

HAWAII TEAMSTERS HEALTH AND WELFARE TRUST

ACTIVES



NOVEMBER 2012

THIS PLAN IS ADMINISTERED 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 Trust Office at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, Telephone: (808) 523-0199 (Oahu) or 1 (866) 772-8989 (Neighbor Islands), 8:00 a.m. - 4:30 p.m. Monday through Friday.

THE BOARD OF TRUSTEES RESERVES THE RIGHT, AT ITS SOLE DISCRETION, TO MODIFY THE PLAN WITH REGARD TO ELIGIBILITY REQUIREMENTS AND BENEFITS AVAILABLE, REQUIRE A CONTRIBUTION FOR THE COST OF BENEFITS, OR TERMINATE BENEFITS AT ANY TIME. THESE CHANGES MAY AFFECT YOU AND YOUR DEPENDENTS. PLEASE READ THIS BOOKLET AND SUBSEQUENT NOTICES THAT ARE MAILED TO YOU CAREFULLY.

HAWAII TEAMSTERS HEALTH AND WELFARE TRUST

Several important 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, 2008:
 - a. The requirement for submittal of the full-time student certification by a school, college or university was changed from 30 days to 45 days after the beginning of each semester.
 - b. The Student Coverage Self-Payment Program was revised to allow a student to continue single coverage for medical and prescription drug benefits for up to 12 consecutive months regardless of age. Previously, the program did not extend coverage beyond the attainment of age 24.
2. Effective November 1, 2008, Southwest Service Administrators was replaced by Benefit & Risk Management Services, Inc. (BRMS) as the Trust Administrator (page 11).
3. Effective January 1, 2010, when a serious illness or injury interrupts the ability of a student dependent from continuing to attend school, Federal law requires health plans to provide up to one year of continued coverage as though such dependent was still attending school (Michelle's Law) (page 27).
4. 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 28).
 - b. The Self-Funded Comprehensive Medical Plan implemented benefit changes in accordance with Federal law to provide parity with respect to financial requirements and treatment limitations between mental health or substance abuse disorder benefits and medical/surgical benefits (Mental Health Parity and Addiction Equity Act of 2008) (pages 53-54).
5. Effective January 1, 2011:
 - a. An adult child dependent who is not eligible for other employer-sponsored health plan coverage (other than the group health plan of a parent) is eligible for dependent coverage under the Trust to age 26 (page 22).

- b. The Student Self-Payment Program was terminated due to the extension of dependent coverage for adult children to age 26 and the removal of student certification as a requirement for continued dependent coverage.
 - c. The requirements of Michelle's Law no longer apply to this Plan due to the removal of student certification as a requirement for continued dependent coverage (page 27).
6. **SELF-FUNDED COMPREHENSIVE MEDICAL PLAN**
- a. Effective May 1, 2007, the Human Papilloma Virus (HPV) Quadrivalent vaccine is a covered immunization when the first dose is administered to an 11-12 year old girl, with the second or third dose administered prior to 13 years of age (page 38).
 - b. Effective September 1, 2007:
 - 1) The Meningococcal vaccine is a covered immunization for beneficiaries age 11 years and older. For younger beneficiaries who are at an increased risk due to immune compromise or other disorders, prior authorization is required (page 39).
 - 2) The Rotavirus vaccine is a covered immunization when the first dose is administered to an infant by 12 weeks of age and the remaining two doses are administered by 32 weeks of age (page 39).
 - c. Effective January 1, 2008, "Life Bed" services utilized in inpatient hospital care are covered, subject to prior authorization (page 42).
 - d. Effective September 1, 2008:
 - 1) The Screening by Low Dose Mammography benefit was revised to cover one mammogram every 12 months for women age 40 and older and to provide that a woman of any age with an increased risk of breast cancer is eligible for a mammogram upon a Physician's recommendation (page 44).
 - 2) The "If Hospitalized on Effective Date" section was revised to provide for coordination of benefits if you are confined in an inpatient facility on the day your coverage under this Plan begins (your effective date) and you had other insurance or coverage immediately prior to your effective date (page 60).
 - e. Effective January 1, 2009:
 - 1) Mental Illness and Drug or Alcohol Dependence benefits include coverage for services rendered by Licensed Mental Health Counselors and Marriage and Family Therapists (pages 53-54).
 - 2) Longs Drugs pharmacies statewide were added as participating medical providers for dispensing immunization vaccines ordered by physicians. When you pick up your immunization vaccine from a Longs Drugs pharmacy, your copayment is 20% of the Eligible Charge for the vaccine. If you obtain your immunization vaccine from a non-participating pharmacy, you must pay the entire cost of the vaccine at the time of purchase and submit a claim for reimbursement to HMA within 90 days. The Plan will reimburse you

80% of the Eligible Charge for the vaccine. Your portion of the cost will be 20% of the Eligible Charge plus any difference between the non-participating pharmacy's actual charge for the vaccine and the Eligible Charge.

- f. Effective August 1, 2009, the Human Papilloma Virus (HPV) Quadrivalent vaccine is a covered benefit for female beneficiaries 13 through 18 years of age at 50% of Eligible Charges (page 38).
- g. 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 53-54):
 - 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 (page 36).
- h. 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. This limitation applies to both participating and non-participating providers (page 63).
 - 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 36 and 63).
- i. Effective September 1, 2011:
 - 1) In accordance with the Patient Protection and Affordable Care Act:
 - a) The Lifetime Maximum limit on the dollar value of essential health benefits payable under the Self-Funded Comprehensive Medical Plan no longer applies (formerly \$2,000,000 per person) (page 30).
 - b) The Annual Maximum benefit amount available under the Self-Funded Comprehensive Medical Plan is \$750,000 per person per plan year (formerly \$400,000 per person per calendar year).
 - 2) The Annual Copayment Maximum will be based on plan year from September 1 to August 31 of the following year (formerly

based on calendar year) (page 31).

- 3) The Annual Deductible will be based on plan year from September 1 to August 31 of the following year (formerly based on calendar year) (page 31).
- j. 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 58).
- k. Effective September 1, 2012, the Annual Maximum benefit amount available under the Self-Funded Comprehensive Medical Plan is \$1,250,000 per person per plan year (formerly \$750,000 per person) (page 30).

7. INDEMNITY PRESCRIPTION DRUG PLAN

- a. Effective October 1, 2008, the Central Fill Program for long term (maintenance) prescriptions is no longer available through Times pharmacies. Central Fill prescriptions may be filled at designated Longs Drugs pharmacies on Oahu.
- b. Effective January 1, 2009, for beneficiaries residing on the islands of Hawaii, Maui and Kauai:
 - 1) The Central Fill Program for long term (maintenance) prescriptions is now available through designated Longs Drugs pharmacies. Your copayment for up to a 60-day supply is \$8.00 for generic drugs and \$24.00 for brand name drugs (page 68).
 - 2) You may obtain your short-term (acute) prescriptions through any participating pharmacy under the Point of Service Program. Your copayment for up to a 15-day supply is \$5.00 for generic drugs and \$15.00 for brand name drugs (page 67).
 - 3) Prescriptions will no longer be available for a 21-day or 30-day supply under the Point of Service Program. However, for pre-packaged prescription drugs that can only be dispensed in “unbreakable” packages (such as creams, ointments, or certain inhalers), the day supply limit shall be equivalent to the package size days supply, not to exceed a 30-day supply, and the applicable 15-day supply copayment will apply (page 67).
- c. Effective March 1, 2009, Safeway pharmacies were added as Central Fill and Point of Service Program pharmacies.
- d. 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 66).
- e. 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.
- f. Effective February 1, 2011, Foodland pharmacies were added as Central Fill and Point of Service Program pharmacies.
- g. Effective October 1, 2011:

- 1) A Step Therapy Program for Cholesterol Medications was implemented. The Step Therapy Program requires beneficiaries who are prescribed a brand name cholesterol medication that has a generic alternative to use the generic medication first. The Plan will only cover brand name cholesterol medications that have a generic alternative if the brand name medication is deemed medically necessary by your physician; however Prior Authorization is required (page 66).
 - 2) The Diabetic Sense Program was implemented. Beneficiaries who enroll in the Program receive free diabetic testing supplies, one glucometer per year, home delivery of diabetic testing supplies, and outreach by a Certified Diabetic Educator (page 66).
- h. Effective March 1, 2012:
- 1) You may obtain up to a 90-day supply under the Mail Order Program at the following copayments (page 69):
 - 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 Pharmicare, in addition to CVS Longs Mail Order and Walgreens Mail Order.
- i. 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 66).
- j. 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 67).

