hospital for any treatment that can be scheduled in advance, your physician must notify HMA and request a Preadmission Review. **If a Preadmission Review is not obtained, the Plan may deny payment of benefits.** Where the admission cannot be scheduled in advance, e.g., in cases of emergency or maternity, HMA must be notified as soon as practical after the admission, but no later than 48 hours or one (1) business day after the admission.

Approval of benefits for a Hospital admission will be based on whether the recommended admission is medically necessary and whether the care can be provided safely and effectively out of the Hospital. HMA will notify you and your physician of the Plan's approval or non-approval of the admission. **You are responsible for all charges related to any Hospital admission for which the Plan has indicated it will not pay benefits.**

## **REVIEW OF INPATIENT HOSPITAL CARE**

When your condition requires you to be hospitalized, HMA reviews each Hospital admission for the appropriateness of the inpatient care being provided and the appropriateness of continuing hospitalization. Inpatient reviews take place after admission and at set intervals thereafter, until you are discharged from the facility. HMA also reviews discharge plans for after-hospital care.

This review of inpatient hospital care is for benefit payment purposes. If HMA has a question about the appropriateness of continuing hospitalization or after-hospital care, or if HMA determines that benefits are not payable, HMA will notify you and your physician. If HMA decides that the continuation of any service or care is not medically necessary or appropriate, benefits under this Plan will not be payable for that continued service or care.

## **IF YOU DO NOT AGREE WITH A BENEFIT DETERMINATION**

If you do not agree with a benefit determination made under the Managed Care Program, you may ask for a second review by HMA or file an appeal with the Trust Fund as provided in the CLAIMS AND APPEALS PROCEDURES section of this booklet.

## **BENEFITS MANAGEMENT PROGRAM**

The Plan may assist members with certain medical conditions by providing benefits for alternative services that are medically appropriate but may not otherwise be covered under this Plan. **The payment of benefits for alternative services is made at the Plan's discretion, as an exception, and in no way**

**changes or voids the Plan benefits or terms and conditions.** Payment for alternative services in one instance does not obligate the Plan to provide the same or similar benefits in any other instance. Benefits for any alternative services for a member’s illness or injury will be paid in lieu of benefits for regularly covered services and will not exceed the total benefits otherwise payable for regularly covered services.

## **MEDICAL BENEFITS**

<b>SERVICES</b>	<b>MEMBER CHARGES</b>
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### **MEDICAL SERVICES**

Doctors’ and other health professionals’ office visits.....	\$14.00 per visit
Preventive Care	
Preventive Care office visits, one per calendar year.....	No charge
Gynecological office visit (female members), one per calendar year.....	No charge
Routine Immunizations	
Under Age 19.....	No charge
Age 19 or older.....	\$10.00 per dose
Influenza and Pneumonia Immunizations .....	No charge
Unexpected Mass Immunizations .....	50% of Eligible Charges

### **SURGICAL SERVICES**

Outpatient surgery and procedures	
Physician’s office .....	\$14.00 per visit
Ambulatory Surgery Center.....	No charge
Inpatient surgery and procedures .....	\$100.00 per admission <i>(Hospital benefits apply)</i>

### **LABORATORY, IMAGING & DIAGNOSTIC TESTING SERVICES**

Outpatient services .....	\$14.00 per service per day
Preventive screening services..... No Charge	
<ul style="list-style-type: none"> <li>• Routine Pap smear, one per calendar year</li> <li>• Screening by low dose mammography               <ul style="list-style-type: none"> <li>– One baseline mammogram during ages 35 through 39</li> <li>– One screening mammogram every 12 months beginning at age 40</li> <li>– A female member of any age with a history of breast cancer, or with an increased risk of breast cancer, or whose mother or sister has had a history of breast cancer, is eligible for a mammogram upon a Physician’s recommendation</li> </ul> </li> </ul>	
Inpatient services .....	No Charge <i>(Included as part of Hospital Services)</i>

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**SERVICES****MEMBER CHARGES**

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**HOSPITAL SERVICES**

Semiprivate Room, Intensive Care Unit,  
Intermediate Care Unit or Isolation Unit  
365 days each calendar year..... \$100.00 per admission

- Room and board
- Doctor's medical and surgical services
- Operating room
- Surgical supplies
- Hospital anesthesia services and supplies
- Drugs and dressings
- Oxygen
- Diagnostic and Therapy services
- Hospital blood transfusion services
- "Life Bed" services (when available)

**EXTENDED CARE SERVICES**

Up to 120 days of extended care services in a  
Skilled Nursing Facility each calendar year ..... No charge

**HOME CARE SERVICES**

Services for homebound members provided by a  
qualified Home Health Agency ..... No charge

Physician house calls ..... \$14.00 per visit

**HOSPICE SERVICES**

Services (in lieu of other Plan benefits) for  
treatment of terminal illness ..... No charge

**EMERGENCY CARE AND AMBULANCE SERVICES**

Coverage for initial emergency treatment only:

- At a facility within the Hawaii Service Area..... \$30.00 per visit
- At a facility outside the Hawaii Service Area ..... 20% of Eligible Charges

Ground Ambulance services..... 20% of Eligible Charges

Air Ambulance services ..... 10% of Eligible Charges

**URGENT CARE SERVICES**

Coverage for initial care only when you are  
temporarily away from the Hawaii Service Area..... 20% of Eligible Charges

**MATERNITY SERVICES**

**Note:** Medical, Surgical, Hospital and other benefits are available for pregnancy, childbirth, or other termination of pregnancy and related medical conditions. Diagnostic tests for an unborn Child are eligible for payment only when medically necessary. Benefits are available to a newborn child for in-hospital routine nursery care and for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Doctors’ services for routine obstetrical care (prenatal visits, delivery, and postpartum visit)

after confirmation of pregnancy ..... No charge

- Physician services benefits for routine obstetrical care are also available for Nurse-Midwife services. Services must be rendered by a properly licensed Nurse-Midwife who is certified by the American College of Nurse-Midwives and is formally associated with a Physician for purposes of supervision and consultation. Nurse-Midwife benefits are in lieu of benefits for Physician services.

Inpatient stay and inpatient care for newborn

during mother’s hospital stay ..... \$100 per admission

- Hospital benefits are also available for services of a properly licensed birthing center approved by the Claims Administrator when such birthing center is used instead of regular Hospital facilities for childbirth. Benefits for birthing center services are in lieu of benefits for Hospital Services.

Artificial Insemination .....\$14.00 per visit

In Vitro Fertilization ..... 20% of Eligible Charges

- Limited to 1 procedure per lifetime
- Limited to female members covered under the Plan for at least 12 consecutive months

Family planning office visits ..... \$14.00 per visit

Involuntary infertility office visits ..... \$14.00 per visit

Contraceptive aids and devices (FDA approved)

to prevent unwanted pregnancies ..... 50% of Eligible Charges

*(Office visit copayment applies)*

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**SERVICES**

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**MEMBER CHARGES**

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**MENTAL ILLNESS / ALCOHOL AND DRUG DEPENDENCE SERVICES**

## Outpatient Care

Office visits ..... \$14.00 per visit

Psychological testing ..... \$14.00 per service per day

## Inpatient Care

(Hospital or Qualified Treatment Facility)..... \$100.00 per admission

## Specialized Facility Services

(Services in a specialized mental health,  
alcohol, or drug dependency treatment unit  
or facility approved by the Plan)

Day treatment or partial hospitalization services ..... \$14.00 per visit

Non-hospital residential services ..... \$100.00 per admission

**OTHER SERVICES**

## Allergy Testing and Treatment Materials

(one series per calendar year) ..... \$14.00 per visit

Blood, Blood Products and Blood Bank service charges..... No Charge

## Chemotherapy medications for treatment of

cancer if skilled administration is required ..... No Charge

*(Office visit copayment applies)*

Dialysis and Supplies (Outpatient)..... 10% of Eligible Charges

Diabetes equipment and related supplies ..... 30% of Eligible Charges

Appliances and Durable Medical Equipment ..... 20% of Eligible Charges

*(\$500 allowance for Hearing Aids)*

Implanted internal prosthetics, devices and aids .....No Charge

Medical Foods for inborn metabolic disorders ..... 20% of Eligible Charges

## Outpatient Injections and Intravenous

administration of medication or of nutrient

solutions required for primary diet when skilled

administration is required ..... No Charge

*(Office visit copayment applies)*

## Outpatient Physical Therapy, Occupational

Therapy, and Speech Therapy..... \$14.00 per visit

Transplant Donor Services ..... 10% of Eligible Charges

Evaluations for the use of hearing aids ..... \$14.00 per visit

## NON-EMERGENCY INTER-ISLAND TRAVEL BENEFITS

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

- Reimbursement for roundtrip airfare, not to exceed \$200.00.
- Reimbursement for taxi fare to and from the airport, not to exceed \$50.00.

