HAWAII TEAMSTERS HEALTH AND WELFARE TRUST

ACTIVES

AUGUST 2018

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Information Needed	Contact the following
Eligibility, Enrollment, Benefits	Trust Fund Office c/o Benefit & Risk Management Services, Inc. 560 North Nimitz Highway, Suite 209 Honolulu, Hawaii 96817 Oahu: 523-0199 Neighbor Islands: 1 (866) 772-8989
UHA 600 Medical Plan	University Health Alliance (UHA) 700 Bishop Street, Suite 300 Honolulu, Hawaii 96813 Customer Services: 532-4000 Neighbor Islands: 1 (800) 458-4600 *www.uhahealth.com*
HMO Medical Plan (Self-Insured)	Hawaii-Mainland Administrators, LLC (HMA) 1440 Kapiolani Boulevard, Suite 1020 Honolulu, Hawaii 96814 Oahu: 951-4641 Neighbor Islands: 1 (877) 384-2875 *www.hma-hi.com/teamsters/hmo*
Indemnity Prescription Drug Plan (Self-Insured)	OptumRx National Help Desk: 1 (888) 869-4600 *www.optumrx.com*
Vision Care Plan	Vision Service Plan (VSP) Oahu: 532-1600 Neighbor Islands: 1 (800) 522-5162 Nationwide: 1 (800) 877-7195 *www.vsp.com*
Chiropractic Care Plan	ChiroPlan Hawaii, Inc. 711 Kilani Avenue, Room 4 Wahiawa, Hawaii 96786 Oahu: 621-4774 Neighbor Islands: 1 (800) 414-8845 *www.chiroplanhawaii.com*
HDS Dental Plan (Self-Insured)	Hawaii Dental Service 700 Bishop Street, Suite 700 Honolulu, Hawaii 96813 Customer Services: 529-9248 Neighbor Islands: 1 (844) 379-4325 *www.HawaiiDentalService.com*
DCCH Dental Plan (formerly Gentle Dental)	Dental Care Centers of Hawaii P.O. Box 893896 Mililani, Hawaii 96789 Membership Services: 284-6545
Life Insurance Plan	Pacific Guardian Life Insurance Company 1440 Kapiolani Boulevard, Suite 1700 Honolulu, Hawaii 96814 Oahu: 955-2236 Neighbor Islands: 1 (800) 367-5354 *www.pacificguardian.com*

THIS PLAN IS ADMINISTERED BY

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

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

IMPORTANT NOTICE

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. ELIGIBILITY RULES

A. Effective December 9, 2016, the strike benefit provision was clarified (page 16).

2. DEPENDENT COVERAGE

A. Effective September 1, 2014, in accordance with the Patient Protection and Affordable Care Act of 2010, dependent coverage is available to all children under 26 years of age regardless of whether they may be eligible for other employer-sponsored health coverage (page 21).

3. UHA 600 MEDICAL PLAN

A. Effective March 1, 2018:

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

(2) Prescription drug benefits for UHA 600 Plan members will be provided through the Trust's Indemnity Prescription Drug Plan (page 97).

4. COMPREHENSIVE MEDICAL PLAN (SELF-INSURED)

A. Effective September 1, 2011, the $5,000 benefit limit for in vitro fertilization is removed. However, coverage is still limited to one procedure per lifetime.

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

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

D. Effective February 1, 2014, the Non-Emergency Inter-Island Travel benefit was enhanced to provide: (i) reimbursement of qualified lodging expenses up to a maximum of $100 per night for two nights (previously not covered), and (ii) travel benefits for members who reside on Oahu (previously limited to neighbor island beneficiaries only).

E. Effective June 1, 2014, the Human Papilloma Virus (HPV) quadrivalent vaccine is a covered benefit for eligible male beneficiaries (previously only covered for female beneficiaries).

F. Effective September 1, 2014, in accordance with the Patient Protection and Affordable Care Act of 2010, the $2,000,000 per person annual dollar maximum for essential health benefits is removed.

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

H. Effective June 1, 2016:

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

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

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

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

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

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

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

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

J. Effective March 1, 2018, the UHA 600 Medical Plan replaced the Comprehensive Medical Plan (page 28).

5. INDEMNITY PRESCRIPTION DRUG PLAN (SELF-INSURED)

A. Effective February 1, 2013, the Step Therapy Program was expanded to include other targeted medications (previously limited to cholesterol medications) (page 99).

B. Effective June 1, 2014, oral specialty medications are limited to a 30-day supply and require prior authorization (page 99).

C. Effective November 1, 2014, prior authorization is required for compounded medications costing more than $200 (page 99).

D. Effective June 1, 2016:

(1) The Indemnity Prescription Drug Plan became a non-grandfathered health plan under the Patient Protection and Affordable Care Act of 2010 (page 27).

(2) There is an Annual Copayment Maximum of $2,000 per individual and $4,000 per family of three or more for covered prescription drug services received during a plan year (previously there was no copayment maximum) (page 97).

(3) Prescription drug benefits for HMO Medical Plan members will be provided through the Indemnity Prescription Drug Plan (page 97).

E. Effective March 1, 2018:

(1) Prescription drug benefits for UHA 600 Medical Plan members will be provided through the Indemnity Prescription Drug Plan (page 97).

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

6. HMO MEDICAL PLAN (SELF-INSURED)

A. Effective September 1, 2011:

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

(2) The $500 allowance for hearing aids is removed. Hearing aids are covered at 80% of Eligible Charges and limited to one device per ear every three years (pages 87 and 90).

B. Effective January 1, 2016, benefit payments for covered inpatient and emergency services rendered outside the Service Area shall not exceed 170% of the Eligible Charge for the same or comparable services rendered within the Service Area (previously limited to no more than 150% of the Eligible Charge for the same or comparable services rendered within the Service Area) (page 88).

C. Effective June 1, 2016:

(1) The HMO Medical Plan became a non-grandfathered health plan under the Patient Protection and Affordable Care Act of 2010 (page 27).

(2) Routine patient costs for services or items furnished in connection with participation in an approved clinical trial are covered for qualified beneficiaries in accordance with Federal law (previously not a benefit) (page 81).

(3) Well-child care physician visits are covered from birth through age 21 years at no charge (previously covered from birth through 18 months) (page 85).

(4) One preventive care office visit per year for beneficiaries age 22 years and older is covered at no charge (previously covered from age two) (page 85).

(5) Preventive Health Care services and items as defined by Federal law are covered at no charge (pages 85 and 92).

(6) Standard immunizations for beneficiaries age 19 and older are covered at no charge (previously $10 per dose) (page 85).

(7) The copayment for hospital emergency room services received outside the Service Area is $30 per visit (previously covered at 80% of Eligible Charges) (page 86).

(8) Preventive Health Care screening services as defined by Federal law are covered at no charge (previously $14 per service per day for certain services) (page 85).

(9) Laboratory tests prescribed in connection with well-child care are covered at no charge (previously $14 per service per day for certain tests) (page 85).

(10) Lactation counseling and rental of breastfeeding equipment are covered at no charge (previously not a benefit) (page 87).

(11) FDA approved contraceptive methods for women for the prevention of unwanted pregnancies are covered at no charge (previously covered at 50% of Eligible Charges) (page 87).

D. Effective September 1, 2017:

(1) Life Bed services are not covered.

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

E. Effective March 1, 2018, the coverage criteria for in vitro fertilization services is revised by (i) removing the requirement of 12 consecutive months of coverage under the Plan immediately preceding the in vitro fertilization procedure; and (ii) shortening the durational requirement for a history of infertility from five years to four years, 12 months of which must be consecutive months of coverage under the Plan (page 91).

7. HMO PRESCRIPTION DRUG BENEFITS (SELF-INSURED)

A. Effective August 1, 2013, a beneficiary may obtain two 30-day supplies of a prescription or refill for maintenance drugs at two times the 30-day copay from a retail pharmacy under the Point of Service Program (page 104).

B. Effective June 1, 2016:

(1) Prescription drug benefits for HMO Medical Plan members will be provided through the Indemnity Prescription Drug Plan (page 97).

(2) There is an Annual Copayment Maximum of $2,000 per individual and $4,000 per family of three or more for covered prescription drug services received during a plan year (previously there was no copayment maximum) (page 97).

8. HAWAII DENTAL SERVICE PLAN (SELF-INSURED)

A. Effective September 1, 2015, dental benefits provided through the HDS Plan are self-insured by the Hawaii Teamsters Health and Welfare Trust. The Trust Fund has contracted Hawaii Dental Service to be the Claims Administrator (page 113).

B. Effective January 1, 2016, the Plan Maximum increased from $1,500 per person to $1,700 per person per calendar year (page 118).