8. KAISER FOUNDATION HEALTH PLAN

- a. Effective September 1, 2011:
- 1) 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 71). The prescription drug benefits of the Self-Funded HMO Plan are administered by Catamaran (formerly Catalyst Rx) (page 91).
 - 2) 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.

9. VISION CARE PROGRAM

- a. Effective September 1, 2007, the Indemnity Vision Care allowances were increased.
- b. Effective March 1, 2011, the Indemnity Vision Care benefit program administered by HMA was replaced by the VSP Advantage Plan (page 95).

10. CHIROPPLAN HAWAII

- a. Effective January 1, 2008, chiropractic benefits are available to all active participants and their eligible dependents through ChiroPlan Hawaii (page 99).

11. HAWAII DENTAL SERVICE (HDS)

- a. Effective September 1, 2007, evidence based plan benefits were incorporated into the dental plan, as follows (pages 106-107):
 - 1) Bitewing x-rays are now covered twice per calendar year through age 14 and once per calendar year thereafter (previously covered twice per calendar year for all members).
 - 2) Full mouth x-rays are now covered once every five years (previously once every three years).
 - 3) Fluoride varnish is covered once per calendar year for patients at high risk of caries (previously not covered).
 - 4) Two additional cleanings (or periodontal maintenance) per calendar year for diabetic patients and one additional cleaning (or periodontal maintenance) per calendar year for expectant mothers are covered.
 - 5) Endosteal implants are covered as an alternate benefit to a 3-unit bridge under prosthodontic benefits. The plan benefit is limited to reimbursement of a 3-unit bridge.
- b. Effective July 1, 2008, the maximum benefit amount per calendar year increased from \$1,000 per person to \$1250 per person.
- c. Effective January 1, 2009, the maximum benefit amount per calendar year increased from \$1,250 per person to \$1500 per person (page 106).
- d. Effective September 1, 2011:
 - 1) Fluoride is covered twice per calendar year through age 17 (formerly once per calendar year) (page 106).
 - 2) The implant benefit is revised to no longer require an implant to be between two natural teeth.

12. GENTLE DENTAL

- a. Effective September 1, 2007, the office visit copayment increased from \$9.00 to \$10.00 per visit.
- b. Effective September 1, 2010, the Dental Laboratory charges applicable to members with less than 24 months of continuous enrollment in the Gentle Dental Plan, will increase 7% per year over the next two years.
- c. Effective September 1, 2012, the office visit copayment increased from \$10.00 to \$11.00 per visit (page 110).

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

Sincerely,
BOARD OF TRUSTEES

HAWAII TEAMSTERS HEALTH AND WELFARE TRUST

TRUST OFFICE

560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817
Telephone: (808) 523-0199
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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.

CONSULTANT

Benefit Plan Solutions, Inc.

LEGAL COUNSEL

Kawashima Law Group LLLC

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 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817
Phone: (808) 523-0199

Participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer is a sponsor of the plan and, if so, the sponsor's address.

IDENTIFICATION NUMBERS

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

TYPE OF PLAN

Welfare - medical, prescription drug, vision care, chiropractic, dental, and life insurance benefits.

TYPE OF ADMINISTRATION

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

AGENT FOR SERVICE OF LEGAL PROCESS

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

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

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

EMPLOYER TRUSTEES

Darrel Tajima
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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 Hawaii Teamsters Health and Welfare Trust is maintained pursuant to collective bargaining agreements between the Hawaii Teamsters and Allied Workers Union, Local 996 or the Cement, Quarry Workers, Ready Mix and Dump Truck Workers, Local 681 and various employers. The terms of these agreements vary in some respects as to eligibility requirements and benefits provided.

A copy of any applicable 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 out of which all plan benefits and expenses are paid are contributed by 1) employers who are parties to the collective bargaining agreements which require contributions to the Health and Welfare Trust, 2) the Union on behalf of their staff employees, 3) active participants (i.e., self-payments and COBRA payments), and 4) investment earnings. The amount of employer contributions is calculated by multiplying the contribution rate specified in the applicable collective bargaining agreement by the number of covered employees. The employer contributions may vary depending on the terms of the collective bargaining agreement. Employee contribution amounts for self-payments and COBRA payments are established annually by the Board of Trustees.

FUNDING MEDIUM

All contributions to the Health and Welfare Trust 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

To qualify for benefits, you must work in the Union Local 681 or 996 bargaining unit for employers who have a signed collective bargaining agreement, or for an employer who has entered into a written participation agreement with the Trust obligating the employer to contribute to the Hawaii Teamsters Health and Welfare Trust on your behalf at a monthly contribution established by the Board of Trustees.

ESTABLISHING ELIGIBILITY

You will be eligible for benefits on the first day of the calendar month following the month in which your employer makes the required contribution on your behalf. The actual date on which an employer is required to begin contributing for a new hire is dependent on the collective bargaining agreement between each employer and the respective union.

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

NOTE: The benefits which you are eligible for depend on your employer's collective bargaining agreement. The various benefits available under the Trust are as follows:

1. Medical
2. Prescription drug
3. Vision care
4. Chiropractic care
5. Dental
6. Life insurance

Some employees are covered for all of the above benefits while others are covered for only one or some of the benefits. If you are unsure of which benefits you are eligible for, contact the Trust Office.

CONTINUING ELIGIBILITY

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

IF YOU ARE DISABLED

If, while eligible for benefits, you become disabled and unable to work, your benefits may continue for up to six (6) months following the month in which your disability began, provided your employer continues to make the required contributions to the Trust on your behalf for at least three (3) months following the month in which you became disabled.

IN THE EVENT OF A STRIKE

If, while you are eligible for benefits a strike occurs, you will continue to be covered for benefits for the duration of the strike or for up to three (3) months following the month in which the strike began, whichever is shorter. If the strike continues beyond three (3) full months and you lose your eligibility, you will re-establish your eligibility on the first day of the calendar month following the month in which the strike ended.

IF YOU ENTER THE ARMED FORCES

When you enter the Armed Forces, coverage for you and your dependents will be continued until the end of the month for which the required employer contribution was last paid. After the end of that month, you may elect to continue coverage for yourself and your dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended in December 2004.

To continue coverage during a military leave of at least 31 days, you must self-pay an amount which is equal to 102% of the actual cost of the benefits chosen, as determined by the Board of Trustees. The maximum amount of time that coverage may be continued through self-payments is 24 months. Your coverage will continue until your discharge from military service or 24 months, whichever occurs first.

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Hawaii Teamsters Health and Welfare Trust has agreed to allow those contributing employers who are required to provide family and medical leave for their employees, pursuant to the Family and Medical Leave Act (FMLA) and/or applicable State law, to make contributions to the Trust to continue coverage for those employees while they are on family and medical leave. If your employer is required to provide family and medical leave and you are eligible, your coverage will continue under the Hawaii Teamsters Health and Welfare Trust provided your employer continues to make monthly contributions to the Trust on your behalf as established by the Board of Trustees.

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

LOSS OF ELIGIBILITY

You will continue to be eligible for benefits provided through the Hawaii Teamsters Health and Welfare Trust as long as your employer makes the required contributions to the Trust on your behalf. You will lose eligibility on the earliest of the following dates:

1. The last day of a calendar month for which your employer made the required contribution, or
2. The date this plan terminates.

NOTE: If your employer fails to make the required contributions on your behalf, your coverage will terminate on the first day of the calendar month following the month in which your employer fails to make the required contribution. Your coverage will be reinstated prospectively on the first day of the calendar month following the month in which your employer makes the required contribution.