## EMERGENCY SERVICES

### GENERAL PROVISIONS

A medical emergency is a sudden, unexpected, and potentially life-threatening situation that requires immediate medical attention. Examples include, but are not limited to:

- Heart attack or stroke symptoms
- Extreme difficulty breathing
- Sudden or extended loss of consciousness
- Uncontrollable bleeding
- Sudden loss of vision

If you think you are having an emergency, seek immediate medical attention. Do not take the time to call your Primary Care Physician as precious time may be wasted. If you think you need an ambulance, call 911.

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

If you are admitted to a non-contracted facility, you or a family member must notify HMA within 48 hours after care begins (or as soon as reasonably possible) by calling the phone number on the back of your member identification card. This must be done, or your claim for payment may be denied. The Plan may arrange for your transfer to another facility as soon as it is medically appropriate to do so.

**In a medical emergency, go to the nearest emergency room.** The following is a list of preferred emergency facilities:

### Oahu

The Queen's Medical Center  
1301 Punchbowl Street  
Honolulu, Hawaii 96813  
(808) 538-9011



## Maui

Maui Memorial Medical Center  
221 Mahalani Street  
Wailuku, Hawaii 96793  
(808) 242-2343

## Hawaii

Hilo Medical Center  
1190 Waiuanue Avenue  
Hilo, Hawaii 96720  
(808) 932-3000

Kona Community Hospital  
79-1019 Haukapila Street  
Kealahou, Hawaii 96750  
(808) 322-4413

North Hawaii Community Hospital  
67-1125 Mamalahoa Highway  
Kamuela, Hawaii 96743  
(808) 881-4730

## CARE RECEIVED FROM NON-CONTRACTED PROVIDERS

**At a non-contracted facility within the Service Area**, benefits are limited to care authorized under a written referral and emergency benefits.

**Outside the Service Area**, benefits are limited to care authorized under a written referral, emergency benefits, ambulance services, and urgent care services for members temporarily away from the Service Area. “Urgent Care Services” means **initial care** for a sudden and unforeseen illness or injury when you are temporarily outside the Service Area which is required to prevent serious deterioration of your health and which cannot be delayed until you are medically able to safely return to the Service Area. **Continuing or follow-up treatment from a non-contracted provider is not covered unless treatment meets the criteria for Emergency Services or Urgent Care Services.**

When you are temporarily traveling outside the Service Area, you may require medical services for emergent or urgent problems. Please have your HMA member identification card with you at all times. If you are admitted to a hospital, you or a family member must call the HMA toll-free number found on the back of your ID card within 48 hours of your hospital admittance (or by the next business day) or your claim may be denied.

## EXCLUSIONS

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

- Cosmetic services (services that may improve physical appearance but do not restore or materially improve a body function).
- Treatment of baldness, including hair transplants and topical medications.
- Treatment with non-ionizing radiation.
- Eye refractions, eyeglasses or contact lenses, and refractive eye surgery to correct visual problems.
- Dental services done only by dentists and not physicians. These exclusions include orthodontia, dental splints and other dental appliances, dental prostheses, osseointegration and all related services, removal of impacted teeth, and any other procedures involving the teeth, gums, and structures supporting the teeth. In addition, any services in connection with the diagnosis or treatment of temporomandibular joint problems or malocclusion (misalignment of the teeth or jaws) are not eligible for benefits under this Plan.
- Rest Cures.
- Routine physical examinations, screens or checkups except for well-baby care and preventive care services, screening services provided under Laboratory, Imaging and Diagnostic Testing Services, and physical examinations required by an educational institution for students in grades K through 6.
- Services which are or may be covered by Workers' Compensation or any other employer's liability insurance.
- Services provided without charge by any federal, state, municipal, territorial, or other government agency.
- Services for which no charge or collection would be made if you or your dependents had no health plan coverage.
- Services provided by a member of your immediate family or household.
- Services or expenses connected with confinement which is primarily for custodial or domiciliary care.
- Services due to acts of war (whether or not a state of war legally exists) or required during a period of active duty that exceeds 30 days in any armed forces.
- The following costs and services for infertility, in vitro fertilization, or artificial insemination:
  - The cost of equipment and of collection, storage and processing of sperm.
  - In vitro fertilization using either donor sperm or donor eggs.
  - Artificial insemination using donor sperm.

- Services and drugs related to conception by artificial means other than artificial insemination or in vitro fertilization.
- Reversal of sterilization.
- Services related to sexual transformation or sexual dysfunction or inadequacies.
- Biofeedback and other forms of self-care or self-help training and any related diagnostic testing.
- Human growth hormone therapy except for replacement therapy services approved by the Claims Administrator to treat hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection or radiation therapy.
- Weight loss or weight control programs.
- A physician's waiting or stand-by time.
- Private duty nursing.
- Foot orthotics except for specific diabetic conditions.
- The following costs and services for transplants:
  - Non-human and artificial organs and their implantation.
  - Bone marrow transplants associated with high-dose chemotherapy for the treatment of solid tissue tumors, except for germ cell tumors and neuroblastoma in children.
- Long-term physical therapy, long-term speech therapy, and maintenance therapies; group exercise programs; speech therapy for children with developmental learning disabilities (developmental delay).
- Experimental or investigational services.
- Services not medically necessary.
- Services for injuries or illnesses caused or alleged to be caused by third parties or in motor vehicle accidents.
- Services for which coverage has been exhausted, services not listed as covered, or excluded services.

## LIMITATIONS

Benefits and services are subject to the following conditions and limitations:

- Coverage for Ambulance services is limited to transporting a member from the place where an injury occurred or an illness first required care to the nearest facility equipped to furnish emergency treatment for such injury or illness. Air ambulance service benefits are limited to inter-island transportation within the State of Hawaii.
- Appliances and Durable Medical Equipment coverage is limited to the initial provision and replacement of the following:
  - artificial limbs, eyes, and similar non-experimental appliances
  - casts, splints, trusses, braces, and crutches
  - oxygen and rental of equipment for its administration
  - rent or purchase of wheelchair and hospital-type bed
  - use of an iron lung, artificial kidney machine, pulmonary resuscitator, and similar special medical equipment
  - hearing aids

For the initial provision and replacement of hearing aids, Plan benefits are limited to one device per ear every three years.

All appliances and durable medical equipment must be prior authorized by the Claims Administrator.

- Benefits for outpatient Chemotherapy for malignancies are subject to prior authorization by the Claims Administrator.
- Outpatient Diagnostic and Therapy benefits for the following services are subject to prior authorization by the Claims Administrator:
  - MRI, MRA, and PET scans
  - Gamma knife or X-knife procedures
  - Greater than three (3) OB ultrasounds per pregnancy
  - Radiotherapy
- Benefits for outpatient Dialysis and Supplies are subject to prior authorization by the Claims Administrator.
- Diabetes Equipment and supplies necessary to operate them are subject to Medicare coverage guidelines and limitations.
- Home Health Care benefits are subject to the following conditions and limitations:
  - Services must be received from a qualified home health agency which meets Medicare requirements and is approved by the Claims Administrator.
  - The Member's physician must certify, in writing, that the Member is homebound due to an injury or illness, is in need of skilled health services, and would require inpatient Hospital or Skilled Nursing Facility care if there were no home health care visits.