9. DENTAL CARE CENTERS OF HAWAII (formerly GENTLE DENTAL)

A. Effective September 1, 2014, the office visit copayment increased from $11.00 to $12.00 per visit (page 120).

B. Effective July 1, 2015, Hawaii Family Dental Centers is no longer a provider under the DCCH plan. You must receive services from one of the following DCCH dental providers: Kaizen Dental Center (Honolulu) or Healthy Smiles Family Dental (Kapolei) (page 121).

10. CLAIMS AND APPEALS PROCEDURES

A. Effective September 1, 2014, following an adverse benefit determination on appeal, you have the right to bring a civil action under section 501(a) of ERISA within two years after receipt of the written notice of Initial Benefit Determination (previously there was no time limit) (pages 128 and 133).

B. Effective June 1, 2016:

(1) Following an adverse benefit determination on appeal involving medical necessity or a rescission of coverage, a beneficiary may request an external review by an Independent Review Organization (page 128).

(2) Pending the outcome of an appeal, benefits for an ongoing course of treatment will not be reduced or terminated without advance notice and an opportunity for review (page 128).

C. Effective April 1, 2018, disability benefit claims will be subject to new claims and appeals procedures in accordance with Federal law (page 130).

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
Toll Free: 1 (866) 772-8989

SATELLITE OFFICE
Telephone: (808) 842-0392

BOARD OF TRUSTEES

EMPLOYER TRUSTEES
Darrel Tajima
Jenny Lemaota
T.K. Hannemann (Alternate)

UNION TRUSTEES
Ronan Kozuma
Millie Downey
Frederick Liva (Alternate)

CONTRACT ADMINISTRATOR
Benefit & Risk Management Services, Inc.

PLAN CONSULTANT
Benefit Plan Solutions, Inc.

LEGAL COUNSEL
Yee & Kawashima, LLLP

AUDITOR
Lemke, Chinen & Tanaka, CPA, Inc.

CUSTODIAN
First Hawaiian Bank

INVESTMENT MANAGER
First Hawaiian Bank

TABLE OF CONTENTS

UNIVERSITY HEALTH ALLIANCE (UHA)

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

NAME OF THE PLAN

Hawaii Teamsters Health and Welfare Plan

PLAN SPONSOR AND PLAN ADMINISTRATOR

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

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

IDENTIFICATION NUMBERS

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

TYPE OF PLAN

Welfare - medical, prescription drug, 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
Director of Human Resources
Meadow Gold Dairies – Hawaii
925 Cedar Street
Honolulu, Hawaii 96814

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

T.K. Hannemann (Alternate Trustee)
Director of Human Resources
Oahu Transit Services, Inc.
811 Middle Street
Honolulu, Hawaii 96819

UNION TRUSTEES

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

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

Frederick Liva (Alternate Trustee)
Business Representative
Teamsters Union Local 996
1817 Hart Street
Honolulu, Hawaii 96819

APPLICABLE COLLECTIVE BARGAINING AGREEMENT

The Hawaii Teamsters Health and Welfare Plan is maintained pursuant to collective bargaining agreements between the Hawaii Teamsters and Allied Workers Union, Local 996 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 into a savings account. Funds are then withdrawn and deposited into a checking account out of which premium payments are made to the insurance carriers that provide benefits, as directed by the Contract Administrator, and benefits are paid to participants. Self-insured medical benefits are paid by the Trust through Hawaii-Mainland Administrators, LLC, which handles claims administration services for the HMO Medical Plan. Self-insured prescription drug benefits are paid by the Trust through the Pharmacy Benefits Manager OptumRx. Self-insured dental benefits are paid by the Trust through the claims administrator Hawaii Dental Service. Funds in excess of those needed for immediate requirements are invested in accordance with general investment guidelines as determined and reviewed by the Trustees.

FISCAL YEAR

September 1 through the following August 31

PLAN AMENDMENT AND TERMINATION

The Trust Agreement for the Hawaii Teamsters Health and Welfare Trust gives the Board of Trustees the authority to terminate the Plan or amend or eliminate eligibility requirements and benefits available under the Plan, at any time.

For example, benefits may be amended or eliminated if the Board of Trustees determines that the Trust does not have funds to pay for the benefits being provided.

The Trust may be terminated or amended at any time by a majority of the Employer Trustees and a majority of the Union Trustees signing a written document.

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

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

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

Upon termination of the Hawaii Teamsters Health and Welfare Trust, any assets remaining shall be used to satisfy all obligations 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 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 rate 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 upon the collective bargaining agreement between each employer and the 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 for which you are eligible depend upon 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 contribution 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 months following the month in which your disability began, provided your employer continues to make the required contribution to the Trust on your behalf for at least three months following the month in which you became disabled.

For purposes of this section, "unable to work" means the following:

- For a bargaining unit employee, "unable to work" means being unable to perform work described in the applicable collective bargaining agreement.
- For a non-bargaining unit employee, "unable to work" means being unable to perform the regular and customary (normal) duties of his or her occupation as determined by the Plan Administrator.

If you become disabled, you must notify the Trust Office, in writing, no later than 30 days after the date on which the disability commenced. The Trust Office will let you know what information is required in order for you to receive benefits while you are disabled.

IN THE EVENT OF A STRIKE

If, while you are eligible for benefits a strike occurs and you lose your eligibility as a result of the strike, you will continue to be covered for benefits for up to three months or the duration of the strike, whichever is shorter. You will re-establish your eligibility on the first day of the calendar month following the month in which the strike ended, provided your employer makes the required contribution on your behalf.

Example 1: Your employer makes the required contribution on your behalf in December and you are eligible for benefits in January. A strike occurs in January and your employer does not make a contribution for the duration of the strike which ends in April. You lose your eligibility as a result of the strike in February. You will continue to be covered for benefits for the duration of the strike (February, March and April). You will re-establish your eligibility on May 1st, provided your employer makes the required contribution on your behalf.

Example 2: Your employer makes the required contribution on your behalf in December and you are eligible for benefits in January. A strike occurs in January and your employer does not make a contribution for the duration of the strike which ends in June. You lose your eligibility as a result of the strike in February. You will continue to be covered for benefits for up to three months during the strike (February, March and April). You may continue your coverage for the remainder of the strike (May and June) by enrolling in the Employee Self-Payment Program or the COBRA Program. You will re-establish your eligibility on July 1st, provided your employer makes the required contribution on your behalf.

IF YOU ENTER THE ARMED FORCES

When you enter the Armed Forces, you must notify the Trust Office, in writing, no later than 30 days following your date of entry. 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, or forgo continued coverage if it is not needed.

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. Self-payments must be received by the Trust Office within 30 days after the first day of the period covered by the payment. Failure to make timely payment will result in termination of coverage.

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 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 contribution to the Trust on your behalf. You will lose eligibility on the earliest of the following dates:

1. The last day of the 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 contribution 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 consecutive months by making self-payments to the Trust. However, you must enroll in the Employee Self-Payment Program within 30 days following notification of your ineligibility. After the six months are up, you may elect to continue coverage under the COBRA Program if your employer continues to be delinquent.

The amount 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 day 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 A SELF-PAYMENT 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 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 below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, and, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan.** If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under this Plan, (e.g. employee continues working even though entitled to Medicare) then COBRA is not available.

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

Continued Coverage For	Qualifying Event	Maximum Period of Coverage
You and your eligible Dependents	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 to the Trust Office within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage. The extended COBRA coverage period of up to 29 months for disability not only applies to the disabled Qualified Beneficiary or the disabled covered employee but also to all other Qualified Beneficiaries covered with the disabled beneficiary through the same initial Qualifying Event.

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

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

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 date of marriage, birth, adoption, or placement for adoption. Coverage will be effective on the date of the event. If you do not enroll your new dependent within this 30-day period, you must wait until the next open enrollment period. **Exception for newborn child:** If you do not enroll your newborn

child within this 30-day period, coverage will become effective on the first day of the calendar month following receipt of notification and the proper documentation by the Trust Office. 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 child loses coverage under another group health plan, you may enroll your spouse or dependent child for coverage for the balance of the period of COBRA Continuation Coverage. Your spouse or dependent child must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA health care plan and declined, your spouse or dependent child must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll your spouse or dependent child within 30 days after the termination of the other coverage or within 60 days after the termination of coverage under Medicaid or CHIP in accordance with Federal law. Coverage will be effective on the first day of the calendar month following termination of the other health plan coverage. If you fail to request enrollment during this 30-day or 60-day period, you must wait until the next open enrollment period. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

When COBRA Ends

If COBRA is elected, the continued coverage will begin on the date that coverage under the 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 ceases to provide any health coverage;
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 new group plan contains an exclusion or limitation with respect to any pre-existing condition of the individual, then COBRA coverage may be continued until the earlier of the end of the exclusion or limitation period, or the occurrence of one of the other events stated above).