HOW TO CONTINUE YOUR COVERAGE IF YOU LOSE ELIGIBILITY

If your eligibility for benefits terminates, you may continue your coverage by electing one of the following options:

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

Employee Self-Payment Program for Employees of Delinquent Employers

When you become ineligible for benefits as a result of your employer failing to make the required contribution, you can continue your coverage for medical and prescription drug benefits for up to six (6) consecutive months by making self-payments to the Trust. However, you must enroll in the Employee Self-Payment Program for Delinquent Employer Contributions within 30 days following notification of your ineligibility. After the six (6) months are up, you may elect to continue coverage under the COBRA Program if your employer continues to be delinquent.

The amount that you must pay each month under the Employee Self-Payment Program is based on the cost of the benefits as determined by the Board of Trustees, from time to time.

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

Contact the Trust Office if you wish to make a self-payment. The Trust Office can tell you the amount of your payment and explain the payment procedure.

COBRA Program

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

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

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

1. **“Qualified Beneficiary”**: Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
 - A child of the covered employee, who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO) during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
 - A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a “Qualified Beneficiary.” This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.
2. **“Qualifying Event”**: Qualifying Events are those shown in the chart on page 18. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, and, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan. If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under this Plan, (e.g. employee continues working even though entitled to Medicare) then COBRA is not available.

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

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

* Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become totally disabled within the meaning of Title II or Title XVI of the Social Security Act. This additional 11 months is available to employees and enrolled dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage.

** For a qualified Spouse or Dependent child whose continuation is due to an employee’s termination of employment or reduction in employment hours, the continuation period may be extended if another qualifying event occurs during the 18-month COBRA period. Coverage may be extended for up to 36 months from the date they first qualified.

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

Notices Related to COBRA Continuation Coverage

The Trust Office will determine the occurrence of a Qualifying Event in the event of your termination or reduction in hours. The Qualifying Event in these cases will be the date of your loss of coverage under the plan. Your employer

is responsible for notifying the Trust Office within 30 days in the event of your death, termination of employment, reduction in hours, or entitlement to Medicare benefits.

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

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

That written notice should be sent to the Trust Office located at 560 N. Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, phone (808) 523-0199 or 1 (866) 772-8989. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

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

Electing COBRA Continuation Coverage

When the Trust 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, your Spouse, and/or Dependent children will have 60 days after the date your coverage under the Trust terminates or the date the Trust Office sends notice to you, your Spouse, and/or Dependent children, whichever is later, in which to elect COBRA continuation coverage (the “election period”).

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

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

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

The COBRA Continuation Coverage that Will Be Provided

Under the COBRA Program, you may choose to be covered for only core benefits (medical and prescription drug), or core plus non-core benefits (medical, prescription drug, vision care, chiropractic care, and dental benefits),

based on your benefit eligibility at the time of your loss of coverage. 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 Continuation Coverage (the Cost of COBRA)

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

The first COBRA payment must be received by the 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 Trust through the date that COBRA election is made. Subsequent payments must be received by the Trust Office within 30 days after the first day of the period covered by the payment.

Addition of Newly Acquired Dependents

If, while you (the employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 30 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the Trust Office to add a dependent.

Loss of Other Group Health Plan Coverage

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

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll your Spouse or dependent within 30 days after the termination of the other coverage or within 60 days after the termination of coverage under Medicaid or CHIP in accordance with Federal law. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

End of COBRA

If COBRA is elected, the continued coverage will begin on the date that coverage under the Hawaii Teamsters Health and Welfare Trust 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 Hawaii Teamsters Health and Welfare Trust 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, everyone must complete (and keep current) a Trust enrollment form and all other applicable insurance carrier enrollment forms. It is important to remember that no premiums will be paid until these enrollment forms are completed and processed by the Trust Office.

If you have not done so already, you should complete the enrollment forms, listing your beneficiary and all of your eligible dependents. If you are married, you must submit a certified copy of your marriage certificate and spouse's birth certificate. If you have dependent children, you must submit a certified copy of each child's birth certificate or adoption papers, if applicable.

Newly hired employees and employees of employers who have just signed the Collective Bargaining Agreement should obtain their enrollment forms from their employer or the Trust Office. After completing the enrollment forms, return them to the Trust Office. The Trust Office will process the enrollment forms and retain the Trust enrollment form for its records.

It is important to keep the Trust Office informed of any change in your personal or family situation, or mailing address. You must notify the Trust Office, in writing, and submit the proper documentation when required, if:

- You change your address or telephone number,
- You get married, divorced, or widowed,
- You want to add a new dependent such as a new baby or an adopted child,
- You become disabled.

ELIGIBLE DEPENDENTS

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

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

1. To add a spouse, you must submit proper documentation, in writing, to the Trust Office within 30 days from the date of marriage. If you do not notify the Trust Office within this 30-day period, you must wait until the next open enrollment period to add your spouse.
2. To add a newborn child as a dependent, you must notify the Trust Office within 30 days from the date of birth. You may call the Trust Office to notify them of the birth. Your telephone call will be documented as initial notification to the Trust and coverage will become effective on the newborn's date of birth *provided* you submit the proper documentation, to include a completed enrollment form and copy of the birth certificate,

to the Trust Office. If you do not notify the Trust Office within this 30-day period, coverage will become effective on the first day of the month following the month in which you provided the Trust Office with proper notification and documentation.

3. To add a dependent child other than a newborn, you must submit proper documentation, in writing, to the Trust Office within 30 days from the date of adoption or placement for adoption, or the date on which you were granted legal guardianship or custody of the child. 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 dependent child.

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

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

A former spouse who loses eligibility upon divorce or legal separation, or a child who ceases to be eligible for dependent coverage under the Trust, may continue coverage by electing and making payments under the COBRA program.

Restrictions on Eligibility of Dependents

1. An eligible person may be covered either as an employee, or as a dependent of an employee, but not both.
2. If both parents are covered as employees under the Hawaii Teamsters Health and Welfare Trust, either parent (but not both) may cover the children as dependents.

SPECIAL ENROLLMENT PERIODS

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

1. If you initially declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards the other health plan coverage. However, you must request enrollment within 30 days after coverage under the other health plan ends (or after the employer stops contributing toward the other coverage).
2. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and/or your dependents in this plan. However, you must request enrollment within 30 days after the date of marriage, birth, adoption, or placement for adoption.
3. If you and/or your dependent's Medicaid or State Children's Health Insurance Program (CHIP) coverage is terminated due to loss of eligibility, or if you and/or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, you may enroll yourself and/or your dependents in this plan. However, you must request enrollment within 60 days of such event.

To request special enrollment or obtain more information, contact the Hawaii Teamsters Health and Welfare Trust Office.

If you fail to enroll during this special enrollment period, coverage for yourself and/or your dependents will not be effective until the next open enrollment period following the date of notification to the Trust.

Exception: In the case of a newborn child, if you do not request enrollment within this special enrollment period, coverage will become effective on the first day of the month following the month in which you notify the Trust Office and submit the required documentation in accordance with Plan rules.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Hawaii Teamsters Health and Welfare Trust is required to provide benefits in accordance with the requirements of a qualified medical child support order. A qualified medical child support order is a judgment, decree, or order issued by a court of competent jurisdiction or an administrative agency that requires a group health plan to provide coverage to the child(ren) of a plan participant pursuant to a state domestic relations law, and which the Plan Administrator determines is qualified under the terms of ERISA and applicable state law.

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

1. The name and last known address of the participant and each affected child (except that the mailing address of a state official may be substitut-

- ed for that of a child);
2. A reasonable description of the type of coverage to be provided to the child, or the manner in which coverage is to be determined; and
 3. The period for which coverage must be provided.

Additionally, an order is “qualified” only if it does not require the Trust to provide any type or form of benefit, or any option not otherwise provided by the Trust (except to the extent necessary to meet the requirements of state law).

All medical child support orders shall be delivered to the Administrator of the Hawaii Teamsters Health and Welfare Trust. When the medical child support order is received, the Trust will determine whether or not the order meets the criteria to be considered a qualified medical child support order and notify the participant and alternate recipient(s) of such determination. An alternate recipient is any child of a participant who is recognized under a medical child support order as having a right to enrollment in the Trust.

If a medical child support order is determined to be “qualified,” each alternate recipient named in the order who is not already enrolled in the Trust will be enrolled in the Trust. The alternate recipient’s benefit options will be as specified in the order or, if no options are specified in the order, as selected by the participant.