- If the need for home health care services exceeds 30 days, the Member’s physician must recertify that additional visits are required and provide a continuing plan of treatment at the end of each 30-day period of care.
- There is no coverage for home health care services furnished primarily to assist in meeting personal, family, or domestic needs such as general household services, meal preparation, shopping, bathing, or dressing.
- Home health care must be prior authorized by the Claims Administrator.
- Hospice benefits are subject to the following conditions and limitations:
  - All hospice services must be received from a contracted provider operating under generally accepted standards for hospices.
  - The hospice provider and the Member’s physician must certify, in writing, that the Member is terminally ill and has a life expectancy of six months or less.
  - A Member who elects hospice benefits will not be eligible for any other benefits for treatment of the terminal illness while the hospice election is in effect, except medical service benefits from a physician. However, the Member may continue to receive benefits for all other illnesses or injuries.
  - Hospice care must be prior authorized by the Claims Administrator.
- Coverage for In Vitro Fertilization is limited to one procedure per lifetime whether successful or not. In vitro fertilization services are covered for female members who have been covered under the Plan for 12 consecutive months immediately preceding the in vitro fertilization procedure. The following requirements and criteria for in vitro fertilization apply:
  - The Member’s oocytes are to be fertilized with her spouse’s sperm.
  - The Member and her spouse have a history of infertility of at least 5 years duration, or infertility is associated with one or more of the following medical conditions: endometriosis; exposure in utero to diethylstilbestrol (des); blockage or surgical removal of one or both fallopian tubes (lateral or bilateral salpingectomy); or abnormal male factors contributing to the infertility.
  - The Member has been unable to attain a successful pregnancy through other applicable infertility treatments for which coverage is available under this Plan.
  - The in vitro fertilization procedure must be performed at a medical facility that conforms to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.
  - The in vitro fertilization procedure must be prior authorized by the Claims Administrator.
- “Life Bed” services will be covered when available under Hospital care, but only with prior notification to the Claims Administrator.

- Benefits for Mental Illness and Alcohol or Drug Dependence services are subject to the following conditions and limitations:
  - For inpatient Hospital or facility services, a preadmission review is required.
  - The Plan will pay for up to one (1) visit per day for services of a contracted Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist to a Member being treated in a Hospital or Qualified Treatment Facility.
  - Mental illness services must be for a nervous or mental disorder classified as such in the current version of the Diagnostic and Statistical Manual of the American Psychiatric Association and must be provided under an individualized treatment plan approved by a Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist.
  - Outpatient alcohol or drug dependence treatment services must be provided under an individualized treatment plan approved by a Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist who is a certified substance abuse counselor.
  - The cost of educational programs to which drunk or drugged drivers are referred by the judicial system and any and all services performed by mutual self-help groups are not eligible for benefits.
- Coverage for Oral Surgical services performed by a dentist is limited to cases in which the dentist is performing emergency or surgical services that could also be performed by a physician. Hospital inpatient benefits are available for dental services only when a physician certifies, in writing, that the Member has a separate medical condition, such as hemophilia, that makes hospitalization necessary for the Member to safely receive dental services or that the oral surgery itself requires hospitalization.
- Benefits for Outpatient Physical Therapy services are subject to the following conditions and limitations. Services must be:
  - rendered by a registered physical therapist (R.P.T.) or registered occupational therapist (O.T.R.)
  - ordered by a physician under an individual treatment plan
  - medically necessary to restore musculoskeletal function that was lost or impaired by illness or injury
  - reasonably expected to improve the patient's condition through short-term care
  - prior authorized by the Claims Administrator
- Benefits for Outpatient Speech Therapy services are subject to the following conditions and limitations. Services must be:
  - rendered by a certified speech therapist
  - ordered by a physician under an individual treatment plan
  - medically necessary to restore speech or hearing function that was lost or impaired by illness or injury

- reasonably expected to improve the patient’s condition through short term care
- prior authorized by the Claims Administrator
- Skilled Nursing Facility benefits are subject to all of the following conditions and limitations:
  - The Member must be admitted by a physician with prior authorization from the Claims Administrator, confined as a registered bed patient, and attended by a physician.
  - Confinement in the facility is not primarily for comfort, convenience, rest cure, or domiciliary care.
  - If the Member’s confinement exceeds 30 days, the attending physician must submit an evaluation report to the Claims Administrator at the end of each 30-day period of confinement.
- Tuberculin skin test is limited to one (1) per calendar year, unless medically necessary.
- Well child laboratory tests (birth through age 5) are limited to two tuberculin tests, two blood tests (hemoglobin or hematocrit), and one urinalysis.
- Covered transplants are limited to kidney, cornea, bone marrow (excluding bone marrow transplants associated with high-dose chemotherapy for the treatment of solid tissue tumors, except for germ cell tumors and neuroblastoma in children), liver, heart, heart-lung, lung, simultaneous kidney-pancreas, small bowel, and small-bowel-liver transplants. Prior authorization is required for transplant evaluations and all transplants except kidney and cornea.
- Eligible medical and hospital costs of the organ donor or services of an organ bank are covered only when a Plan Member is the recipient. Coverage of expenses for screening of donors is limited to the expenses associated with the actual donor. If a donor is covered under another medical plan, the donor’s medical plan shall be the primary plan and its benefits shall apply, and there is no coverage under this Plan.
- Reconstructive surgery is covered only when required to restore, reconstruct, or correct any bodily function that was lost, impaired, or damaged as a result of an illness or injury. Reconstructive surgery for congenital anomalies (defects present from birth) is covered only when the defect severely impairs or impedes normal, essential bodily functions and is medically necessary. Prior authorization is required for these services.

## ADDITIONAL INFORMATION

### IF HOSPITALIZED ON THE EFFECTIVE DATE

If you are confined in a Hospital or in a Skilled Nursing Facility, or other inpatient facility at the time your coverage under this Plan begins and were not a beneficiary under some other medical plan of the Trust immediately prior to the Effective Date of such coverage, you will be entitled to benefits for the injury or illness which required such confinement from the effective date of eligibility under this Plan. However, if you had other insurance or coverage immediately prior to the effective date under this Plan, which extends coverage for any services related to the hospitalization or other inpatient facility, the Plan will provide coordination of benefits with your existing coverage in accordance with the National Association of Insurance Commissioners (NAIC) primary and secondary rule until the termination of your existing coverage. Thereafter, the Plan will provide coverage in accordance with the Plan document and plan of benefits.

### INCORRECT OR FALSE INFORMATION

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

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

### COORDINATION OF BENEFITS (DUAL COVERAGE)

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

In order to coordinate benefits, it is necessary to determine which plan is primary (pays first) and which plan is secondary (pays second) for each family member. The Plan's determination of which health plan is primary is modeled according to the guidelines provided by the National Association of Insurance Commissioners (NAIC). For an employee under this Plan, this Plan will be primary. For a working spouse who has coverage through his or her employer's plan or another group plan, the other plan will be primary. **This Plan will not pay benefits on a secondary basis.**



## **Special Provisions Relating to Medicare**

The Federal Medicare Program will be considered the primary plan unless the Beneficiary is an active employee covered under an employer or group plan. Where an employee or dependent is covered by both Medicare and an employer or group health plan, applicable Federal laws or regulations will determine which plan is primary.

