HAWAII TEAMSTERS TRUST FUNDS

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Hawaii Truckers-Teamsters Union Pension Plan • Teamsters Health & Welfare Trust Fund • Teamsters Legal Services Plan • Teamsters Training and Opportunity Program

August 19, 2002

TO: **ALL ACTIVE PLAN PARTICIPANTS OF THE HAWAII TEAMSTERS HEALTH & WELFARE TRUST**

FROM: **BOARD OF TRUSTEES**

RE: **SUMMARY PLAN DESCRIPTION (SPD) CHANGES REQUIRED BY THE DEPARTMENT OF LABOR AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

Outlined below are the Summary Plan Description (SPD) changes, which are required by the Department of Labor and the Health Insurance Portability and Accountability Act (HIPAA). These changes will be incorporated in the SPD, which is currently being rewritten. Until the revised SPD is issued, please retain this information for your files.

I. SUMMARY OF PLAN PROVISIONS RELATING TO PLAN TERMINATION AND AMENDMENT

Page 9 of the SPD dated July 1999 is revised to read as follows:

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 to 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 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 by the insurance carriers of the termination of the plan, should contact the various insurance carriers for information on conversion to an individual plan offered by the respective insurance carriers.

Upon the 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 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.

II. HEALTH INSURANCE PORTABILITY ACT (HIPAA) AND THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Page 15 of the SPD dated July 1999 is revised to include the following provision:

SPECIAL ENROLLMENT PERIODS

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Hawaii Teamsters Health and Welfare Trust allows enrollment during a special enrollment period if you qualify under one (1) of the following two (2) requirements:

1. You declined coverage for yourself and/or your dependent(s) as a result of coverage under another group health plan, or

2. You obtain a new dependent through marriage, birth, adoption, or placement of adoption.

If you declined enrollment for yourself and/or your dependent(s) (including your spouse) because of other health insurance coverage, you may enroll yourself and/or your dependents) provided you request enrollment within 30 days after your coverage under the other health plan ends.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your new dependent(s) provided you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you fail to enroll during the special 30-day period, you must wait until the next open enrollment date.

Page 17 of the SPD dated July 1999 is revised to include the following provisions:

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, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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

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

III. INDEMNITY PRESCRIPTION DRUG BENEFITS

Page 49 of the SPD dated July 1999 is revised to replace the first paragraph in the "Drugs Covered" section with the following paragraph:

DRUGS COVERED

The 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 requesting your physician to write to the Trust prior to dispensing the drug. The Trust 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:

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

IV. KAISER PLAN

The Kaiser Plan section of the SPD dated July 1999 regarding the items listed below are revised to include the following:

PARTICIPATING PROVIDERS

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

PRESCRIPTION DRUGS

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

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

CLAIMS FOR BENEFITS

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

V. REVISED STATEMENT OF ERISA RIGHTS

The "STATEMENT OF ERISA RIGHTS" on page 105 of the SPD dated July 1999 is revised in its entirety to read as follows:

As a participant in the Hawaii Teamsters Health and Welfare Trust, 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 Pension and Welfare Benefits Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

VI. REVISED CLAIMS AND APPEALS PROCEDURES

On page 103 of the SPD dated July 1999, the section entitled "APPEALS PROCEDURE" is revised to read "CLAIMS AND APPEALS PROCEDURES". In addition, the section on self-insured claims is revised to read as follows:

CLAIMS AND APPEALS PROCEDURES

SELF-INSURED CLAIMS FOR BENEFITS PROVIDED DIRECTLY FROM THE HAWAII TEAMSTERS HEALTH AND WELFARE TRUST (i.e., medical, prescription drug, and vision care)

CLAIMS

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

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

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

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

INITIAL CLAIMS

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

- **URGENT CARE CLAIMS: 72 HOURS**

  You will be notified within 72 hours from the receipt of your claim whether your claim is approved or denied. If you fail to follow the Plan's claims filing procedure or submit an incomplete urgent care claim, you will receive oral notification (or written notification, if you request) within 24 hours of the day the claim was received. The notification will indicate what the proper procedures are for filing claims, or what additional information is needed to complete your claim. You will be given forty-eight (48) hours from the date you are notified to complete your claim.

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

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

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

- **PRE-SERVICE CLAIMS:** **15 CALENDAR DAYS** (with possible 15-day extension)

  A pre-service claim is any claim which requires approval before care is rendered. Pre-service claims include pre-authorizations and utilization review decisions. For specific procedures on obtaining prior approvals for benefits, pre-authorizations or utilization reviews, refer to the specific sections of the self-insured benefits described in this booklet. If you fail to follow the Plan's claims filing procedure, you will receive oral notification (or written notification, if you request) within five (5) days of the day the claim was received. The notification will indicate what the proper procedures are for filing claims.

- **POST-SERVICE CLAIMS:** **30 CALENDAR DAYS** (with possible 15-day extension)

  A post-service claim is any claim which does not require approval before care is rendered. An extension for pre-service and post-service claims will only be available if there are circumstances beyond the Plan's control that interfere with a timely claim determination. In order for the Plan to get an extension, the Plan must provide you with advance notice identifying the circumstances which provide the basis for the extension and the date that the Plan is expected to make its decision. If the extension is caused by your failure to provide the necessary information to decide the claim, the notice of extension will indicate what additional information is needed to complete your claim. You will be given forty-five (45) days from the date you are notified to provide additional information to complete your claim.

- **CONCURRENT CARE CLAIMS**

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

INITIAL BENEFIT DETERMINATION

If your pre-service claim or urgent care claim is approved by the Claims Administrator, you will receive a notice informing you of the approval. No approval notice will be provided for post-service claims.

If your claim is denied by the Claims Administrator, you will be provided written notice of the denial at no cost to you. Examples of a denied claim include a determination to reduce or terminate a benefit or a failure to make whole or partial payment of a benefit by the Plan. In the case of urgent care claims, the Plan may first notify you orally, with a written notice to follow in three (3) days. The notice of denial, whether oral or written, will contain the following information:

(a) The specific reason(s) for the denial, with reference(s) to the specific Plan provisions;

(b) A description of any additional material or information necessary to complete your claim and why the information is needed;

(c) 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;

(d) 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;

(e) 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

(f) A description of the expedited review process applicable to the claim, if the denial involved a claim for urgent care.

APPEALS

If you wish to appeal the denial of any claim for benefits by the Claims Administrator, you have 180 days 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.

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

YOUR RIGHT TO INFORMATION

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

(a) Reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits; and

(b) The identity of any medical or vocational experts that were hired on behalf of the Plan to provide advice in connection with your initial benefit determination, whether or not their advice was relied upon in making the determination.

APPEAL OF AN URGENT CARE CLAIM

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

APPEAL OF A PRE-SERVICE CLAIM

If you are appealing a denial that is considered a pre-service claim, you must submit a written request for review of the initial denial. The Benefits and Appeals Committee must issue its decision no later than **30 days from the time the appeal is received**.

APPEAL OF A POST-SERVICE CLAIM

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

NOTIFICATION OF DETERMINATION ON APPEAL

You will receive written notification informing you of the determination 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.

The preceding is for informational purposes only, and is a summary of the claims and appeals procedure in general. 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 Document will control. Please refer to these documents for specific questions about claims and appeals procedure.