For further information on medical child support orders, contact the Hawaii Teamsters Health and Welfare Trust Office.

MEDICAL BENEFITS

CHOICE OF PLANS

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.

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

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

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 days, or
2. You meet one of the requirements specified in the Special Enrollment Periods section.

HOW TO SECURE BENEFITS

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

You should have your membership card available whenever you schedule or seek medical care. If you do not have your membership card, 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. You should also 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

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

An employee covered under a group plan will receive a certificate of creditable coverage issued by the insurance carrier or plan whenever a cancellation of coverage occurs. This certificate acknowledges “credit” for time covered under the health plan. The credit will be applied toward any exclusion period for a pre-existing condition which may be required under some individual and out-of-state plans. The term “pre-existing condition” is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within six (6) months of enrolling in a new plan.

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, 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 (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, the Self-Funded Comprehensive Medical Plan and Self-Funded HMO Plan provide coverage for the following services in connection with a covered mastectomy:

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

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.

MICHELLE'S LAW

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

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

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, and the Self-Funded HMO 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. 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

Telephone: (808) 951-4621

Toll Free: 1 (866) 377-3977

Website: www.teamsters-hma.com

E-mail: 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 carry-over 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 33).

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 33).

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 these cases, HMA's Medical Consultants, who are qualified practicing physicians, will recommend the Eligible Charge by comparing the complexity of the infrequent service with similar, frequent services 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:

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

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 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.

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	<ul style="list-style-type: none"> • All inpatient admissions including acute, skilled and observation days
OUTPATIENT SERVICES	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Physical Therapy • Speech Therapy • Occupational Therapy
OTHER MEDICAL SERVICES	<ul style="list-style-type: none"> • Durable Medical Equipment (DME) • Hospice Care • Home Health Services • Infusion Therapy • Human Growth Hormone Therapy • Dialysis • Chemotherapy • Radiation Therapy • Orthotics and Prosthetics

MENTAL HEALTH / SUBSTANCE ABUSE SERVICES	<ul style="list-style-type: none"> • Mental Health Services – treatment plan required • Substance Abuse Services – treatment plan required
OUT-OF-STATE SERVICES	<ul style="list-style-type: none"> • All non-emergency inpatient admissions, services, or procedures
INTER-ISLAND TRAVEL BENEFIT (Available only to beneficiaries who do not reside on Oahu)	<ul style="list-style-type: none"> • Inter-island travel to obtain non-emergency medically necessary services which are not available on the island where the beneficiary resides
For emergency or maternity admissions, you must notify the HMA Health Services Department within 48 hours or by the next business day.	

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 and your physician, HMA’s Health Services Department will determine whether or not a second surgical opinion is required. If a second surgical opinion is required and arranged by HMA, the Plan will cover 100% of 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>Physician Visits 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>Well-Baby Care Visits Eight visits during the first two years of a child's life, and one visit each year during ages two, three, four, and five. Well-baby immunizations are covered under Immunizations below. Well-baby routine laboratory tests are covered under Outpatient Laboratory and X-ray Services.</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>Immunizations Cholera, diphtheria, hepatitis, influenza, measles, rubella, mumps, whooping cough, polio, smallpox, tetanus, typhoid, typhus, chicken pox, human papilloma virus, meningococcal, rotavirus and streptococcus pneumonia. See Special Notes for coverage limitations.</p>	<p>You owe a copayment of 20% of Eligible Charges (You owe a copayment of 10% of Eligible Charges for well-baby immunizations)</p>	<p>You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges</p>
<p>Hospital Visit 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>

PHYSICIAN SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Skilled Nursing Facility Visit One per day during an inpatient confinement, up to 120 visits per calendar year	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
Consultation Visit Medical or surgical, one visit per confinement in a hospital or skilled nursing facility as medically necessary and approved by HMA	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
Surgery 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
Anesthesiology Services 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

Well-Baby Visits

- When a well-baby visit cannot be scheduled within the designated benefit period, the visit may be covered if rendered within 30 days of the benefit period, as long as the total number of well-baby visits allowed is not exceeded.

Immunizations

- The Human Papilloma Virus (HPV) quadrivalent vaccine is covered when the first dose is administered to an 11-12 year old female beneficiary with the second or third dose administered prior to 13 years of age. Coverage is provided at 50% of the Eligible Charge for services of a participating or non-participating provider when the vaccine is administered to a 13 through 18 year old female beneficiary.

- The Meningococcal vaccine is covered for beneficiaries from the age of 11 years. Prior authorization is required for beneficiaries younger than 11 years of age who are at increased risk due to immune compromise or other disorders.
- The Rotavirus vaccine is covered when the first dose is administered to an infant by 12 weeks of age and the remaining 2 doses of the vaccine are administered by 32 weeks of age.

Surgery

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

Reconstructive Surgery

- The Plan will pay benefits for reconstructive surgery only when it is required to restore, reconstruct, and correct any bodily function that was lost, impaired, or damaged as a result of an illness or injury.
- Reconstructive surgery for congenital anomalies (i.e., defects present from birth) is payable only when the defect severely impairs or impedes normal, essential bodily functions and is medically necessary. (Note: This benefit is available for active employees and their dependents only.)
- Reconstructive surgery of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications in all stages of the mastectomy, including lymphedemas, are covered when medically necessary.

Oral Surgery

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

- Physician benefits are available for certain oral surgical services provided by a physician or a dentist. Services of a dentist are covered only when: a) the dentist is performing emergency services or surgical services and b) these services could also be performed by physicians (M.D. or D.O.).
- The Plan does not pay for dental services that are generally done only by dentists and not by physicians. Regardless of the symptoms or illness being treated, services such as orthodontia, dental splints and other dental appliances, dental prostheses, osseointegration and all related services, removal of impacted teeth and any other 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		
Room & Care 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
Intermediate Care and Isolation Unit	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
Intensive Care or Coronary Care Unit Operated according to standards acceptable to the Trust	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
Ancillary Inpatient Services Operating room, surgical supplies, drugs, dressings, hospital anesthesia services and supplies, oxygen, antibiotics, blood transfusion services	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges

HOSPITAL INPATIENT SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Laboratory and X-ray Services		
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 for a member being treated for mental illness are covered under Mental Illness or Alcohol or Drug Dependence Services and are subject to the limitations specified in that section.

OUTPATIENT LABORATORY AND X-RAY SERVICES

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

OUTPATIENT LABORATORY AND X-RAY SERVICES SPECIAL NOTES

- Laboratory tests in connection with well-baby care visits are limited to the following tests through age five: two tuberculin tests (tine or skin sensitivity), two blood tests (hemoglobin or hematocrit) and one urinalysis.
- Screening by low-dose mammography is limited to one baseline mammogram 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.		
Room & Care 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
Inpatient Services 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
Laboratory and X-ray Services	For participating providers whose laboratory and X-ray services are not included in a single, all-inclusive amount per day, this Plan 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
Other Laboratory and X-ray Services	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 which 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

HOSPICE CARE SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
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
Emergency Room Use	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
Automobile Ambulance	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
Air Ambulance 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
Physician Services 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
Surgery for Complications of Pregnancy Including ectopic pregnancy	See Physician Services for benefits	See Physician Services for benefits
Nurse-Midwife Services	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
Hospital Services Hospital Services shall count against the 365-day maximum for hospital benefits	See Hospital Inpatient Services for benefits	See Hospital Inpatient Services for benefits
Birthing Center Services	You owe no copayment	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges

MATERNITY SERVICES

MATERNITY SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
<p>In Vitro Fertilization 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)</p>		
Inpatient Hospital Services	See Hospital Inpatient Services for benefits	See Hospital Inpatient Services for benefits
Physician Services	See Physician Services for benefits	See Physician Services for benefits
Laboratory and X-ray Services	See Outpatient Laboratory and X-ray Services for benefits	See Outpatient Laboratory and X-ray Services for benefits
Prescription Drugs	See Indemnity Prescription Drug section for benefits	See Indemnity Prescription Drug section for benefits

MATERNITY SERVICES SPECIAL NOTES

- 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.