## **Motor Vehicle Insurance Cases**

For motor vehicle insurance cases, motor vehicle insurance will be considered primary for payment, and those benefits will be applied first before any medical expenses benefits of this Plan apply. You must provide the Claims Administrator with a list of the medical expenses that the motor vehicle insurance covered. The list of expenses will be reviewed and upon verification that benefit maximums were met, this Plan will then begin paying benefits. If another person caused the motor vehicle accident, refer to the “Third Party Liability” section.

## **SPECIAL PROVISIONS RELATING TO MEDICAID**

In determining or making any payment for you under this Plan, eligibility for, or provision of state-provided medical assistance will not be taken into account.

## **WORKERS’ COMPENSATION**

If you are entitled to receive disability benefits or compensation under any Workers’ Compensation or Employer’s Liability Law for an injury or illness, the Plan will not pay benefits for any services relating to such injury or illness. If you formally appeal the denial of a Workers’ Compensation claim, you must notify the Trust of such appeal. Upon the execution and delivery to the Trust of all documents it requires to secure its rights of reimbursement, the Plan may pay such benefits. However, such payments shall be considered only as an advance or loan to you. If your claim is declared eligible for benefits under Workers’ Compensation or Employer’s Liability Law or if you reach a compromise settlement of the Worker’s Compensation claim, you agree to repay 100% of the advance or loan, without any deduction for legal fees or costs which you incurred or paid, within 10 calendar days of receiving payment. If reimbursement is not made as specified, the Plan, at its sole option, may:

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

## **THIRD PARTY LIABILITY**

If your injury or illness is or may have been caused by a third party and you have a right or assert a right to recover damages from that third party or your own insurance company, the Plan is not liable for benefits in connection with services rendered for such injury or illness. However, upon the execution and delivery to the Trust of all documents it requires to secure its rights of reim-

bursement, the Plan may pay such benefits. Such payments shall be considered only as an advance or loan to you and you agree to repay 100% of this advance or loan, without any deduction for legal fees and costs which you incurred or paid, from any recovery received, however classified or allocated, and you promise not to waive or impair any of the rights of the Trust without its written consent.

If the Plan makes payments for such injury or illness, the Trust shall have reimbursement rights and shall have a lien against any recovery you obtain from the third party or your insurance company (whether by lawsuit, settlement, or otherwise) to the extent of the Plan payments (i.e., that portion of the total recovery which is due the Trust for benefits paid). Such lien may be filed with the third party, his or her agent or insurance company, your insurance company, or the court. If you do not repay the loan from the recovery, the Trust has the right to either:

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

## **CLAIMS FILING AND PAYMENT**

### **HOW TO FILE A MEDICAL CLAIM**

All claims must be filed within one (1) year after the date services are rendered. No claim will be paid unless it is supported by the provider's report regarding the services rendered.

#### **When you receive covered services from a contracted Plan provider:**

- The provider will file a claim for you and payment will be made directly to the provider.
- You pay only the applicable copayment for the covered service to the provider at the time services are received.

#### **When you receive covered services from a non-contracted provider:**

- Ask the provider to file a claim with HMA on your behalf, OR
- Send HMA a completed claim form signed by the provider and attach a copy of the itemized bill or receipt.
- Payment will be made directly to you.
- You are responsible for paying the non-contracted provider the total charge, which includes the Plan payment and the applicable copayment for the covered service, plus any amount of the provider's charge that exceeds the Eligible Charge, except for emergency services.

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

## **CLAIMS AND APPEALS PROCEDURES**

Specific information about the Plan's claims and appeals procedures are contained in the SELF-INSURED CLAIMS AND APPEALS PROCEDURES section of this booklet.

## **DISCLAIMER**

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

The Self-Funded HMO Medical 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 Self-Funded HMO 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.

## **SELF-FUNDED HMO PRESCRIPTION DRUG BENEFITS**

If you have selected the Self-Funded HMO Medical Plan administered by HMA for your medical coverage, you and your eligible dependents are eligible for the following Self-Funded HMO Prescription Drug benefits administered by Catamaran (formerly Catalyst Rx), the Trust's Pharmacy Benefits Manager.

The Self-Funded HMO Prescription Drug Plan partially covers the cost of drugs for which a prescription by a licensed prescriber is required by law when such prescriptions are purchased through the Point of Service Program at a Participating Pharmacy within the Hawaii service area or through the Mail Order Program. To locate a Participating Pharmacy near you, contact the Pharmacy Benefits Manager for assistance at:

**CATAMARAN**  
1600 Kapiolani Boulevard, Suite 1322  
Honolulu, Hawaii 96814

**Customer Service**  
**Phone: 1 (888) 869-4600**  
**Website: [www.catamaranrx.com](http://www.catamaranrx.com)**

The prescription drug benefit includes only the drugs listed on the Self-Funded HMO Plan list of covered drugs (Formulary) that meet Formulary criteria and restrictions. (The Formulary is reviewed throughout the year and is subject to change. You may view the Formulary online at [www.catamaranrx.com](http://www.catamaranrx.com).) Any other drugs will not be covered unless medically necessary and prescribed by a physician, and authorized by the Plan prior to dispensing. Participating pharmacies may substitute a chemical or generic equivalent for a brand name drug except when a physician directs that substitution is not permissible. If you request a brand name drug which has a generic equivalent when it has not been deemed medically necessary by a physician, you will be charged the applicable copayment plus the difference in cost between the brand name drug and its generic equivalent. If you have any questions about a particular drug, contact the Pharmacy Benefits Manager.

**POINT OF SERVICE PROGRAM****For each prescription or refill when the quantity does not exceed:**

- A 15-day consecutive supply .....\$12.00 per prescription or refill  
(Acute medications/initial fill) or the cost of the drug  
(whichever is less)
- A 30-day consecutive supply .....\$14.00 per prescription or refill  
(Unbreakable package\*/  
Maintenance medications) or the cost of the drug  
(whichever is less)

\*For covered drugs or items that can only be dispensed in unbreakable packages, the days supply limit shall be equivalent to the package size day supply, with a single copayment of \$14.00 per prescription or refill for up to a 30-day supply, or the cost of the drug, whichever is less, charged to the member.

- A 90-day consecutive supply .....\$42.00 per prescription or refill  
(Unbreakable package\*\*/  
Maintenance medications) or the cost of the drug  
(whichever is less)

\*\* For covered drugs or items that can only be dispensed in unbreakable packages, the days supply limit shall be equivalent to the package size day supply, with a single copayment of \$42.00 per prescription or refill for up to a 90-day supply, or the cost of the drug, whichever is less, charged to the member.

**MAIL ORDER PROGRAM** (through designated Mail Order providers)**For each prescription or refill when the quantity does not exceed:**

- A 90-day consecutive supply .....\$28.00 per prescription or refill  
(Maintenance medications) or the cost of the drug  
(whichever is less)

**Note: Prescription drugs are available under the Mail Order Program only after the member has obtained a prior dispensed prescription for that drug and dosage for a minimum 15-day supply.**

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.

## EXCLUSIONS

- Drugs for which a prescription is not required by law (e.g., over-the counter drugs) and non drug items, except for the following items which are covered only when a physician has issued a prescription and the Plan has received verification that such items are necessary for treatment of an illness or injury:
  - Ointments and lotions for the skin which are prepared by a pharmacist.
  - Special vitamins prescribed for the treatment of a severe vitamin deficiency.
  - Insulin and diabetic supplies prescribed for the treatment of diabetes. Coverage of diabetic supplies is limited to syringes, needles, lancets, sugar test tablets and tapes, and acetone test tablets.
  - Smoking deterrents. Coverage of smoking deterrents is limited to two 12-week cycles per year.
  - Anti-obesity drugs.
  - Aspirin. Coverage of aspirin is limited to men and women age 45 or older.
  - Fluoride. Coverage of fluoride is limited to children up to age 5.
  - Folic acid. Coverage of folic acid is limited to women up to age 55.
  - Iron supplements. Coverage of iron supplements is limited to children up to age 1.
- Injectable drugs, *except for* insulin and injectable contraceptives.
- Immunization agents.
- Agents used in skin tests to determine allergic sensitivity.
- Contraceptives, *except for* oral contraceptives prescribed for specific hormonal disorders, generic oral and injectable contraceptives, and certain brand name oral and injectable contraceptives approved by the Plan. Brand name contraceptives with generic equivalents require Prior Authorization from the Plan.
- Appliances.
- Drugs dispensed to a member confined as a registered bed patient in an inpatient facility.
- Non-Formulary drugs.
- Drugs obtained from a pharmacy not designated by the Plan as a Participating Pharmacy.