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

GENERAL INFORMATION

ENROLLMENT FORMS

To be covered for benefits, you 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 or benefits will be paid on your behalf 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 choice of medical and dental plans, your beneficiary or beneficiaries, 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 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.

Important Notice

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

- You change your name, address or telephone number.
- You get married, divorced, or legally separated.
- A covered family member dies.
- You want to add a new dependent such as a new baby or an adopted child or there is a change in the status of a dependent child.
- You become disabled.
- You enroll in Medicare.
- You have other health care coverage.

Failure to give timely notice to the Trust may cause:

- You to be liable to the Trust for any benefits paid to an ineligible person;
- Benefit payments being delayed until eligibility issues have been resolved;
- Your spouse and/or dependent children to lose their right to continue coverage under COBRA; or
- Coverage of a dependent child to end when it might otherwise continue because of a disability.

ELIGIBLE DEPENDENTS

Effective September 1, 2014, eligible dependents include your legal spouse and all children under 26 years of age.

The term "spouse" shall refer to individuals who are lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages.

The term "children" shall include the participant's 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 a birth certificate, marriage certificate, or the signing of an affidavit, to determine the eligibility of a dependent under this section.

1. To add a new spouse, you must submit proper documentation, in writing, to the Trust Office within 30 days from the date of marriage. Coverage will be effective on the date of marriage. If you do not notify the Trust Office within this 30-day period, you must wait until the next open enrollment period to add your 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 calendar month following receipt of notification and the proper documentation by the Trust Office.
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. Coverage will be effective on the date of the event. 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**.**

If your Child is Disabled

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, submit satisfactory proof to the Trust of his or her incapacity within 31 days following such child's 26th birthday and periodically, thereafter, when requested. 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.

When a Dependent is No Longer Eligible for Dependent Coverage

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, as described in the COBRA Program section.

When a covered dependent is no longer eligible for dependent coverage, you must notify the Trust Office, in writing, on or before the first day of the calendar month following the date on which eligibility ceased and provide the proper documentation, as required by the Trust.

Example 1: If your adult dependent child attains age 26 on June 15, you must notify the Trust Office by July 1. Dependent coverage for such child will terminate on June 30 unless COBRA is elected.

Example 2: If your divorce is finalized (i.e. the divorce decree is signed by the judge) on July 1, you must notify the Trust Office by August 1 and provide the proper documentation such as a copy of the divorce decree. Dependent coverage for your former spouse will terminate on July 31 unless COBRA is elected.

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

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. 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 your and/or your dependent's Medicaid or State Children's Health Insurance Program (CHIP) coverage is terminated due to loss of eligibility, or if you and/or your dependent become eligible for a premium assistance subsidy through Medicaid or CHIP for coverage under this Plan, you may enroll yourself and/or your dependents in this Plan. However, you must request enrollment within 60 days of such event.

If you fail to request enrollment during this special enrollment period, coverage for yourself and/or your dependents will not be effective until the next open enrollment period following the date of notification to the Trust. **Exception for newborn child:** 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 calendar month following receipt of notification and the proper documentation by the Trust Office in accordance with Plan rules.

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

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 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 state domestic relations 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 substituted for that of a child);
2. A reasonable description of the type of coverage to be provided to the child, or the manner in which 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 benefit 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

Note: *Effective March 1, 2018, the UHA 600 Medical Plan, provided through University Health Alliance, replaced the Trust's Comprehensive Medical Plan.*

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

1. The UHA 600 Medical Plan (UHA Plan), or
2. The HMO Medical Plan (HMO Plan) which is available only on Oahu, Maui, and Hawaii.

To enroll in the HMO Plan, you must reside within the Plan's service area which includes the islands of Oahu, Maui, and Hawaii. If you reside outside the Plan's service area, you are not eligible to enroll in the HMO Plan. If you are enrolled in the HMO Plan and subsequently move outside the Plan's service area for more than 60 consecutive days, you must notify the Trust Office in writing. You will not be allowed to continue coverage under the HMO Plan and must enroll in the UHA Plan.

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

How to Secure Benefits

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

You should have your member ID card available whenever you schedule or seek medical care. If you do not have your ID card, be sure to tell the provider in advance that you are a UHA 600 Plan member or an 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.

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, unless:

1. You are enrolled in the HMO Plan and subsequently move outside the Plan's service area for more than 60 days, or
2. You meet one of the requirements specified in the Special Enrollment Periods section.

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

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

Procedure for Requesting and Receiving a HIPAA Certificate of Creditable Coverage

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

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

Effective September 1, 2010, the following provisions apply to the Hawaii Teamsters Health and Welfare Trust. Under GINA, group health plans and health insurance issuers generally may not:

- Adjust premium or contribution amounts for the covered group on the basis of genetic information;
- Request or require an individual or a family member to undergo a genetic test;
- Request, require, or purchase genetic information for underwriting purposes;
- Request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment or coverage under the plan.

However, a doctor or health care professional who is providing health care services to you may request that you undergo a genetic test, which you voluntarily agree to, for treatment of a health condition. Then, the group health plan and health insurance issuer may obtain and use the results of a genetic test to make a determination regarding payment for medically necessary health care services, provided only the minimum amount of information necessary is requested.

In addition, group health plans may request, but not require, a participant or beneficiary to undergo a genetic test for research purposes if certain conditions are met, including that:

- The request is made in writing;
- The research complies with Federal and State laws;
- The plan clearly indicates to the participant or beneficiary that compliance with the request is voluntary; and
- The plan indicates that noncompliance will have no effect on eligibility or benefits.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)

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

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

Effective June 1, 2016, the Hawaii Teamsters Health and Welfare Trust elected to change the status of its Comprehensive Medical Plan (Self-insured), HMO Plan (Self-insured) and Indemnity Prescription Drug Plan (Self-insured) from "grandfathered" to "non-grandfathered" health plan status under the Patient Protection and Affordable Care Act of 2010 (PPACA or Affordable Care Act). Questions regarding the change from grandfathered to non-grandfathered health plan status can be directed to the *Trust Administrator at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817, telephone: (808) 523-0199 or Neighbor Islands Toll Free: 1 (866) 772-8989.*

UNIVERSITY HEALTH ALLIANCE (UHA)
UHA 600 MEDICAL PLAN

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

UNIVERSITY HEALTH ALLIANCE
700 BISHOP STREET SUITE 300
HONOLULU, HAWAII 96813
CUSTOMER SERVICES
PHONE: (808) 532-4000
TOLL FREE: 1 (800) 458-4600
FAX: 1 (866) 572-4393
WEBSITE: uhahealth.com

GENERAL INFORMATION

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

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

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

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

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

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

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

ANNUAL AND LIFETIME BENEFIT MAXIMUMS

There is no annual or lifetime dollar benefit maximum for benefits paid or provided under this Plan on your behalf. However, certain benefits have annual maximums. For example, home health care is limited to 150 visits per calendar year. Please see the Medical Plan Benefits section on pages 39 - 64 for a description of these benefit maximums as well as other limitations that may apply to covered services.

ANNUAL DEDUCTIBLE

This Plan has no annual deductible.

ELIGIBLE CHARGE

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

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

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

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

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

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

COPAYMENT AND COINSURANCE

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

ANNUAL OUT-OF-POCKET MAXIMUM

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

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

CHOICE OF HEALTH CARE PROVIDERS

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

Participating Providers

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

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

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

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

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

Non-Participating Providers

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

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

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

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

SERVICES OUTSIDE THE SERVICE AREA

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

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

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

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

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

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

The following require Prior Authorization (see Health Care Services Program, pages 32 - 37):

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

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

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

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

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

HEALTH CARE SERVICES PROGRAM

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

PAYMENT DETERMINATION CRITERIA

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

- The service must be listed as a covered benefit and not be excluded as a benefit under this Plan;
- The service must be medically necessary for the diagnosis or treatment of your illness or injury; and
- When required under this Plan, the service must be prior authorized and consistent with UHA's Guidelines for prior authorizations.

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

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

MEDICAL NECESSITY

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

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

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

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

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

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

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

(A) Effectiveness is determined first by scientific evidence;

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

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

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

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

PRIOR NOTIFICATION OF ADMISSIONS AND CONCURRENT REVIEW

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

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

- Elective admission to a hospital, skilled nursing facility, or rehabilitation facility;
- Provision of any chemical dependency/substance abuse residential treatment.