Nurse-Midwife Services

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

Birthing Center Services

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

Newborn Child

- Hospital and physician benefits are available for in-hospital, routine nursery care of a newborn.
- In order for a newborn child to be eligible for benefits from the date of birth for illness, injury, premature birth care, or birth defect, you must enroll this child as a dependent within 30 days of birth.
- 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
INPATIENT		
Hospital and Facility Services 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
Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor and Marriage and Family Therapist Services 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
OUTPATIENT		
Outpatient Facility, Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor and Marriage and Family Therapist 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
PSYCHOLOGICAL TESTING	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>Allergy Testing and Treatment Materials 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>Appliances and Durable Medical Equipment</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>Blood, Blood Products and Blood Bank Service Charges Cost of blood and blood products except when donated, and blood bank service charges. Any additional charges for autologous blood (reserved for the person who donated the blood) are excluded as a benefit</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>Chemotherapy 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>Dialysis and Supplies</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>

OTHER MEDICAL SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Evaluations for the Use of Hearing Aids	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
Outpatient Injections 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
Physical Therapy 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
Speech Therapy 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
Transplant Donor Services 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; and
 - 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.
- When the beneficiary seeking inter-island travel benefits is a minor Child under 18 years of age, the Plan will also reimburse qualified travel expenses for one accompanying parent or guardian up to the benefit limitation.

EXCLUSIONS AND LIMITATIONS

No benefits 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 bodily 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 well-baby care and the screening services provided under Outpatient Laboratory and X-ray Services
- Services which are or may be covered by Worker's 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 tax
- Services not described as covered in this booklet or in the Self-Funded Comprehensive Medical Plan document

IF HOSPITALIZED ON THE 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 family member. The Plan’s determination is based on guidelines provided by the National Association of Insurance Commissioners (NAIC).

The following is a chart to assist in determining which plan is primary for different family members:

<u>Patient</u>	<u>Employee’s Plan</u>	<u>Spouse’s Plan</u>
Employee	Primary	Secondary
Employee’s Spouse	Secondary	Primary
Dependent Children*		
Employee’s Birthday is earlier in Calendar Year	Primary	Secondary
Spouse’s Birthday is earlier in Calendar Year	Secondary	Primary

* For dependent children, the Plan uses the “birthday rule” to determine which plan pays first. The birthday rule provides that the plan of the parent whose birthday is earlier in the calendar year is primary. For example, if the Employee’s birthday is in January and the Spouse’s birthday is in March, the Employee’s plan is the primary plan. If both parents have the same birthday, the plan of the parent who has had coverage for the longest period of time will be considered the primary plan.

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.

Where an employee or dependent is covered by both Medicare and this Plan, applicable Federal statutes will determine which plan is primary.

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. 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 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 an injury or illness is, or may have been caused, by a third party and you have a right or assert a right to recover damages from that third party or your own insurance company, the Plan is not liable for benefits in connection with services rendered for such injury or illness. However, upon the execution and delivery to the Trust 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 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 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 the physician, hospital and HMA have your correct mailing address.
- Ask your physician or hospital to file a claim directly on your behalf.

All claims must be filed within one (1) year after the date of service.

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 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 only and is only a summary of coverage. Its contents are subject to the provisions of the Self-Funded Comprehensive Medical Plan Document and all amendments thereto. 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 following prescription drug benefits are available to you and your eligible dependents if all of the following statements are true:

1. You are covered for medical benefits through the Hawaii Teamsters Health and Welfare Trust.
2. Your employer's collective bargaining agreement requires an additional contribution to provide the prescription drug benefit.
3. You have selected the Self-Funded Comprehensive Medical Plan for your medical coverage.

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

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

DRUGS COVERED

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

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

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

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

Under the Indemnity Prescription Drug Plan, you have four (4) options for obtaining covered prescription drugs:

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

To obtain services through the Point of Service and Central Fill Programs, you must use participating or designated pharmacies and present your 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. If you have any questions about how to use these programs, please contact the Pharmacy Benefits Manager at 1 (888) 869-4600.

A brief description of each program is outlined below.

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

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

	Participating Pharmacy
Generic Drugs, Insulin, Diabetic Supplies	\$ 5.00 copayment
Brand Name Drugs	\$15.00 copayment*
Days Supply Limit**	Up to 15 days

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

** For prescription drugs that can only be dispensed in “unbreakable” packages (e.g. creams, ointments, certain inhalers), the days supply limit shall be equivalent to the package size days supply, not to exceed a 30-day supply, with 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) <u>15-Day Supply</u>
Generic Drugs, Insulin, Diabetic Supplies	\$ 5.00 copayment
Brand Name Drugs	\$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) <u>60-Day Supply</u>
Generic Drugs, Insulin, Diabetic Supplies	\$ 8.00 copayment
Brand Name Drugs	\$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 copayments listed below:

	<u>90-day Supply Limit*</u>
Generic Drugs, Insulin, Diabetic Supplies	\$ 8.00 copayment
Brand Name Drugs	\$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:

	<u>30-day Supply Limit</u>
Generic Drugs, Insulin, Diabetic Supplies	100% of the Eligible Charge or the cost of the prescription, whichever is less
Non-Substitutable Brand Name Drugs	80% of the Eligible Charge or the cost of the prescription, whichever is less
Substitutable Brand Name Drugs	75% of the Eligible Charge or the cost of the prescription, whichever is less

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 though it is more than a 30-day supply.

How to File a Direct Member Reimbursement Program Claim:

Claim forms are available from the Pharmacy Benefits Manager. A completed claim form, together with your receipts, must be submitted to the Pharmacy Benefits Manager within 90 days from the date you purchased the drug. Payment will be made directly to you. Any claims received by the Pharmacy Benefits Manager more than 90 days after the purchase date 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 sensitivity.
- Contraceptives, except oral contraceptives 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.

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

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
E-mail: 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.

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, recom-

mend, 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 condition 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

SERVICES	MEMBER CHARGES
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MEDICAL SERVICES

Doctors’ and other health professionals’ office visits	\$14.00 per visit
Preventive Care	
Well Child office visits (8 routine visits from birth to age 2)	No charge
Preventive Care office visits (Age 2 and older), 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
• Routine Pap smear, one per calendar year	
• Screening by low dose mammography	
– One baseline mammogram during ages 35 through 39	
– One screening mammogram every 12 months beginning at age 40	
– 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	
Inpatient services.....	No charge <i>(Included as part of Hospital Services)</i>

SERVICES**MEMBER CHARGES**

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
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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
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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
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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 from the date of birth for routine nursery care, circumcision, premature birth care, illness, injury, or birth defect if the Child is enrolled as a Beneficiary with the Trust within 30 days after birth.

Doctors' services for routine obstetrical care (prenatal visits, delivery, and postpartum visit) after confirmation of pregnancyNo 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 Fertilization20% 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)

SERVICES**MEMBER CHARGES**

**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 requiredNo Charge

(Office visit copayment applies)

Dialysis and Supplies (Outpatient)10% of Eligible Charges

Diabetes equipment and related supplies30% of Eligible Charges

Appliances and Durable Medical Equipment20% of Eligible Charges

(\$500 allowance for Hearing Aids)

Implanted internal prosthetics, devices and aidsNo Charge

Medical Foods for inborn metabolic disorders20% of Eligible Charges

Outpatient Injections and Intravenous administration

of medication or of nutrient solutions required for

primary diet when skilled administration is requiredNo Charge

(Office visit copayment applies)

Outpatient Physical Therapy, Occupational Therapy,

and Speech Therapy\$14.00 per visit

Transplant Donor Services10% 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.
- When the member seeking inter-island travel benefits is a minor Child under 18 years of age, the Plan will also reimburse qualified travel expenses for one accompanying parent or guardian up to the benefit limitation.

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 Waianuenue 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. For a child who is covered by both parents, the plan of the parent whose birthday occurs earlier in the calendar year is primary. For example, if the employee's birthday is in January and the spouse's birthday is in March, the employee's plan is the primary plan. If both parents have the same birthday, the plan of the parent who has had coverage for the longest period of time will be considered the primary plan. **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 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 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

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.) 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.

VISION CARE BENEFITS

You and your eligible dependents will be eligible for vision care benefits if:

1. You are covered for medical benefits through the Hawaii Teamsters Health and Welfare Trust, and
2. Your employer's collective bargaining agreement requires an additional contribution to provide for the vision care benefit.