## **DISCLAIMER**

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

The Self-Funded HMO Prescription Drug 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 Self-Funded HMO Plan Document, the HMO Plan (Self-Funded) Prescription Drug Rider and all amendments thereto. These documents are on file with the Hawaii Teamsters Health and Welfare Trust Office. Please refer to these documents for specific questions about coverage.

# **KAISER FOUNDATION HEALTH PLAN INC.**

Note: Effective September 1, 2011, the Trust's Self-Funded HMO Plan replaced the Kaiser Permanente Plan. Only those Retirees and their spouses under 65 years of age who were enrolled in the Kaiser Permanente Plan prior to September 1, 2011 may continue coverage under the Kaiser Permanente Plan.

## **KAISER PERMANENTE**

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

When you join, you and other enrolled members of your family are encouraged to follow a health maintenance program with covered benefits such as periodic health evaluations, eye examinations for glasses, and pediatric check-ups. 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 obtain your medical care directly from Kaiser Permanente facilities and physicians. You may choose your personal doctor from a staff of over 450 highly qualified physicians representing all major specialties. Your personal Kaiser Permanente physician is responsible for your medical care and arranges consultations with other specialists, as necessary. All care and services need to be coordinated by a Kaiser Permanente physician.

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

### **LIVE OR WORK**

Subscribers may live or work in the Hawaii service area and enroll (or continue to be enrolled) in a Kaiser Permanente plan as long as they live in the State of Hawaii. Family dependents must live in the Hawaii service area to enroll (or continue to be enrolled) in a Kaiser Permanente plan.

### **LOCATIONS**

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



Hospital. Members on Kauai receive hospital care at the Samuel Mahelona Memorial Hospital, West Kauai Medical Center, or Wilcox Memorial Hospital. Members on Molokai receive hospital care at Molokai General Hospital and on Lanai, at Lanai Community Hospital.

For detailed information on the Kaiser Permanente locations, please contact the Customer Service Center at 432-5955 (Oahu), or 1 (800) 966-5955 (Neighbor Islands), or visit the website at [www.kaiserpermanente.org](http://www.kaiserpermanente.org).

## MEDICAL OFFICE VISITS

You may schedule routine visits to physicians or other health professionals by calling in advance to arrange appointments. In case of sudden illness, you can be seen by a physician that same day by calling one of Kaiser Permanente’s conveniently located facilities and describing your condition. Referrals to non-Kaiser Permanente physicians and hospitals may be made for very specialized care.

## BASIC MEDICAL BENEFITS

SERVICES	MEMBER CHARGES
<b>OUTPATIENT SERVICES</b>	
Office Visits (doctors and other health professionals) .....	\$15.00 per visit
Annual Preventive Health exam .....	No charge
Annual Gynecological exam for female members .....	No charge
Eye Exams for eyeglasses .....	\$15.00 per visit
Ear Exams to determine the need for hearing correction.....	\$15.00 per visit
Routine Immunizations .....	No Charge
Influenza (flu) and Pneumococcal Immunizations .....	No Charge
Unexpected Mass Immunizations .....	50% of applicable plan charges
Laboratory procedures, Prescribed Imaging and Other Diagnostic services.....	\$15.00 per department per day
Outpatient Surgery and procedures .....	\$15.00 per visit
Short Term Physical, Speech and Occupational Therapy .....	\$15.00 per visit
Radiation / Inhalation Therapy .....	\$15.00 per visit
Chemotherapy Medications for treatment of cancer	
If skilled administration is required .....	No Charge (Members must pay applicable Copayment for office visit)
If self-administered.....	\$15.00 per prescription
Casts and Dressings .....	No Charge (Members must pay applicable Copayment for office visit)

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**SERVICES**

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**MEMBER CHARGES**

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**HOSPITAL SERVICES**

Semiprivate room, Private room (when prescribed), or Intensive Care Unit .....	\$100.00 per admission
Operating Room .....	No Charge
Doctor's Medical and Surgical services.....	No Charge
Hospital Anesthesia services .....	No Charge
Drugs and Dressings .....	No Charge
Laboratory procedures, Prescribed Imaging and Other Diagnostic services.....	No Charge
Radiation / Inhalation Therapy .....	No Charge
Short-term Physical, Speech, and Occupational Therapy.....	No Charge
Special Duty Nursing (when prescribed) .....	No Charge
Blood Transfusions.....	No Charge

**EXTENDED CARE SERVICES**

Up to 60 days of extended care services in a skilled nursing facility per benefit period .....	No Charge
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**EMERGENCY CARE SERVICES**

Coverage for initial emergency treatment only	
Within the Hawaii service area.....	\$25.00 per visit (plus other applicable plan charges)
Outside the Hawaii service area.....	20% of applicable plan charges

**OBSTETRICAL CARE, FAMILY PLANNING, AND INFERTILITY SERVICES**

Doctors' services after confirmation of pregnancy (routine prenatal visits, delivery, and care in hospital) .....	No Charge
Routine care for newborn during mother's hospital stay.....	No Charge
Caesarean sections (medically necessary) .....	No Charge
Elective interrupted pregnancy (limited to two (2) procedures per lifetime).....	\$15.00 per visit
In vitro fertilization .....	20% of applicable plan charges
• Limited to (one) 1 procedure per lifetime under Kaiser Permanente	
• Limited to female members using spouse's sperm	
• Excluded for member or member's spouse who has had voluntary surgically induced sterility (with or without reversal)	
Family planning services.....	\$15.00 per visit
Infertility services (not including lab, prescription drugs).....	\$15.00 per visit
Contraceptive Aids and Devices (FDA approved) to prevent unwanted pregnancy .....	50% of applicable plan charges

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**SERVICES**

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**MEMBER CHARGES**

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**MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES**

Outpatient services .....\$15.00 per visit

Hospital Care.....\$100.00 per admission

- Hospital care includes services of physicians and mental health professionals or physician's visits in a Specialized Facility.

Specialized Facility services

(Services in a specialized mental health or chemical dependence treatment unit or facility approved by the Hawaii Permanente Medical Group)

Day Treatment or Partial Hospitalization services .....\$15.00 per visit

Non-Hospital residential services.....\$100.00 per admission

**OTHER SERVICES**Ambulance services .....20% of applicable charges  
plus any charges above  
applicable chargesPrescribed drugs that are on the Formulary  
and administered at Kaiser Permanente Medical  
Offices, Emergency Departments and Urgent  
Care Centers .....No Charge for most drugs  
(Members must pay applicable  
Copayment for office visit)

Diabetes supplies.....50% of applicable charges

Tobacco cessation drugs and products.....No charge

Home Health services (for home-bound  
members when prescribed by a Kaiser  
Permanente physician)

Nurse and Home Health Aide visits.....No Charge

Hospice Care .....No Charge

Internal prosthetics, devices and aids.....No Charge

Smoking cessation classes .....Members pay the prevailing rates

**SUPPLEMENTAL CHARGES MAXIMUM**

Your out-of-pocket expenses for covered

Basic Health Services are capped each year

by a Supplemental Charges Maximum .....\$1,750.00 per member,  
\$5,250.00 per family unit  
(3 or more members),  
for a calendar year

You must retain your receipts for the charges you have paid, and when the maximum amount has been paid, you must present these receipts to Kaiser's Business Office at the following locations: Moanalua Medical Center, Honolulu Clinic, Waipio Clinic, or to the cashier at other clinics, or the Patient

Accounting Office at 711 Kapiolani Boulevard, Honolulu, Hawaii 96813. After verification that the Supplemental Charges Maximum has been paid, you will be given a card which indicates that no additional Supplemental Charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits to get the Supplemental Charges waived.