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

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

PRIOR AUTHORIZATION

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

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

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

How to Obtain Prior Authorization

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

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

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

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

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

- Member name, address, birth date, and UHA Member Number
- Requesting provider's name, specialty, phone and fax numbers
- Information about the member's other health insurance, if any
- Name of the provider of the requested service
- Name of the facility where the requested service will be performed
- Diagnoses, procedures, and supporting medical information
- Information about whether the member's condition is employment or automobile related
- If the prior authorization is for a drug override, the name of the drug and reason for the override
- Provider acknowledgement that the requested service meets the definition of medically necessary

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

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

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

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

If your request is denied in whole or in part, UHA will provide an explanation, including the specific reason for denial and reference to the health plan terms upon which the denial was based. If you disagree with UHA's denial, you may file an appeal in accordance with the appeal procedures on pages 75 - 79.

Expedited Review

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

You may make your request for an expedited review orally or in writing to the Health Care Services Department. The information required to process your request includes the same information required on the Prior Authorization Request form, as described above. If you qualify for an expedited decision but UHA does not have sufficient information on which to make an expedited decision, UHA will inform you within 24 hours of receiving your request and you will have at least 48 hours after receiving such notice to submit the required information.

Services Requiring Prior Authorization

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

Inpatient and Ambulatory (Outpatient) Surgical Procedures

- All ablative treatment for Atrial Fibrillation
- Ambulatory surgery proposed to be done in an inpatient setting
- Arthroscopy, hip, surgical; with removal of loose body or foreign body – with femoroplasty, acetabuloplasty, or labral repair
- Artificial disc insertion in cervical spine (lumbar **NON-COVERED**)
- Autologous chondrocyte implantation and Carticel
- Bariatric surgery
- Blepharoplasty (upper eyelids only) and Repair of Blepharoptosis; (lower eyelids are **NON-COVERED**)
- Electromagnetic Navigation Bronchoscopy
- Emerging Technology (T codes)
- Hepatic resection, radiofrequency ablation and cryotherapy; chemoembolization, and microsphere radiocolloid infusion/embolization
- Hyperbaric oxygen treatment

- Implantation of intrastromal corneal ring segments
- In vitro fertilization services
- Kyphoplasty and vertebroplasty
- Lung Volume Reduction
- Organ, bone marrow, and stem cell transplant services: transplant evaluations, organ donor services, transplant procedures
- Osteochondral allograft
- Panniculectomy and Abdominoplasty
- Photodynamic therapy for actinic keratoses and other skin lesions. (Photodynamic therapy for acne is **NON-COVERED***)
- Prophylactic Mastectomy
- Prostatectomy (open or robotic); XRT (external beam or by brachytherapy)
- Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors
- Reduction Mammaplasty (not related to Breast Reconstruction following mastectomy for cancer)
- Rhinectomy; partial
- Stereotactic radiosurgery (SRS) and fractionated stereotactic body radiotherapy (SRBT)
- Thoracic sympathectomy for hyperhidrosis
- Tissue-engineered skin substitutes
- Transcatheter aortic-valve implantation for aortic stenosis
- Transcatheter mitral valve repair
- Transmyocardial laser revascularization
- Treatment of varicose veins: all procedures require prior authorization. (Sclerotherapy for spider veins is **NON-COVERED*)**

***COSMETIC PROCEDURES ARE NON-COVERED SERVICES.**
For the most current list of cosmetic procedures, visit the UHA website at uhahealth.com/forms#providers. **If a procedure or service could conceivably be considered to be cosmetic in nature, Prior Authorization must be obtained.**

Diagnostic Testing and Radiology Procedures

- Charged-Particle (Proton or Helium Ion) Radiation Therapy
- CTCA – Computerized tomography of the coronary arteries (computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium is NON-COVERED)
- CTCA – Coronary Computed Tomography Angiography
- Genetic testing
- Oncotype DX
- PET Scans
- Psychological Testing
- Sleep Studies – additional sleep study within the five year period. Physicians should order and providers should perform a split night study when possible.
- Virtual Colonoscopy

Medical Equipment and Appliances and Supplies

- Continuous Glucose Monitoring System
- External Insulin Pump
- Home Ventilator
- Medical equipment and appliances purchase greater than $500
- Medical equipment and appliances rental greater that $100/month
- Negative Pressure Wound Therapy

- Oscillatory Device for Bronchial Drainage
- Oxygen and oxygen equipment for home use
- Positive Airway Pressure Devices for the Treatment of Obstructive Sleep Apnea
- Power mobility devices and push-rim activated power assist devices
- Pulse Oximeter for Children
- Repair and maintenance of medical equipment and appliances
- Spinal Cord Stimulators for Pain Management
- Transcutaneous Electrical Nerve Stimulation
- Wheelchairs; pediatric and adult

Out-of-State Services

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

Prosthetics

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

Rehabilitative Services

- Cognitive Rehabilitation
- Habilitative Services
- Physical and Occupational therapy (after a combined total of 32 units [1 unit = 15 minutes] or 8 sessions; per calendar year). Payment is limited to 4 units/session.
- Residential Treatment for Chemical Dependence (only for facility non-participating providers and out-of-state treatments)
- Speech Therapy
- Applied Behavior Analysis for Autism Spectrum Disorders

Home Health Services

- Home Health Services after the first 12 visits
- Home total parenteral nutrition for adults

Miscellaneous Services

- Gastrointestinal tract imaging, intraluminal (e.g. capsule endoscopy), colon, with interpretation and report
- Anoscopy with directed submucosal injection of bulking agent for fecal incontinence
- Electrophysiologic evaluation of subcutaneous implantable (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)
- Orthodontic Services for Orofacial Anomalies
- Oral Surgery
- Gender Identity Services
- Experimental and Investigational Services

Prescription Drugs

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

Services Requiring Advance Notification

The following services require advance notification:

Elective Hospital Admissions

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

Chemical Dependency/Substance Abuse Residential Treatment

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

RETROSPECTIVE REVIEW

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

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

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

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

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

IMPORTANT QUESTIONS TO ASK WHEN YOU RECEIVE CARE

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

1. **Is the service a Covered Service?** To receive benefits, the care you receive must be a covered service. Please refer to the Medical Plan Benefits section (pages 39 - 64) and Services Not Covered section (pages 65 - 69) for information on what services are covered and not covered.
2. **Is the provider a Participating Provider?** The amount this Plan pays and the amount you must pay depend on whether the provider of service is a Participating or Non-Participating provider. Please refer to the Choice of Health Care Providers section, (pages 30 - 31) for more information.
3. **Is the care Medically Necessary and does it meet Payment Determination Criteria?** Please refer to the Health Care Services Program section (pages 32 - 37) for the definition of medically necessary and UHA's payment determination criteria.
4. **Is the service subject to Prior Authorization requirements?** Some services require prior authorization by UHA before you receive the services. Please refer to the Health Care Services Program section (pages 32 - 37) for information on prior authorization requirements.
5. **Is the service subject to a Benefit Maximum?** Certain services may have a maximum limit on the dollar amount, the number of visits, or other limitation. Information on benefit maximums for specific services is provided in the Medical Plan Benefits section (pages 39 - 64).
6. **Is the provider of service qualified and a recognized provider?** To determine if a provider is qualified and recognized, UHA considers the following:
    - Is the provider appropriately licensed?
    - If a facility, is the provider accredited by a recognized accrediting agency?
    - Is the provider qualified under the requirements of the federal Medicare program?
    - Is the provider certified by the appropriate government authority?
    - Are the services rendered within the lawful scope of the provider's licensure, certification, or accreditation?
7. **Did a provider order the care?** To be covered, all services must be ordered by a recognized provider.

MEDICAL PLAN BENEFITS

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

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

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

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

PREVENTIVE CARE SERVICES

PREVENTIVE CARE SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Well Child Care Physician Office Visits	No Copayment	No Copayment
Well Child Immunizations	No Copayment	No Copayment
Well Child Care Laboratory Tests	No Copayment	No Copayment
Preventive Medicine Office Visits	No Copayment	No Copayment
Well Woman Exam	No Copayment	No Copayment
Screening Laboratory Services - Outpatient	No Copayment	No Copayment
Adult Immunizations	No Copayment	No Copayment
Mammography for Breast Cancer Screening	No Copayment	No Copayment
Cervical Cancer Screening (Pap Smear)	No Copayment	No Copayment
Chlamydia Screening	No Copayment	No Copayment
Osteoporosis Screening	No Copayment	No Copayment
Colorectal Cancer Screening	No Copayment	No Copayment

PREVENTIVE CARE SERVICES SPECIAL NOTES

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

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

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

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

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

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

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

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

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

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

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

A woman may receive a screening mammogram more often if she has a history of breast cancer or if her mother or sister has a history of breast cancer. Each member's frequency of testing should be determined after consultation with her physician to assure that current recommendations and personal risk factors are considered.