If you are eligible for vision care benefits, you will be covered 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>
COPAYMENT: \$10.00 total (exam, lenses, and/or frame)		
EYE EXAMINATION Optometrist (O.D.) or Ophthalmologist (M.D.)	100% after copayment	Up to \$ 45.00
APPLIANCES 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, 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.

CHIROPRACTIC BENEFITS



A Chiropractic Managed Care Network

All active employees and their eligible dependents are eligible for chiropractic benefits provided through ChiroPlan Hawaii Inc.

WHAT ARE THE BENEFITS?

The following chiropractic services are covered:

SERVICE	PLAN PAYS
Office Visits (includes evaluation, exam, manipulations, and therapy modalities), up to 24 visits per calendar year	
• Initial Office Visit (First visit)	100% after \$20.00 copayment per visit
• Follow-up Office Visit	100% after \$15.00 copayment per visit
X-rays – limited to one (1) series of film per body region per calendar year	Up to \$100 per calendar year

Benefits are available only if services are received from a ChiroPlan Hawaii network provider. Chiropractic services must be therapeutically necessary, as determined by ChiroPlan Hawaii, in order to be covered. Preventive or maintenance care is not covered under the Plan.

HOW DO I USE THE PLAN?

1. To schedule an appointment, contact a ChiroPlan Hawaii provider of your choice and identify yourself as a member of the Hawaii Teamsters Health & Welfare Trust. A referral from a medical doctor is not required.
2. When you receive services from a ChiroPlan Hawaii network provider, you pay the provider a \$20.00 copayment for the first office visit and a \$15.00 copayment for follow-up office visits. Up to 24 visits per calendar year are covered by the plan. No copayment is required for covered X-rays. The plan will pay up to the maximum allowed for covered X-rays.
3. If you require services in excess of the calendar year limits described above, you will be charged according to the provider's usual and customary fees for the services.

HOW DO I CONTACT CHIROPPLAN?

For assistance in finding a ChiroPlan Hawaii provider in your area, contact the ChiroPlan Hawaii office on Oahu at 621-4774, or from the neighbor islands, call toll free at 1 (800) 414-8845. You may also visit their website at www.chiroplanhawaii.com to obtain a provider listing and additional information on ChiroPlan providers.

The preceding chiropractic benefits are insured under an insurance contract issued by ChiroPlan Hawaii, Inc., 711 Kilani Avenue, Room 4, Wahiawa, Hawaii 96786. The services provided by ChiroPlan Hawaii, Inc. include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes and is only a summary of coverage. Its contents are subject to provisions of the Group Agreement for Chiropractic Benefits 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.

DENTAL BENEFITS

All employees and their eligible dependents are eligible for dental benefits.

CHOICE OF PLANS

Employees may choose either the Hawaii Dental Service (HDS) fee for service dental plan or a prepaid dental plan offered through Gentle Dental (available only on Oahu and in Kona). The main benefit provisions of the HDS and Gentle Dental plans are summarized on the following pages. The principal difference between the two plans is that under the HDS Plan, you may select any dentist, however, only a percentage of your expenses may be covered. If you select the Gentle Dental Plan, you must use one of the Gentle Dental clinic facilities, however, your out-of-pocket expenses are limited to an \$11.00 office visit charge and laboratory costs, if necessary.

OPEN ENROLLMENT PERIOD

You may change dental plans during the annual open enrollment period. If you wish to change plans, contact the Trust Office during the month of July of any year. The change will become effective September 1st. No change between dental plans may be made at any other time unless you meet one of the requirements specified in the Special Enrollment Periods section.



GETTING STARTED

REGISTER FOR ONLINE MEMBER INFORMATION

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

To register:

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

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

EFFECTIVE DATE OF ELIGIBILITY

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

- At your first appointment, let your dental office know that you are covered by HDS and present your HDS membership card.

- If you need dental services immediately after your effective date of dental coverage but have not received your HDS membership card, you may print or request a card through the HDS website at www.deltadentalhi.org or you may ask your dentist to confirm your eligibility with HDS prior to receiving services.

SPOUSE AND/OR DEPENDENT COVERAGE

Your eligible dependents are those that are described under the General Information section under “ELIGIBLE DEPENDENTS”.

UPDATING INFORMATION

To ensure that you and your family receive the full benefits of your plan and to ensure HDS processes your dental claims accurately, please notify the Hawaii Teamsters Health and Welfare Trust Office immediately of any of the following:

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

COMPLETION OF PROCEDURES WHEN ELIGIBILITY ENDS

If a dental procedure is in progress when your eligibility ends, coverage for services in progress may continue for a maximum of 30 days following the date your eligibility ends.

However, HDS shall determine the applicable Plan Benefit for dental work within 30 days of the termination of eligibility or Contract Agreement cancellation, as long as the specific dental procedure has been started before the date of ineligibility or Contract Agreement cancellation.

SELECTING A DENTIST

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

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

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

ON THE MAINLAND – CHOOSE A DELTA DENTAL PARTICIPATING DENTIST

HDS is a member of the Delta Dental Plans Association (DDPA), the nation’s largest and most experienced dental benefits carrier with a network of more than 236,500 dentist locations.

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

For a list of Delta Dental participating dentists, visit the HDS website at www.deltadentalhi.org and click on “Members/Find a Participating Dentist.” Click on the link at the bottom of the page to search for a Mainland dentist. Select “Delta Dental Premier” as your plan type. Or you may call the HDS Customer Service Department.

VISITING A DELTA DENTAL PARTICIPATING DENTIST

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

VISITING A NON-PARTICIPATING DENTIST

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

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

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

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

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

Explanation of Benefits (EOB) report.

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

HELPING YOU MANAGE YOUR COSTS

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

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

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

HDS REPORTS AND PAYMENTS

EXPLANATION OF BENEFITS (EOB) REPORT

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

You can receive EOBs through the mail or electronically. If you receive EOBs through the mail, you will not receive an EOB for services with no patient share or when only tax is due.

To receive EOBs electronically, register as a user on the HDS website at www.deltadentalhi.org. Select "New User" and complete the "Member Registration" form. If you are already a registered user, login and select "Edit My Profile", then select "Yes" under "Request Electronic EOB".

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

CALCULATING YOUR BENEFIT PAYMENTS

Determining the amount you should pay your HDS participating dentist is based on a simple formula (see box to the right). HDS will pay the "% Plan Covers" amount. You are responsible for the balance owed to your dentist, which includes the Approved Amount (the maximum amount that the member is responsible for), any applicable deductible amounts, and taxes, less the HDS payment. Participating dentists are paid based upon their Allowed Amount (the amount to which the benefit percentage is applied to calculate the HDS payment).

Dentist's Allowed Amount X % plan covers
<hr/>
HDS Payment
Dentist's Allowed Amount <minus HDS Payment>
<hr/>
Patient share

QUESTIONS ON YOUR CLAIMS

If you have questions or concerns about your dental claims, please call the HDS Customer Service Department at 529-9248 on Oahu or toll free at 1-800-232-2533, extension 248.

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

DUAL COVERAGE/COORDINATION OF BENEFITS

- Please be sure to let your dentist know if you are covered by any other dental benefits plan(s).
- When you are covered by more than one dental benefits plan, the amount paid will be coordinated with the other insurance carrier(s) in accordance with guidelines and rules of the National Association of Insurance Commissioners. Total payments or reimbursements will not exceed the participating dentist's Allowed Amount when HDS serves as the second plan.
- There is a limit on the number of times certain covered procedures will be paid and payment will not be made beyond these plan limits.
- Coverage of identical procedures will not be combined in cases where there are multiple plans. For example, if you have two plans and each includes two cleanings during each calendar year, your benefits will cover two cleanings (not four) in each calendar year.