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

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

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

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

## EMERGENCY SERVICES

### GENERAL PROVISIONS

A medical emergency is a potentially life threatening situation that requires immediate medical attention such as:

- Heart attack or stroke symptoms
- Extreme difficulty breathing
- Sudden or extended loss of consciousness
- Uncontrollable bleeding
- Sudden loss of vision

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

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

If you are admitted to a non-Kaiser Permanente facility, you or a family member must notify Kaiser Permanente within 48 hours after care begins (or as soon as reasonably possible) by calling the phone number on the back of your Kaiser Permanente identification card. This must be done, or your claim for payment may be denied. Kaiser Permanente may arrange for your transfer to a Kaiser Permanente facility as soon as it is medically appropriate to do so.

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

- |                |  |
|----------------|--|
| <b>Maui</b>    | Maui Memorial Medical Center   |
| <b>Hawaii</b>  | Hilo Medical Center<br>Kona Community Hospital<br>North Hawaii Community Hospital          |
| <b>Kauai</b>   | Samuel Mahelona Memorial Hospital<br>West Kauai Medical Center<br>Wilcox Memorial Hospital |
| <b>Molokai</b> | Molokai General Hospital   |
| <b>Lanai</b>   | Lanai Community Hospital   |

## **CARE RECEIVED OUTSIDE THE KAISER PERMANENTE SYSTEM**

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

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

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

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

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

tal, you or a family member must call the toll-free number found on the back of your ID card within 48-hours of your hospital admittance or your claim may be denied.

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

Kaiser Permanente will terminate the membership of members who move anywhere outside the Hawaii service area. Until that time, you will only be covered for initial emergency care in accordance with your Health Plan benefits. Before you move outside the Hawaii service area, you should contact the Trust Office to discuss your options.

## MEDICAL PLAN EXCLUSIONS

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

The following services are excluded:

- **Acupuncture.**
- **Alternative medical services** not accepted by standard allopathic medical practices such as: hypnotherapy, behavior testing, sleep therapy, biofeedback, massage therapy, naturopathy, rest cure, and aroma therapy.
- **Artificial aids** such as eyeglasses, corrective lenses, and hearing aids.
- **All blood, blood products, blood derivatives, and blood components** whether of human or manufactured origin and regardless of the means of administration, *except* units of whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin. Donor directed units are not covered. There is no charge to Medicare members for blood, blood products, blood derivatives, or blood components covered under Medicare or for their administration.
- **Cardiac rehabilitation.**
- **Chiropractic services, except** Medicare members are entitled to manual manipulation of the spine to correct subluxation when prescribed by a Kaiser Permanente physician and performed by a Health Plan designated provider.
- Services for **confined members** (confined in criminal institutions or quarantined).
- **Contraceptive foams and creams, condoms,** or other non-prescription substances used individually or in conjunction with any other prescribed drug or device.
- **Corrective aids and appliances** such as orthotics.
- **Cosmetic services,** such as plastic surgery or other services to change physical appearance, which will not result in significant improvement in physical

function, including treatment for complications resulting from cosmetic services. This exclusion does not apply to procedures that a) will correct significant disfigurement resulting from an injury or medically necessary surgery, b) are incident to a covered mastectomy, or c) treatment for complications resulting from cosmetic services provided by a physician in a Health Plan facility.

- **Custodial services or services in an intermediate level care facility.**
- Continuation in a course of treatment for members who are disruptive or physically abusive.
- **Dental care services** such as dental x-rays, dental implants, dental appliances or orthodontia, and services relating to Temporomandibular Joint Dysfunction (TMJ) or Craniomandibular Pain Syndrome.
- **Durable medical equipment** such as crutches, canes, oxygen-dispensing equipment, hospital beds, and wheelchairs used in the member's home (including an institution used as his or her home), *except* diabetes glucose meters and external insulin pumps for non-Medicare members. Medicare members are covered for DME as provided under Medicare.
- **Employer or Governmental Responsibility:** services that an employer is required by law to provide or that are covered by Workers' Compensation or employer liability law; services for any military service-connected illness, injury or condition when such services are reasonably available to the member at a Veterans Administration facility; services required by law to be provided only by, or received only from a government agency.
- **Experimental or investigational services.**
- **External prosthetic devices**, such as artificial limbs, except Medicare covered devices for Medicare members.
- **Eye examinations** for contact lenses and **eye exercises.**
- **Eye surgery** solely for the purpose of correcting refractive defects of the eye such as Radial keratotomy (RK) and Photo-refractive keratectomy (PRK).
- **Routine foot care**, unless medically necessary.
- **Health Education:** specialized health promotion classes and support groups (such as the bariatric surgery program).
- **Homemaker services.**
- The following costs and services for **infertility, in vitro fertilization or artificial insemination:**
  - The cost of equipment and of collection, storage, and processing of sperm.
  - In vitro fertilization using either donor sperm or donor eggs.
  - In vitro fertilization that does not meet state law requirements.
  - Services related to conception by artificial means other than artificial insemination or in vitro fertilization, such as ovum transplants, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT); including prescription drugs related to such services and donor sperm and donor eggs used for such services.
  - Services to reverse voluntary, surgically-induced infertility.

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



## LIMITATIONS

Benefits and services are subject to the following limitations:

- Services may be curtailed because of major disaster, epidemic, or other circumstances beyond Kaiser Permanente's control such as a labor dispute or a natural disaster.
- Coverage is not provided for treatment of conditions for which a member has refused recommended treatment for personal reasons when Kaiser Permanente physicians believe no professionally acceptable alternative treatment exists. Coverage will cease at the point the member stops following the recommended treatment.
- Members are covered for **contraceptive drugs and devices** only when the prescription drugs meet all of the following criteria:
  - Prescribed by a licensed Prescriber;
  - The drug is one for which a prescription is required by law; and
  - Obtained at pharmacies in the Service Area operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc.
- **Internally implanted prosthetics, devices, and aids** (such as pacemakers, hip joints, surgical mesh, stents, bone cement, bolts, screws, and rods) are subject to Medicare coverage guidelines and limitations.
- **Diabetes equipment** and supplies necessary to operate them are subject to Medicare coverage guidelines and limitations, must be preauthorized in writing by Kaiser Permanente, and obtained from a Health Plan designated vendor.
- Short-term **physical, occupational and speech therapy services** means medical services provided for those conditions which meet all of the following criteria:
  - 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, speech, or occupational therapist, as appropriate; and
  - As determined by a Physician, the therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury.

Neurological and/or musculoskeletal function is sufficient when one of the following **first** occurs:

- Neurological and/or musculoskeletal function is the level of the average healthy person of the same age;
- Further significant functional gain is unlikely; or
- The frequency and duration of therapy for a specific medical condition as specified in Kaiser Permanente Hawaii's Clinical Practice Guidelines has been reached.