Diagnostic mammography benefits are covered under Diagnostic Testing, Laboratory and Radiology Services.

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

Chlamydia Screening: Covered, one per calendar year.

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

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

DISEASE MANAGEMENT PROGRAMS

DISEASE MANAGEMENT PROGRAMS	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Smoking Cessation Program	No Copayment	Not Covered
Nutritional Counseling Programs	No Copayment	No Copayment
Asthma Education Program	No Copayment	Not Covered
Diabetes Self-Management Training and Education Program	No Copayment	No Copayment

DISEASE MANAGEMENT PROGRAMS SPECIAL NOTES

Smoking Cessation Program: Covered, but only through UHA Participating Providers.

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

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

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

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

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

PHYSICIAN SERVICES

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

PHYSICIAN SERVICES SPECIAL NOTES

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

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

Examples of an emergency include:

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

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

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

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

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

SURGICAL SERVICES

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

SURGICAL SERVICES SPECIAL NOTES

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

Assistant Surgeon: Covered, but only when:

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

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

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL SERVICES

HOSPITAL SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Ambulatory Surgery Center (ASC)	10% of Eligible Charge	30% of Eligible Charge
Hospital Room and Board	10% of Eligible Charge	30% of Eligible Charge
Special Care Units (Coronary care, intensive care, telemetry, or isolation)	10% of Eligible Charge	30% of Eligible Charge
Ancillary Inpatient Services	10% of Eligible Charge	30% of Eligible Charge
Emergency Room (For emergencies only)	10% of Eligible Charge	10% of Eligible Charge

HOSPITAL SERVICES SPECIAL NOTES

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

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

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

Hospital Room and Board: Covered, including:

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

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

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

Examples of an emergency include:

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

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

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

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

SKILLED NURSING FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Room and Board (Up to 120 days per calendar year)	10% of Eligible Charge	30% of Eligible Charge
Ancillary Services	10% of Eligible Charge	30% of Eligible Charge

SKILLED NURSING FACILITY SERVICES SPECIAL NOTES

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

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

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

Ancillary Services: Covered, including routine supplies, prescribed drugs and medications, dressings, oxygen, diagnostic and therapeutic services.

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

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

HOME HEALTH CARE AND HOSPICE SERVICES

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

HOME HEALTH CARE AND HOSPICE SERVICES SPECIAL NOTES

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

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

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

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

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

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

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

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

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

DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES

DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Allergy Testing	20% of Eligible Charge	30% of Eligible Charge
Diagnostic Mammography	No Copayment	30% of Eligible Charge
Diagnostic Testing – Inpatient	10% of Eligible Charge	30% of Eligible Charge
Diagnostic Testing – Outpatient	20% of Eligible Charge	30% of Eligible Charge
Genetic Testing and Counseling *Prior Authorization required for testing.*	20% of Eligible Charge	30% of Eligible Charge
Genetic Testing and Counseling related to Breast Cancer (BRCA) screening *Prior Authorization required.*	No Copayment	No Copayment
Laboratory and Pathology – Inpatient	10% of Eligible Charge	30% of Eligible Charge
Laboratory and Pathology – Outpatient	20% of Eligible Charge	30% of Eligible Charge
Radiology – Inpatient	10% of Eligible Charge	30% of Eligible Charge
Radiology – Outpatient *Prior Authorization required for PET scans and CTCA.*	20% of Eligible Charge	30% of Eligible Charge
Tuberculin Test	No Copayment	No Copayment

DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SPECIAL NOTES

Allergy Testing and Treatment Materials: Covered.

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

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

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

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

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

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

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

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

CHEMOTHERAPY AND RADIATION THERAPY SERVICES

CHEMOTHERAPY AND RADIATION THERAPY SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Chemotherapy *Prior Authorization required for certain treatments.*	20% of Eligible Charge	30% of Eligible Charge
Oral Chemotherapy *Benefits are available for these drugs under this Plan only if you do not have a drug plan which provides coverage for oral chemotherapy. Prior Authorization required for certain drugs.*	No Copayment	Not Covered
Oral Chemotherapy by Mail Order (limited to a 30-day supply) *Benefits are available for these drugs under this Plan only if you do not have a drug plan which provides coverage for oral chemotherapy. Prior Authorization required for certain drugs.*	No Copayment	Not Covered
Radiation Therapy – Inpatient	10% of Eligible Charge	30% of Eligible Charge
Radiation Therapy – Outpatient *Prior Authorization required for certain treatments.*	20% of Eligible Charge	30% of Eligible Charge

CHEMOTHERAPY AND RADIATION THERAPY SPECIAL NOTES

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

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

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

ORGAN TRANSPLANT SERVICES

ORGAN TRANSPLANT SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Transplant Evaluation *Prior Authorization required.*	No Copayment	Not Covered
Corneal Transplants	10% of Eligible Charge	30% of Eligible Charge
All Other Organ Transplants *Prior Authorization required.*	No Copayment	Not Covered
Organ Donor Services *Prior Authorization required.*	20% of Eligible Charge	30% of Eligible Charge

ORGAN TRANSPLANT SERVICES SPECIAL NOTES

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

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

Benefits are not available for any of the following:

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

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

Corneal Transplants: Covered

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

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

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

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

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

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

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

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

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

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

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

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

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

MENTAL HEALTH AND SUBSTANCE ABUSE SPECIAL NOTES

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

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

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

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

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

Outpatient Services: ***Covered, as follows:***

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

Inpatient Services: Covered, as follows:

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

SPECIFIC BENEFITS FOR CHILDREN

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

SPECIFIC BENEFITS FOR CHILDREN SPECIAL NOTES

Newborn Circumcision: Covered.

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

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

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

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

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

SPECIFIC BENEFITS FOR WOMEN

SPECIFIC BENEFITS FOR WOMEN	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Birthing Room	No Copayment	20% of Eligible Charge
Cervical Cancer Screening (Pap smear)	No Copayment	No Copayment
Family Planning	10% of Eligible Charge	30% of Eligible Charge
Mammography for Breast Cancer Screening	No Copayment	No Copayment
Maternity Care	10% of Eligible Charge	30% of Eligible Charge
Tubal Ligation	10% of Eligible Charge	30% of Eligible Charge
Termination of Pregnancy	10% of Eligible Charge	30% of Eligible Charge
Well Woman Exam	No Copayment	No Copayment
Oral Contraceptives from Pharmacy (30-day supply) *Benefits are available for these contraceptives under this Plan only if you do not have a drug plan which provides coverage for contraceptives.*	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)
Oral Contraceptives by Mail Order & Maintenance Retail (60-day supply for Brand 90-day supply for Generic) *Benefits are available for these contraceptives under this Plan only if you do not have a drug plan which provides coverage for contraceptives.*	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)	Not Covered
Over-the-Counter (OTC) Contraceptives from Pharmacy *Benefits are available for these contraceptives under this Plan only if you do not have a drug plan which provides coverage for contraceptives.*	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)	No Copayment (Generic, Preferred Brand, or Non-Preferred Brand)
Contraceptive Cervical Caps/ Diaphragms	No Copayment	No Copayment
Contraceptive Implants, Injections, IUDs	No Copayment	No Copayment

SPECIFIC BENEFITS FOR WOMEN SPECIAL NOTES

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

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

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

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

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

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

Maternity length of stay, covered for up to:

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

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

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

Termination of Pregnancy: Covered.

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

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

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

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

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

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

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

SPECIFIC BENEFITS FOR MEN

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

SPECIFIC BENEFITS FOR MEN SPECIAL NOTES

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

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

Erectile Dysfunction: Covered, for services, supplies, prosthetic devices, and injectables to treat erectile dysfunction due to organic cause as defined by UHA or as described under Gender Identity Services (page 62).