FRAUD AND ABUSE PROGRAM

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

CONFIDENTIAL FRAUD HOTLINE

From Oahu: (808) 529-9277

Toll Free: 1-800-505-9277

E-mail: [*HDSCompliance@hdsonline.org*](mailto:HDSCompliance@hdsonline.org)

SUMMARY OF DENTAL BENEFITS

BENEFIT	PLAN COVERS
PLAN MAXIMUM (per member per calendar year)	\$1,500
DIAGNOSTIC	
• Examinations – once per calendar year	100%
• Bitewing x-rays	100%
– Twice per calendar year through age 14	
– Once per calendar year thereafter	
• Other x-rays – (full mouth limited to once every five years)	100%
PREVENTIVE	
• Cleanings – twice per calendar year	100%
– Expectant mothers – cleanings or periodontal maintenance* three times per calendar year	
– Diabetic patients – cleanings or periodontal maintenance* four times per calendar year	
* Periodontal maintenance benefit level	*80%
• Fluoride –twice per calendar year (through age 17)	100%
• Fluoride varnish – once per calendar year (limited to patients who are at high risk of caries due to root exposure, dry mouth syndrome, history of radiation therapy, or other conditions documented by the dentist)	100%
• Space maintainers (through age 17)	80%
• Sealants (through age 18) – one treatment application, once per lifetime only to permanent posterior molar and bicuspid teeth with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.....	80%
RESTORATIVE	80%
• Amalgam (silver-colored) fillings	
• Composite (white-colored) fillings – limited to the anterior (front) teeth	
• Crowns and gold restorations (once every five years when teeth cannot be restored with amalgam or composite fillings)	
NOTE: Composite (white) and Porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	
ENDODONTICS	80%
• Pulpal therapy	
• Root canal treatment, retreatment, apexification, apicoectomy	

BENEFIT**PLAN COVERS**

PERIODONTICS	80%
<ul style="list-style-type: none">• Periodontal scaling and root planing – once every two years• Gingivectomy, flap curettage, and osseous surgery – once every three years• Periodontal Maintenance – twice per calendar year after qualifying periodontal treatment	
PROSTHODONTICS	80%
<ul style="list-style-type: none">• Fixed bridges (ages 16 and older) – once every five years• Dentures (complete and partial – ages 16 and older) – once every five years• Implants (covered as an alternate benefit)	
ORAL SURGERY	80%
ADJUNCTIVE GENERAL SERVICES	80%
<ul style="list-style-type: none">• Palliative treatment (for relief of pain but not to cure)	

BENEFIT EXCLUSIONS

The following are general exclusions not covered by the plan:

- Services for injuries and conditions that are covered under Workers' Compensation or Employer's Liability Laws; services provided by any federal or state government agency or those provided without cost to the eligible person by the government or any agency or instrumentality of the government.
- Congenital malformations, medically related problems, cosmetic surgery or dentistry for cosmetic reasons.
- Procedures, appliances or restorations other than those for replacement of structure loss from cavities that are necessary to alter, restore or maintain occlusion.
- Treatment of disturbances of the temporomandibular joint (TMJ).
- Orthodontic services.
- Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to a patient by a dentist.
- All transportation costs such as airline, taxi cab, rental car and public transportation.
- Other exclusions are listed in the Schedule of Benefits, which is included in the Hawaii Teamsters Health and Welfare Trust dental contract.

ACCESS TO HDS INFORMATION 24/7

Visit HDS Online at www.deltadentalhi.org to:

CHECK

- Whether you and/or your dependents are eligible for HDS benefits
- What services are covered by your plan
- What the limits are of each type of covered service and how much you have used

SEARCH

- For an HDS participating dentist by specialty, location, handicap accessibility, weekend hours, and more
- For a Delta Dental participating dentist on the Mainland, Guam or Saipan

VIEW

- Your own tooth chart – see what services have been performed on each tooth
- Your EOB statements (and print them out)
- A list of frequently asked questions
- HDS contact information

DOWNLOAD & PRINT

- A summary of your benefits for tax purposes
- Blank claim forms
- An HDS membership card
- HDS Notice of Privacy Practices

REQUEST

- To receive an e-mail when your claim is processed
- To receive EOB statements through e-mail
- An HDS membership card to be mailed to you

VISIT HDS DENTEL

From Oahu: 545-7711

Toll free: 1-800-272-7204

HDS DenTel is an automated phone service that allows HDS members to:

- Find out when they are eligible for coverage for their next dental visit
- Obtain claims information
- Have a summary of their plan benefits faxed or mailed to them; simply by following the prompts on the phone.

HOW TO CONTACT HDS

CUSTOMER SERVICE REPRESENTATIVES

From Oahu: 529-9248

Toll free: 1-800-232-2533, ext. 248

Fax: 529-9366

Toll-free Fax: 1-866-590-7988

Monday through Friday

7:30 a.m. - 4:30 p.m.

Hawaii Standard Time

SEND WRITTEN CORRESPONDENCE TO:

Hawaii Dental Service

Attn: Customer Service

700 Bishop Street, Suite 700

Honolulu, Hawaii 96813-4196

E-mail: *HDSCustomerService@hdsonline.org*

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

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

GENTLE DENTAL

(Formerly Dental Care Centers of Hawaii)

WHAT IS THE GENTLE DENTAL PROGRAM?

It is a prepaid dental coverage program designed and provided by the same health care professionals delivering your dental care. Who else is better qualified to understand your needs more than your dentist? The only charge is \$11.00 per office visit (administrative fee) and laboratory costs, if necessary.

HOW DOES THE PROGRAM WORK?

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

CHOOSING YOUR OWN PERSONAL DENTIST

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

IS THERE A PREAUTHORIZED WAITING PERIOD?

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

MAJOR BENEFITS AND COVERED SERVICES:

SERVICES	MEMBER COPAYMENT
Diagnostic	
Office visits.....	\$11.00 per visit
Oral examinations	No charge
Full mouth x-ray	No charge
Panorgraphic x-ray	No charge
Each additional film	No charge
Emergency treatment	No charge
Prophylaxis (teeth cleaning)	
Regular cleaning (semi-annual)	No charge
Topical fluoride	No charge
Scaling and polishing	No charge
Restorative Dentistry (amalgam fillings)	
Cavities involving one surface.....	No charge
Cavities involving two surfaces	No charge
Cavities involving three surfaces	No charge

Endodontics

Root canals	No charge
Pulp capping	No charge
Pulpotomy	No charge

Oral Surgery

Simple extractions	No charge
Surgical	No charge
Third molars/wisdom teeth	No charge

Periodontics (gum treatment)

Emergency treatment	No charge
Scaling and Curettage	No charge
Periodontal surgery	No charge

Crown and Bridge*

¾ or full metal cast crown	No charge
Porcelain fused to metal crown (molars not included)	No charge
Stainless steel crown	No charge
Space maintainers	No charge

Removable Prosthodontics (partials and dentures)*

Complete upper denture	No charge
Complete lower denture	No charge
Partial denture	No charge
Relines	No charge
Denture adjustment after six months of delivery	No charge
Denture repairs	No charge

Orthodontics (braces)

The plan covers 24 months of usual and customary treatment for your family at predetermined rates.

* **Dental Laboratory** – Dental laboratory charges will apply if you have not met the eligibility requirement. After two (2) years of continuous enrollment in the Gentle Dental Plan, you will not be required to pay the laboratory charges. For a copy of the current Laboratory Fee schedule, contact the Trust Office.

PRINCIPAL EXCLUSIONS AND LIMITATIONS

1. Orthodontics.
2. Cosmetic dentistry performed solely to improve appearance.
3. Dispensing of drugs.
4. Hospitalization when desired by the patient for any dental procedure.
5. Services reimbursable under any other insurance or health care plan.
6. Services for injuries or conditions covered by Workers' Compensation or any employer's liability law.

7. Services which Gentle Dental dentists do not feel are necessary for dental health.
8. Services that cannot be performed due to the general health of the patient.
9. Treatment required for conditions resulting from a major disaster or epidemic.

WHAT IF I ALREADY HAVE DENTAL COVERAGE?

Some families have coverage with two (2) or more dental plans. The Gentle Dental Plan considers the other plan the primary carrier, responsible for dental charges incurred by those members with dual coverage.