- **Occupational therapy** is limited to hand rehabilitation services and medical services to achieve improved self-care and other customary activities of daily living.
- **Speech-language pathology** is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin.
- **Tuberculin skin test** is limited to one per calendar year, unless medically necessary.
- **Transplant services for transplant donors.** Health Plan will pay for medical services for living organ and tissue donors and prospective donors if the medical services meet all of the 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.
  - The terms, conditions, and Supplemental Charges of the transplant-recipient Kaiser Permanente member will apply to the donor. Supplemental Charges for medical services provided to transplant donors are the responsibility of the transplant-recipient Kaiser Permanente member to pay, and count toward the transplant-recipient Kaiser Permanente member's limit on Supplemental Charges.
  - The medical services required are directly related to a covered transplant for a Kaiser Permanente member and required for a) screening of potential donors, b) harvesting the organ or tissue, or c) treatment of complications resulting from the donation.
  - For medical services to treat complications, the donor receives the medical services from Kaiser Permanente practitioners inside a Health Plan Region or Group Health service area.
  - Health Plan will pay for emergency services directly related to the covered transplant that a donor receives from non-Kaiser Permanente practitioners to treat complications.
  - The medical services are provided not later than three months after donation.
  - The medical services are provided while the transplant recipient is still a Kaiser Permanente member, except that this limitation will not apply if the Kaiser Permanente member's membership terminates because he or she dies.
  - Health Plan will not pay for travel or lodging for donors or prospective donors.
  - Health Plan will not pay for medical services if the donor or prospective donor is not a Kaiser Permanente member and is a member under another health insurance plan, or has access to other sources of payment.

The above guidelines do not apply to blood donors.

## **THIRD PARTY LIABILITY, MOTOR VEHICLE ACCIDENTS AND SURROGACY HEALTH SERVICES**

Kaiser Permanente has the right to recover the cost of care for a member's injury 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.

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 costs of Surrogacy Health Services, out of the compensation the member or member's payee are entitled to receive under the Surrogacy Arrangement.

## **BINDING ARBITRATION**

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

## **ADDITIONAL KAISER PERMANENTE INFORMATION**

### **CUSTOMER SERVICE**

When you need help, ask the Customer Service Center:

- Oahu: (808) 432-5955
- Neighbor Islands and outside the Hawaii service area: 1 (800) 966-5955
- TTY hearing/speech impaired: 1 (877) 447-5990
- Phone line hours:
  - Monday through Friday .....8:00 a.m. – 5:00 p.m.
  - Saturday .....8:00 a.m. – 12:00 noon

Specially trained personnel are available to assist you and can tell you about:

- Your benefits
- Claims and billing
- How to file an appeal
- Changing your address on Kaiser Permanente's records
- Replacing your ID card
- Professional qualifications of primary and specialty practitioners

## **IDENTIFICATION CARDS**

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

Your identification card is good for a lifetime - as long as you remain a member. If you lose or damage your ID card or were a previous Kaiser Permanente Hawaii member and no longer have your ID card, call the Customer Service Center at (808) 432-5955 (Oahu) or 1 (800) 966-5955 (Neighbor Islands) to request a new one. Both new and returning health plan members should carry a temporary ID (found on the last page of the enrollment form) for at least 30 days or, for first time Kaiser Permanente members, until the permanent one is mailed to your home.

## **YOUR CURRENT ADDRESS**

It is vitally important that Kaiser Permanente has your current address and phone number. "Partners in Health" and other publications are mailed regularly. Kaiser Permanente also may need to contact you quickly if a member of your family comes in for emergency treatment. Notify the Customer Service Center of any changes.

## **CLAIMS FOR BENEFITS**

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

## **CONVERSION PRIVILEGE**

If your Kaiser Permanente Plan membership through the Hawaii Teamsters Health and Welfare Trust is terminated for any reason, you may apply for a Kaiser Permanente conversion membership under an individual account. However, you must apply within 30 days. Full details on how to retain your Kaiser Permanente membership are available from the Customer Service Center.

## KAISER PRESCRIPTION DRUG BENEFITS

The following prescription drug benefits are available to you and your spouse if:

1. Your medical benefits are provided through the Supplemental Health Plan for OTS Retirees, and
2. You are covered under the Kaiser Permanente Medical Plan or the Kaiser Senior Advantage Plan.

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

If you have any questions on a particular drug, contact the Customer Service Center and/or a clinic pharmacy.

<b>BENEFITS</b>	<b>MEMBER COPAYMENT</b>
<p><b>For each prescription or refill</b>, when the quantity does not exceed:</p> <ul style="list-style-type: none"> <li>• A 30-day consecutive supply of a prescribed drug, or</li> <li>• An amount as determined by the Formulary</li> </ul> <p><b>Self-administered drugs</b> are covered only when all of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Prescribed by a Kaiser Permanente physician or licensed prescriber,</li> <li>• On the Health Plan Formulary and used in accordance with Formulary criteria, guidelines, or restrictions,</li> <li>• The drug is one for which a prescription is required by law, except for insulin, and</li> <li>• Obtained at pharmacies in the service area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc., or pharmacies Kaiser Permanente designates.</li> </ul>	<p>\$15.00 per prescription</p>
<b>Insulin</b>	<p>\$15.00 per prescription</p>

## Mail Order Service

Members may also request refills of maintenance drugs through the mail order service, in which members are entitled to a 90-day supply for a \$30.00 copayment. (**Note: Mail order drugs will not be sent to addresses outside of the service area**). The mail order program does not apply to delivery of certain pharmaceuticals (such as narcotics, tranquilizers, bulky items, and medication affected by temperature). Please mail your refill order before you are down to your last 14 days supply. Allow one to two weeks to receive your medication for refillable orders.

## PRESCRIPTION DRUG PLAN EXCLUSIONS

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

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

## **OTHER KAISER PERMANENTE INFORMATION**

### **Customer Service**

Service assistance, individual plan enrollment,  
benefit information, Out-of plan emergency  
claims .....432-5955 / 1(800) 966-5955

### **Membership Accounting**

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

### **Patient Accounting**

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

### **Mainland Kaiser Facilities**

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

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

The preceding is for informational purposes only and is only a summary of coverage. Its contents are subject to the provisions of the Group Medical and Hospital Service Agreement and Face Sheet, Kaiser Permanente Group Plan Benefit Schedule, Laboratory Services, Imaging Services and Testing Services Rider-\$15 Outpatient, and Prescription Drug Rider 15, 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

## ELIGIBILITY

You and your spouse are eligible for vision care benefits provided under the VSP Advantage Plan.



## 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

<u>BENEFIT</u>	<u>VSP MEMBER DOCTOR</u>	<u>NON-MEMBER PROVIDER</u>
<b>COPAYMENT:</b> \$10.00 total (exam, lenses, and/or frame)		
<b>EYE EXAMINATION</b> Optometrist (O.D.) or Ophthalmologist (M.D.)	100% after copayment	Up to \$ 45.00
<b>APPLIANCES</b> Lenses and Frames		
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
Contact Lenses	Up to \$110.00	Up to \$110.00
Frames Only	Up to \$ 90.00	Up to \$ 40.00

### Contact Lenses

Elective or medically necessary contact lenses may be chosen instead of glasses. Contact lens frequency is the same as spectacle lenses. Under this plan, 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.



## **Elective Contact Lenses**

An allowance of \$110 will be provided for contact lenses and the contact lens exam (fitting and evaluation). 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 coverage 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.

## **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: The VSP Member Doctor will itemize the charges so you will know exactly what portion of the bill is covered under your VSP plan.

### **Out-of-Network Provider**

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.

For faster reimbursement, you may complete a claim form on-line:

- Simply go to [www.vsp.com](http://www.vsp.com), click on the “*Members*” link and log on. Your individual member information will appear.
- Select “*Out-of-Network Reimbursement*” from “*My Benefits> Benefits Resources*”. Complete the submission form in its entirety and print the form.
- Verify that the information is correct, attach your itemized receipts to the form and mail to:

VSP

P.O. Box 997105

Sacramento, CA 95899-7105

OR, you may call VSP Customer Service at (808) 532-1600 (Oahu) or 1 (800) 522-5162 (Toll Free from Neighbor Islands) to obtain a hard copy Out-of-Network Reimbursement Form. Complete the form, attach your receipts and submit to the address above.