SPECIFIC BENEFITS FOR MEMBER AND COVERED SPOUSE

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

IN VITRO FERTILIZATION SPECIAL NOTES

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

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

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

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

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

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

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

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

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

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

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

SPECIFIC BENEFITS FOR DIABETES

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

SPECIFIC BENEFITS FOR DIABETES SPECIAL NOTES

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

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

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

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

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

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

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

COMPLEMENTARY ALTERNATIVE MEDICINE

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

COMPLEMENTARY ALTERNATIVE MEDICINE SPECIAL NOTES

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

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

OTHER MEDICAL SERVICES

OTHER MEDICAL SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Ambulance (ground or air) **For emergencies only**	20% of Eligible Charge	30% of Eligible Charge
Applied Behavioral Analysis for Autism Spectrum Disorders *Prior Authorization required.*	10% of Eligible Charge	30% of Eligible Charge
Bariatric Surgery *Prior Authorization required.*	10% of Eligible Charge	30% of Eligible Charge
Blood, Blood Products & Blood Bank Service Charges	20% of Eligible Charge	30% of Eligible Charge
Dialysis and Supplies	20% of Eligible Charge	30% of Eligible Charge
Evaluations for Use of Hearing Aids	20% of Eligible Charge	30% of Eligible Charge
Growth Hormone Therapy *Prior Authorization required.*	20% of Eligible Charge	30% of Eligible Charge
Home Infusion Therapy *Prior Authorization may be required after first 12 visits.*	20% of Eligible Charge	30% of Eligible Charge
Hyperbaric Oxygen Treatment *Prior Authorization required.*	20% of Eligible Charge	30% of Eligible Charge
Implants	20% of Eligible Charge	30% of Eligible Charge
Inhalation Therapy	20% of Eligible Charge	30% of Eligible Charge
Injectable Medications – Outpatient *Prior Authorization required for certain injectables.*	20% of Eligible Charge	30% of Eligible Charge
Medical Equipment and Appliances *Prior Authorization required when purchase is greater than $500 or rental is greater than $100/month.*	20% of Eligible Charge	30% of Eligible Charge
Medical Foods	20% of Eligible Charge	20% of Eligible Charge
Orthotics	20% of Eligible Charge	30% of Eligible Charge
Physical and Occupational Therapy Services *Prior Authorization required after a total of 32 units (1 unit = 15 minutes).*	20% of Eligible Charge	30% of Eligible Charge

OTHER MEDICAL SERVICES	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Prosthetics *Prior Authorization required when cost is more than $500.*	20% of Eligible Charge	30% of Eligible Charge
Speech Therapy Services *Prior Authorization required.*	20% of Eligible Charge	30% of Eligible Charge

OTHER MEDICAL SERVICES SPECIAL NOTES

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

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

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

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

Bariatric Surgery: Covered, but requires Prior Authorization.

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

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

Dialysis and Dialysis Supplies: Covered

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

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

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

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

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

Home Infusion Therapy: Covered, for services and supplies for outpatient injections or intravenous administration of medication or nutrient solutions required for primary diet. Certain home infusion therapies require Prior Authorization after the first 12 visits.

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

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

Inhalation Therapy: Covered.

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

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

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

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

Repairs and maintenance of appliances and medical equipment

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

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

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

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

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

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

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

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

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

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

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

Group exercise programs are not covered.

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

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

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

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

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

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

SERVICES NOT COVERED

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

Even if a service or supply is not specifically listed as an exclusion, it will not be covered unless it is described as a covered benefit in the Medical Plan Benefits section (pages 39 - 64) and it meets all of the criteria for payment listed in the Health Care Services Program section (pages 32 - 37). If you have any questions about whether a specific procedure, service or supply is a covered benefit, contact UHA Customer Services for assistance.

Experimental or Investigative Treatment

You are not covered for medical treatments, drugs, devices, or care, and all related services and supplies, which cannot be designated as being reasonably necessary for your care relative to other well established available services or equipment, or when the potential therapeutic benefit of such treatments are judged to be of a degree insufficient to offset the risk to patient safety and cost. The Prior Authorization process for experimental and investigative treatments is designed to define and address these issues with consideration for each member's individual circumstances.

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

Non-Routine Care Associated with Clinical Trials

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

FDA Approval Not Obtained

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

Dental Services

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

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

Drugs

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

Vision Services, Eyeglasses and Contacts

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

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

Cosmetic or Reconstructive Services, Supplies or Procedures

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

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

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

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

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

Counseling Services

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

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

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

Autism Services

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

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

Fertility/Infertility

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

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

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

Reversal of Sterilization

You are not covered for reversal of sterilization.

Reversal of Vasectomy

You are not covered for reversal of vasectomy.

Growth Hormone Therapy

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

Transplant and Donor Services

You are not covered for:

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

Exclusion by Type of Provider

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

Emergency Room Visits for Non-Emergencies

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

When Someone Else is Responsible for Payment

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

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

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

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

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

Miscellaneous Exclusions

Airline oxygen: You are not covered for airline oxygen.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wigs: You are not covered for wigs.

FILING CLAIMS FOR PAYMENT

FILING CLAIMS

When you receive services from any provider, be sure to present your UHA identification card. If you have other coverage, you should also present the other carrier's identification card or inform your provider of the other coverage.

When you visit a UHA Participating Provider, the provider will file a claim for payment on your behalf and payment will be sent to the provider. UHA will send you an Explanation of Benefits (EOB) showing the services performed, the amount charged, the amount allowed, the amount paid by UHA, and the amount, if any, that you owe.

When you visit a Non-Participating Provider, the provider may file a claim on your behalf or give you the claim to file with UHA. The provider of service must sign the claim form. UHA will send payment to you along with a Remittance Advice (RA). You are responsible for paying the entire amount charged to the provider. In no event will UHA's payment amount for services rendered by a Non-Participating Provider exceed the amount UHA would pay to a comparable Participating Provider for similar services rendered.

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

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

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

PAYMENT DETERMINATION CRITERIA

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

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

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

INFORMATION REQUIRED ON A CLAIM

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

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

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

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

WHERE TO SEND CLAIMS

Claims should be submitted as soon as possible after the date of service. All claims for payment must be filed with UHA within one year of the date of service. **No payment will be made on any claim received more than one year after the date on which you received the service.**

Claims should be sent to:

UHA
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813

EXPLANATION OF BENEFITS (EOB)

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

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

If you have any questions about your EOB, or think that UHA made an error in paying a claim, please call or write to UHA Customer Services. If after contacting Customer Services you are not satisfied and think UHA made an error in determining benefits or paying your claim, you may request a formal review in accordance with the appeal procedures on pages 75 - 79.

COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

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

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

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

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

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

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

BENEFIT PAYMENTS UNDER COORDINATION OF BENEFITS RULES

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

- Coverage afforded by a specific benefit plan (i.e., drug or specified disease) pays first before the coverage afforded by this Plan.
- The coverage you have as an employee pays first before any coverage you have as a spouse or dependent.

- The coverage you have as an active employee pays before coverage you have as a retiree or under which you are not actively employed.
- When both coverages are employer-sponsored plans and one plan has no coordination of benefits rules and the other does, the plan without coordination of benefits rules pays first.
- When none of these rules apply, the coverage with the earliest continuous effective date pays first.

With respect to children, the following rules apply:

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

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

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

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

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

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

MOTOR VEHICLE ACCIDENT COVERAGE

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

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

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

MEDICARE COORDINATION RULES

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

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

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

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

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

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

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

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

THIRD PARTY LIABILITY RULES

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

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

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

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

If you are in a motor vehicle accident, you must exhaust the motor vehicle personal injury protection mandatory coverage amount specified by state law first, before the coverage under this Plan will apply (See Motor Vehicle Accident Coverage on page 72).

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

1. Give UHA timely notice of each of the following, no later than 30 calendar days after their occurrence:
   a. Your knowledge of any potential claim or source of recovery related to your injury or illness.
   b. Any written claim or demand (including initiation of legal proceedings) made by you or on your behalf.
   c. Any monetary recovery (including any settlement, judgment, award, insurance proceeds, or other payment) from any source of recovery in connection with your illness or injury, including the amount and source of any recovery.
2. Sign and deliver to UHA all liens, assignments and other documents it requires to secure its rights to recover payments. You have a duty to authorize and direct any person or entity making or receiving any payment on account of such injury or illness to pay to UHA so much of such payment as needed to discharge your reimbursement obligations described above.
3. Provide UHA any information reasonably related to its investigation of liability for coverage and rights to repayment, including medical records and documents related to any legal claims.
4. DO NOT release or otherwise impair UHA's rights to repayment, without UHA's express written consent.
5. Cooperate in protecting UHA's rights under these rules, including giving notice of UHA's rights to repayment as part of any written claim or demand made against any other person or party or other source of recovery.

Any notice required by these Rules must be sent to:

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

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

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

If UHA is not reimbursed for its total payment of benefits in connection with your illness or injury, UHA shall have a right of subrogation (substituting UHA to the member's rights of recovery) for all causes of action and all rights of recovery you have against such other person or party or other source of recovery, to the extent of UHA's unreimbursed payments on your behalf.

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

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

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

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

GRIEVANCES AND APPEALS

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

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

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

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

REQUESTING A FORMAL APPEAL

If you are not satisfied with the response you receive from Customer Services, you may appeal the decision by writing to:

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

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

- The date of the request
- Your name
- The date of the service that you believe was denied or paid in error, if any
- A description of the facts related to the appeal and why you believe UHA's decision was in error
- Any other documents relating to your appeal that you would like UHA to review.