OFFICE FACILITIES

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

GENTLE DENTAL CLINIC LOCATIONS

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

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

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

Gentle Dental Mililani
The Town Center of Mililani
95-1249 Meheula Parkway, Suite A-12
Mililani, Hawaii 96789
Phone: 623-2888

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

PROVIDERS

Gentle Dental Kona
Crossroad Medical Center, #203
76-1028 Henry Street
Kailua Kona, Hawaii 96740
Phone: 329-4425

The preceding dental benefits are insured under an insurance contract issued by Dental Care Centers of Hawaii (DBA Gentle Dental), 95-1249 Meheula Parkway, Suite #115, Mililani, Hawaii 96789. The services provided by Gentle Dental include the payment of claims, when necessary, and the handling of claims appeals.

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

LIFE INSURANCE BENEFITS

PACIFIC GUARDIAN LIFE

Only employees of employers whose collective bargaining agreement requires an additional contribution for life insurance benefits are eligible for the following life insurance benefits.

COVERAGE

If you are eligible for life insurance benefits, you will be covered for life insurance in accordance with the following schedule:

	BENEFIT AMOUNT
Active employees (other than OTS non-clerical)	\$2,000
Active employees - OTS non-clerical	\$4,000

BENEFICIARY

On your Trust enrollment form, you may name anyone you wish as your beneficiary to receive your life insurance benefits. You may change your beneficiary at any time by submitting a new Trust enrollment form to the Trust Office. The change is effective on the date you sign the form. Pacific Guardian Life will honor a beneficiary change request only if it is recorded before any payment has been made.

When Pacific Guardian Life receives due proof of your death, the amount of life insurance on your life will be paid.

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

- a) If more than one (1) beneficiary is named, each will be paid an equal share.
- b) If any named beneficiary dies before you, his/her share will be divided equally among the named beneficiaries who survive you.
- c) If no beneficiary is named, or if no named beneficiary survives you, Pacific Guardian Life will pay the first of the following classes of successive preference beneficiaries who survive you:
 - i. All to your surviving spouse; or
 - ii. If your spouse does not survive you, in equal shares to your surviving children; or
 - iii. If no child survives you, in equal shares to your surviving parents; or
 - iv. If no parent survives you, to the executors or administrators of your estate.

If the insurance proceeds are payable to a minor or mentally incompetent person, a certificate showing the appointment as a conservator of the minor or mentally incompetent person must be furnished.

TOTAL DISABILITY

If you become permanently and totally disabled while insured and before you reach the age of 60, your insurance will be continued without any cost to you as long as you remain so disabled.

“Total and permanent” disability means that the disability results from bodily injury or disease which prevents you from working in any occupation for compensation or profit and has existed continuously for at least nine (9) months. You must furnish written proof to Pacific Guardian Life that you are permanently and totally disabled and have been disabled continuously since the date you ceased active work. You must submit this proof within 12 months following the date that you lose eligibility and at least once each year thereafter, if requested.

If you become totally disabled, contact the Hawaii Teamsters Health and Welfare Trust Office for help in submitting the necessary forms.

Any disability caused by disease, infection or poisoning is excluded. However a disability caused by an infection incurred through an accidental wound is covered.

CONVERSION RIGHTS

If you become ineligible for coverage, your life insurance will be continued for 31 days following the termination of your eligibility.

During this 31-day period, you have the right to obtain any regular individual policy issued by Pacific Guardian Life (except Term Insurance). The individual policy will be issued without medical examination at Pacific Guardian Life’s regular premium rates. The amount of the individual policy cannot exceed the amount of insurance for which you were covered under the group policy. You must apply and pay for the first premium within 31 days after your insurance terminates.

The preceding life insurance benefits are insured under an insurance contract issued by Pacific Guardian Life (PGL), 1440 Kapiolani Boulevard, Suite 1700, Honolulu, Hawaii 96814. The services provided by PGL include the payment of claims and the handling of claims appeals.

The preceding information is for informational purposes only and is only a summary of the life insurance coverage. Its contents are subject to the provisions of the Group Life Insurance Master Contract with Pacific Guardian Life, and all amendments thereto, which contain all of the terms and conditions governing life insurance 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.

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)

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 or that of your dependent(s) 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 what the proper procedures are for filing claims, or what additional information is needed to complete your claim. You will be given 48 hours from the date you are notified to complete your claim.

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

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

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

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

A pre-service claim is any claim 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 what the proper procedures are for filing claims.

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

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

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

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

INITIAL BENEFIT DETERMINATION

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

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

- a. 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, guidelines, 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

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 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.

OTHER APPEALS

The Trust Office serves as the Administrator of the Hawaii Teamsters Health and Welfare Trust and maintains the records regarding your eligibility for benefits. Questions concerning enrollment, change of employee status, or change in dependent coverage should be directed to the Trust Office. Any disagreement regarding your eligibility status or the status of your dependent that cannot be resolved by the Administrator may be submitted to the Board of Trustees for review.

You have the right to appeal any decision of the Administrator based on Plan rules adopted by the Board of Trustees (e.g. denial of eligibility or loss of eligibility) by filing a written request for review with the Board of Trustees. Your written request must be filed within 60 days after notification by the Administrator and should describe your version of the facts and reasons why you feel the Administrator's decision was not proper. You should also submit any documents, records, and other information in support of your claim not already furnished to the Plan. If you wish, you (or your authorized representative) may review and obtain copies of all Plan documents, records, and other information relevant to your claim, free of charge.

Upon receipt of your written request for review, the Board of Trustees (or a sub-committee thereof) will review your case and take into account all evidence submitted by you (or your authorized representative), without regard to whether such evidence was submitted or considered in the initial benefit determination. It will be up to the Board of Trustees (or sub-committee thereof) to decide whether a hearing will be useful in reviewing your request. If a hearing is to be held, you will receive at least two (2) weeks prior notice of the time and place of the hearing (unless you agree in writing to a shorter notice period). You and/or your authorized representative may appear at the hearing.

The Board of Trustees (or subcommittee thereof) will render its decision in writing, within 60 days after receipt of your written request for review, unless

special circumstances require an extension of time for processing your request, in which case the decision shall be rendered as soon as possible, but not later than 120 days after receipt of your written request for review. If an extension is required, the Board of Trustees (or subcommittee thereof) must notify you, in writing, prior to the end of the initial 60-day review period and indicate the special circumstances that make the extension necessary and the date by which a decision is expected.

The decision of the Board of Trustees (or sub-committee thereof) will be written in clear, easily understood language and provide the reasons why the decision was made and the specific Plan provisions that support it. If you disagree with the decision on review, you may file suit in federal or state court. If your suit is successful, the court may award you legal costs, including attorneys' fees.

The preceding is for informational purposes only and is a summary of the Trust's claims and appeals procedure. 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 for specific questions about claims and appeals procedure.

INSURED CLAIMS AND APPEALS

Chiropractic benefits are provided through Chiroplan Hawaii, Inc. Vision care benefits are provided through Vision Service Plan. Dental benefits are provided through Hawaii Dental Service and Gentle Dental. Life insurance benefits are provided through Pacific Guardian Life. Participants may obtain information concerning appeals procedures for these insurance plans by contacting the carrier at the address below.

CHIROPPLAN HAWAII, INC.

711 Kilani Avenue, Room 3
Wahiawa, Hawaii 96786
ATTN: Medical Director

VISION SERVICE PLAN

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

HAWAII DENTAL SERVICE

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

GENTLE DENTAL

The Town Center of Mililani
95-1249 Meheula Parkway, Suite 115
Mililani, Hawaii 96789
Attn: Membership Services Department

PACIFIC GUARDIAN LIFE

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

The decision of the insurance carrier shall be final.

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; and
- Request a list of certain disclosures by the Trust of your health information.

You also have the right to make complaints to the Trust as well as the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust 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) 772-8989 (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: 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

ChiroPlan Hawaii, Inc. Chiropractic Plan

Privacy Officer
711 Kilani Avenue, Suite 3
Wahiawa, Hawaii 96786
Phone: 621-4774

VSP Vision Plan

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

HDS Dental Plan

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

Gentle Dental Plan

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

STATEMENT OF ERISA RIGHTS

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

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, 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

In this booklet, we have attempted to explain as briefly as possible the benefits provided to eligible employees and their dependents. The actual Trust Agreement, Plan Documents, policies, contracts, and the various rules and regulations adopted by the Trustees are the final authorities in all matters related to the Hawaii Teamsters Health and Welfare Trust. Copies of these documents are available for you to inspect at the Trust Office during regular business hours.