**IMPORTANT: Out-of-Network Reimbursement requests must be submitted to VSP within six (6) months from the date of service.**

Step 3: VSP will reimburse you up to the scheduled amounts for covered services.

The next time you receive vision services, consider visiting a VSP Member Doctor. You don't have to file a claim. Your coverage will go farther. And VSP guarantees your satisfaction.

## EXCLUSIONS

There is no benefit for professional services or materials connected with:

- 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 + .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
- Low vision services and materials
- Plano contact lenses to change eye color cosmetically
- Costs for services and/or materials exceeding plan benefit allowances
- Artistically-painted contact lenses
- 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 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, when necessary, 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 all 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 FOR BENEFITS PROVIDED DIRECTLY FROM THE HAWAII TEAMSTERS HEALTH AND WELFARE TRUST

*(i.e., Self-Funded Comprehensive Medical, Indemnity Prescription Drug, and Self-Funded HMO Medical and Prescription Drug benefits)*

### CLAIMS

#### REVIEW OF CLAIMS

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 for any benefit under the Self-Funded Comprehensive Medical Plan, Indemnity Prescription Drug Plan, or Self-Funded HMO Medical and Prescription Drug Plan 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 the proper procedures for filing claims, and/or the additional information needed to complete your claim.

You will be given 48 hours from the date you are notified to complete your claim.

Once the necessary information has been submitted, you will receive a decision within 48 hours from the earlier of the following events:

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

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

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

A pre-service claim is any claim involving a requirement or request for approval before care is rendered. Pre-service claims include pre-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 (5) days of the day the claim was received. The notification will indicate the proper procedures for filing claims.

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

A post service claim is any claim submitted after services have been provided to you.

- **Extensions for Pre-Service and Post-Service Claims**

The Plan may extend the time to respond to a pre-service or post-service claim by fifteen (15) days only if there are circumstances beyond the Plan’s control that interfere with a timely determination of the claim. The Plan must provide you with a notice of extension setting forth 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 the information needed to complete your claim. You will be given 45 days from the date you are notified to submit the additional information to complete your claim.

- **Concurrent Care Claims**

If you are currently receiving ongoing treatment under the Plan, you will receive advance notice of any determination to terminate or reduce your treatment. The notice will be provided to you, in advance, to allow you to appeal the determination and have a decision rendered prior to the termination or reduction of your treatment. Any claim involving both urgent care and a request to extend a course of treatment 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, the Claims Administrator will issue a notice informing you of the approval. No approval notice will be provided for post-service claims.

If your claim is denied, 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 (3) days. The notice of denial, whether oral or written, will contain the following information:

1. The specific reason(s) for the denial, with reference(s) to the specific Plan provisions;
2. A description of any additional material or information necessary to complete your claim and why the information is needed;
3. A statement that you may request, free of charge, an explanation of the clinical or scientific judgment used to make the determination applying the terms of the Plan to your medical circumstances, if the denial was based on medical necessity, experimental treatment, or similar exclusion;
4. The identification of any internal rule, guideline, protocol, or other criteria the Plan relied upon in making the determination, and a statement that such rule, guideline, protocol, or other criteria is available to you, free of charge, upon your request;
5. A description of the Plan's review procedures, the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA to appeal a denial based on the review of an earlier decision; and
6. A description of the expedited review process applicable to the claim, if the denial involved a claim for urgent care.

# APPEALS

## SELF-INSURED CLAIMS

If you wish to appeal the denial of any claim for benefits by the Claims Administrator, you have 180 days following your receipt of an adverse benefit determination notice from the Claims Administrator to file an appeal with the Board of Trustees. The Board of Trustees has appointed the Benefits and Appeals Committee to hear all appeals of denied claims.

The appeal will be conducted by the Benefits and Appeals Committee without any preferential treatment given to the determination of the initial claim. The determination on appeal will be made by individuals who were not involved in the determination of the initial claim and who are not subordinates of anyone involved in the initial claim determination.

In considering the appeal, the Benefits and Appeals Committee is required to consider all evidence submitted by you or your authorized representative, whether or not the information was submitted or considered in the initial benefit determination. You have the right to submit written comments, documents, records, and other information relating to your claim for benefits.

If the initial denial involved medical judgment, the Benefits and Appeals Committee must consult with a health care professional who has the appropriate training and experience in the field of medicine. Examples of medical judgment include whether a treatment, drug, or other item is experimental, investigational, or medically necessary or appropriate. If a health care professional is required to be consulted on the appeal, the professional must not be the same individual that was involved in the initial determination of the claim, nor a subordinate of that individual.

### Your Right to Information

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

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

### Appeal of an Urgent Care Claim

If you are appealing a denial of an urgent care claim, you have the option of submitting your appeal orally or in writing. All necessary information will be communicated to you through the quickest method available, such as telephone or fax. **The Benefits and Appeals Committee must issue its decision as soon as possible, but no later than 72 hours from the time the appeal is received.**

### Appeal of a Pre-Service Claim

If you are appealing a denial of a pre-service claim, you must submit a written request for review of the initial denial. **The Benefits and Appeals**

**Committee must issue its decision no later than 30 days from the time the appeal is received.**

### **Appeal of a Post-Service Claim**

If you are appealing a denial of a post-service claim, you must submit a written request for review of the initial denial. **The Benefits and Appeals Committee must issue its decision no later than 60 days from the time the appeal is received.**

### **Notification of Determination on Appeal**

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

## **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 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 a subcommittee 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 (2) 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 a 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 will 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.

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 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, the Plan Documents will control. Please refer to these documents if you have specific questions about claims and appeals procedure.

## **INSURED CLAIMS**

Medical and prescription drug benefits are also provided through Kaiser Foundation Health Plan, Inc. and Hawaii Medical Service Association. Vision care benefits are provided through Vision Service Plan. Life insurance benefits are provided through Pacific Guardian Life. For information concerning appeals procedures for these insurance plans, contact the carrier at the address listed below.

### **KAISER FOUNDATION HEALTH PLAN, INC.**

711 Kapiolani Boulevard  
Honolulu, Hawaii 96813  
Attn: Customer Service

### **HAWAII MEDICAL SERVICE ASSOCIATION**

P.O. Box 860  
Honolulu, Hawaii 96808-0860  
Attn: Customer Service

### **VISION SERVICE PLAN**

3333 Quality Drive  
Rancho Cordova, California 95670  
ATTN: Member Appeals

### **PACIFIC GUARDIAN LIFE**

1440 Kapiolani Boulevard, Suite 1700  
Honolulu, Hawaii 96814  
Attn: Group Claims Department

## 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;
- Obtain a paper copy of the notice of information practices upon request; 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:

**Self-Funded Comprehensive Medical Plan and  
Self-Funded HMO Medical Plan**

Privacy Officer  
Hawaii-Mainland Administrators LLC (HMA)  
1440 Kapiolani Boulevard, Suite 1020  
Honolulu, Hawaii 96814  
Phone: (808) 951-4621

**Indemnity Prescription Drug Plan and  
Self-Funded HMO Prescription Drug Plan**

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

**Kaiser Permanente and Kaiser Senior Advantage  
Medical and Prescription Drug Plans**

Privacy Officer  
Kaiser Foundation Health Plan, Inc.  
711 Kapiolani Boulevard  
Honolulu, Hawaii 96813  
Phone: (808) 432-5090

**HMSA Akamai Advantage Medicare and  
Medicare Group Drug Plans**

Privacy Officer  
Hawaii Medical Services Association  
P.O. Box 860  
Honolulu, Hawaii 96808-0860  
Phone: (808) 948-6111

**VSP Vision Plan**

Member Service Department  
333 Quality Drive  
Rancho Cordova, California 95670  
Phone: 1 (800) 877-7195

# 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 employees and their spouses. The actual Trust Agreement, Plan Documents, policies, contracts, and rules and regulations adopted by the 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.