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

- A copy of documents and information relevant to your claims for payment, request for prior authorization, the rescission of your coverage, or to your appeal.
- Any rule, guideline, or protocol relied upon in making the decision at issue.
- The identity of experts whose advice was obtained in connection with denial of your claim for payment, request for prior authorization, or appeal.

WHO MAY REQUEST AN APPEAL?

You or your designated representative may request an appeal. Designated representatives include:

- A provider.
- A court-appointed guardian or agent under a health care proxy, or other person whom you designate in writing to represent you on your appeal. You must provide UHA with documentation of your designation of a representative to act on your behalf with your appeal.
- A person authorized by law to provide substituted consent for you or to make health care decisions on your behalf.
- A family member or your treating health care professional if you are unable to provide consent.

DECISION MAKING ON APPEALS

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

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

EXPEDITED APPEALS

You may request an expedited appeal:

1. For an acute or urgent condition.
2. If the standard response time (30 or 60 days, as set forth above) for completing an appeal would:
    a. Seriously jeopardize your life or health.
    b. Seriously jeopardize your ability to regain maximum functioning.
    c. Subject you to severe pain that cannot be adequately managed without the care or treatment requested.

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

You may make your request for an expedited appeal in writing to the Appeals Coordinator whose address is given above. You may also orally submit your request for expedited appeal to UHA's Health Care Services Department (532-4006 from Oahu or Toll-free 1-800-458-4600, ext. 300 from the Neighbor Islands).

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

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

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

a. Seriously jeopardize your life or health.

b. Seriously jeopardize your ability to regain maximum functioning.

c. Subject you to severe pain that cannot be adequately managed without the care or treatment requested.

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

APPEALS COMMITTEE REVIEW

UHA's Appeals Committee will review your appeal request. When necessary and as time allows, UHA will obtain the opinion of outside experts not affiliated with UHA to advise the committee. UHA will notify you in writing of its decision within the timeframes specified above. If special circumstances arise requiring additional days, UHA will notify you that additional days are needed to complete the review.

UHA's review on appeal will consider all information submitted by you (whether or not that information was submitted in your initial claim for payment or request for Prior Authorization), will use a different reviewer than the person who decided your original request, and will not give deference to the initial decision.

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

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

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

EXTERNAL REVIEW BY INDEPENDENT REVIEW ORGANIZATION

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

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

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

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

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

You will be notified when an independent review organization (IRO) is assigned your external review. You may submit additional written information to the IRO at the address provided in the notice. The IRO will consider any additional information submitted within five business days after you receive the notice, and may consider additional information received after that date. If any additional information is submitted, it will be shared with UHA in order to give UHA an opportunity to reconsider its denial.

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

EXPEDITED EXTERNAL REVIEW BY THE IRO

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

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

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

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

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

OTHER PROCEDURES FOR EXTERNAL REVIEW

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

1. Request binding arbitration before a mutually selected arbitrator, or
2. File a lawsuit against UHA under section 502(a) of ERISA. UHA waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.

ARBITRATION

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

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

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

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

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

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

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

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

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

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

HMO MEDICAL PLAN
(Self-Insured)

Benefits provided under the HMO Medical Plan are self-insured by the Hawaii Teamsters Health and Welfare Trust. The Trust has contracted Hawaii-Mainland Administrators, LLC (HMA) to handle the claims administration for the HMO Medical Plan. This means that if you choose the HMO 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

HMA Connection Line

Phone: 808-951-4641
Toll Free: 1-877-384-2875
Website: *www.hma-hi.com/teamsters/hmo*

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

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

HOW TO USE THE HMO MEDICAL PLAN

You obtain your medical care through contracted facilities and 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. You may view the provider directory online by logging on to the website at www.teamsterstrustbenefits.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 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.

ACCESSING CARE

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

PAYMENT INFORMATION

PAYMENT DETERMINATION CRITERIA

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

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

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

If You Participate in an Approved Clinical Trial

Although the Plan does not provide benefits for treatment considered to be “experimental” or “investigative”, routine patient costs for services or items furnished in connection with participation in an approved clinical trial will be covered for qualified beneficiaries in accordance with Federal law. Services and items typically covered under this Plan for a patient who is not enrolled in a clinical trial will be covered at the same benefit level for a patient enrolled in a clinical trial. The following are excluded from coverage:

- The cost of the investigational item, device, or service.
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

ANNUAL AND LIFETIME BENEFIT MAXIMUMS

There is no annual or lifetime dollar benefit maximum for benefits paid or provided under this Plan on your behalf. However, certain benefits have annual maximums. For example, skilled nursing facility care is limited to 120 days per calendar year. Please refer to pages 85 - 93 for a description of these benefit maximums as well as other limitations that may apply to covered services.

ANNUAL DEDUCTIBLE

This Plan has no annual deductible.

ELIGIBLE CHARGE

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 individual and $6,000 per family of three or more in any plan year. Once the Annual Copayment Maximum is met, you are no longer responsible for copayment amounts for covered medical services for the rest of that plan year. Each family member must meet the individual Annual Copayment Maximum until the family Annual Copayment Maximum is met. The following payments do not count toward the Annual Copayment Maximum and you are responsible for these amounts even after you have met the Annual Copayment Maximum:

- 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 authorization through HMA's Health Services Department. **Failure to obtain prior authorization will result in a denial of benefits.** You or your physician must call the HMA Health Services Department at (808) 951-4621 (Oahu) or 1 (866) 377-3977 (toll free) before the services are provided.

REFERRALS	• Referrals to specialists for consultations and office visits, including all out-of-state services.
INPATIENT ADMISSIONS	• All inpatient admissions including acute, skilled and observation days
OUTPATIENT SERVICES	• Imaging scans (MRI, MRA, or PET scans) • Gamma knife / X-knife procedures • Greater than three (3) OB ultrasounds per pregnancy • In-vitro fertilization • Reconstructive surgery
OUTPATIENT REHABILITATION SERVICES	• Physical Therapy • Speech Therapy • Occupational Therapy
OTHER MEDICAL SERVICES	• Durable Medical Equipment (DME) • Hospice Care • Home Health Care • Intravenous administration of medication • Human Growth Hormone Therapy • Dialysis • Chemotherapy • Radiation Therapy • Orthotics and Prosthetics • Transplants
OUT-OF-AREA SERVICES	• All non-emergency services outside the service area /out-of-state services
INTER-ISLAND TRAVEL BENEFIT (Available only to beneficiaries who do not reside on Oahu)	• Non-emergency inter-island travel to obtain 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 at (808) 951-4621 (Oahu) or 1 (866) 377-3977 (toll free) within 48 hours or by the next business day.	

SURGICAL REVIEW

Before scheduling any inpatient surgical procedure, your physician must notify HMA and request a Surgical Review. **If a surgical review is required but not obtained, the Plan will 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 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, 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 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 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.

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.

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 (see page 95 and the CLAIMS AND APPEALS PROCEDURES section of this booklet).

MEDICAL BENEFITS

SERVICES	MEMBER CHARGES

MEDICAL SERVICES

Doctors' and other health professionals' office visits ..... $14.00 per visit

Preventive Care

- Well Child office visits (Routine visits from birth through age 21 years) ..... No charge
- Preventive Care office visits (Age 22 and older), one per calendar year ..... No charge
- Gynecological office visit (female members), one per calendar year ..... No charge
- Preventive Health Care services and items ..... No charge

Routine 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
(Hospital benefits apply)

LABORATORY, IMAGING & DIAGNOSTIC TESTING SERVICES

Outpatient services ..... $14.00 per service per day

Preventive Health Care screening services ..... No charge

- Screening services as identified in the current A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) and the Health Resources Service Administration's (HRSA) Women's Preventive Services Guidelines.
- Laboratory tests in connection with well-child care visits as identified in the American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care and one urinalysis through age 5.

Inpatient services ..... No charge
(Included as part of Hospital Services)

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

SERVICES	MEMBER CHARGES

EXTENDED CARE SERVICES

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

HOME CARE SERVICES

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

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

HOSPICE SERVICES

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

EMERGENCY CARE AND AMBULANCE SERVICES

Coverage for initial emergency treatment only:

At a facility within the Hawaii Service Area ..... $30.00 per visit

At a facility outside the Hawaii Service Area ..... $30.00 per visit

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

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

URGENT CARE SERVICES

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

MATERNITY SERVICES

Note: Medical, Surgical, Hospital, and other benefits are available for pregnancy, childbirth, or other termination of pregnancy, and related medical conditions. Diagnostic tests for an unborn Child are eligible for payment only when medically necessary. Benefits are available to a newborn child 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 pregnancy ..... No charge

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

Inpatient stay and inpatient care for newborn during mother's hospital stay ..... $100 per admission

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

SERVICES	MEMBER CHARGES
Lactation counseling and rental of breastfeeding equipment	No charge
Artificial Insemination	$14.00 per visit
In Vitro Fertilization • Limited to 1 procedure per lifetime	20% of Eligible Charges
Involuntary infertility office visits	$14.00 per visit
Family planning office visits	$14.00 per visit
Contraceptive aids and devices (FDA approved) to prevent unwanted pregnancies; patient education and counseling	No charge
MENTAL ILLNESS / ALCOHOL AND DRUG DEPENDENCE SERVICES	
Outpatient Care	
Office visits	$14.00 per visit
Psychological testing	$14.00 per service per day
Inpatient Care (Hospital or Qualified Treatment Facility)	$100.00 per admission
Specialized Facility Services (Services in a specialized mental health, alcohol, or drug dependency treatment unit or facility approved by the Plan)	
Day treatment or partial hospitalization services	$14.00 per visit
Non-hospital residential services	$100.00 per admission
OTHER SERVICES	
Allergy Testing and Treatment Materials (one series per calendar year)	$14.00 per visit
Blood, Blood Products and Blood Bank Service Charges	No Charge
Chemotherapy medications for treatment of cancer if skilled administration is required	No Charge (Office visit copayment applies)
Dialysis and Supplies (Outpatient)	10% of Eligible Charges
Diabetes equipment and related supplies	30% of Eligible Charges
Appliances and Durable Medical Equipment	20% of Eligible Charges
Implanted internal prosthetics, devices and aids	No Charge
Medical Foods for inborn metabolic disorders	20% of Eligible Charges
Outpatient Injections and Intravenous administration of medication or of nutrient solutions required for primary diet, when skilled administration is required	No Charge (Office visit copayment applies)
Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy	$14.00 per visit
Transplant Donor Services	10% of Eligible Charges
Evaluations for the use of hearing aids	$14.00 per visit

NON-EMERGENCY INTER-ISLAND TRAVEL BENEFITS

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

- Reimbursement for roundtrip airfare, not to exceed $200.00;
- Reimbursement for taxi fare to and from the airport, not to exceed $50.00;
- 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. ***Go to the nearest emergency room***. 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.

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.**

For covered services received outside the Service Area, the Plan’s benefit payment will be made as though such services had been rendered within the Service Area. However, the Eligible Charge for covered inpatient and emergency services rendered by out-of-state providers shall not exceed 170% of the Eligible Charge for the same or comparable service rendered within the Service Area, and for all other covered services rendered by out-of-state providers, the Eligible Charge shall not exceed 150% of the Eligible Charge for the same or comparable service rendered within the Service Area.

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.
- 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 for the treatment of an injury or illness resulting from an act of war or armed aggression (whether or not a state of war legally exists) or that occurs during a period of active duty exceeding 30 days in the service of any armed force.
- The following costs and services for infertility, in vitro fertilization, or artificial insemination:
  - The cost of equipment and of collection, storage and processing of sperm;
  - In vitro fertilization using either donor sperm or donor eggs;
  - In vitro fertilization when a surrogate is used.
  - 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 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 other than prescribed Preventive Health Care services.
- 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 except that routine patient costs for services or items furnished in connection with participation in an approved clinical trial will be covered for qualified beneficiaries in accordance with federal law.
- 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 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. 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 four years duration, 12 months of which must be consecutive months of coverage under the Plan, 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 Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.
  - The in vitro fertilization procedure must be prior authorized by 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 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.

- Preventive Health Care services and items are provided without charge. Benefits for Preventive Health Care are subject to the following conditions and limitations.
  - In accord with federal law, Preventive Health Care means and includes:
    (i) Evidence-based items or services having a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved;
    (ii) Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
    (iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the Bright Futures Recommendations for Preventive Pediatric Health Care developed by the American Academy of Pediatrics and supported by the Health Resources and Services Administration (HRSA); and
    (iv) With respect to women, evidence-informed preventive care and screenings provided in the health plan coverage guidelines developed by the Institute of Medicine and supported by the Health Resources and Services Administration (HRSA).

    The list of covered Preventive Health Care items and services is updated from time to time when new recommendations or guidelines are issued. Please contact the Claims Administrator for a current listing of covered services or if you have any questions regarding Preventive Health Care.
  - If a Preventive Health Care item or service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of the Preventive Health Care item or service, the office visit will be provided without charge.
  - If a Preventive Health Care item or service is not billed separately from an office visit and the primary purpose of an office visit is not the delivery of the Preventive Health Care item or service, the office visit copayment shall apply.

- 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.
- 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 will not be coordinated. **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. (See CARE RECEIVED FROM NON-CONTRACTED PROVIDERS, page 88, for more information)

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.

Specific information about the Plan's claims and appeals procedures are contained in the CLAIMS AND APPEALS PROCEDURES section of this booklet on pages 125 - 129.

IF YOU DO NOT AGREE WITH A BENEFIT DETERMINATION

If you do not agree with a benefit determination made by HMA, you may ask for a second review by calling HMA at (808) 951-4621 (Oahu) or 1 (866) 377-3977 (toll free). If you are not satisfied with the response you receive and wish to pursue a claim for coverage, you may file an appeal with the Trust Fund as provided in the CLAIMS AND APPEALS PROCEDURES section of this booklet.

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

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

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

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

The Board of Trustees has appointed the Benefits and Appeals Committee to hear all requests for review of denied claims. Please refer to the Appeals section on pages 127 - 129 for further details on appealing a denied claim to the Board of Trustees.

DISCLAIMER

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

The 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 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.

INDEMNITY PRESCRIPTION DRUG PLAN
(Self-Insured)

The following Indemnity Prescription Drug Plan 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 UHA 600 Medical Plan or the HMO Medical Plan for your medical coverage.

Benefits provided under the Indemnity Prescription Drug Plan are self-insured by the Hawaii Teamsters Health and Welfare Trust. The Trust has contracted OptumRx (formerly Catamaran) as the Pharmacy Benefits Manager to administer and process Indemnity Prescription Drug claims. If you have any questions regarding your prescription drug benefits, please contact the Pharmacy Benefits Manager at:

OptumRx

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

ANNUAL COPAYMENT MAXIMUM

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

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

COVERED DRUGS

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

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

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

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

Preventive Health Care Medications

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

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

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

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

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

The list of covered Preventive Health Care Medications is updated from time to time when new recommendations or guidelines are issued. Please contact the Pharmacy Benefits Manager for a current listing of covered drugs or if you have any questions regarding covered medications. You may view this list online by logging on to the website at www.optumrx.com.

Over-the-Counter Drugs

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

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

Diabetic Sense Program/Healthy Living Program

The Diabetic Sense Program is open to all Plan members who are diagnosed with diabetes or pre-diabetes. OptumRx and Liberty Dialysis offer program enrollees free access to:

- Glucometer (limited to one per year)
- Home delivery of diabetic testing supplies (lancets, test strips, alcohol swabs, etc.)
- Telephone outreach services from a Certified Diabetic Educator

COVERAGE LIMITATIONS

Prior Authorization

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

Generic Substitution

A generic equivalent will be substituted for a brand name drug, except when a physician directs that substitution is not permissible. Plan members who choose not to use the 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 for review. The brand name medication must be deemed medically necessary in order to receive a Prior Authorization.

Step Therapy Program

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

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

Drug Quantity Management Program

Drug Quantity Management is a program designed to promote the appropriate dispensing of drugs and reduction of drug waste through quantity limits on certain medications as recommended by the Food and Drug Administration (FDA). If you are prescribed one of these medications and require more than the recommended quantity per prescription, your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager.

Specialty Medications

Specialty medications are high-cost drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. Specialty medications are limited to a 30 day supply. Your physician must submit a Prior Authorization request to the Pharmacy Benefits Manager for coverage approval when you are prescribed a new or different specialty medication.

Compounded Medications

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

DRUGS NOT COVERED

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

- Injectable drugs dispensed under the Medical Plan.
- Immunization agents.
- Agents used in skin tests for determining sensitivity.
- Fertility agents, other than oral prescription drugs for in vitro fertilization (Prior Authorization is required).
- Appliances and other non-drug items.
- Drugs furnished to hospital or skilled nursing facility inpatients.
- Drugs for treatment of sexual dysfunction or inadequacies.
- Drugs which may be purchased without a prescription, except as specified above.
-

IF YOU DO NOT AGREE WITH A BENEFIT DETERMINATION

If you do not agree with a benefit determination made by the Pharmacy Benefit Manager, you may ask for a second review by calling OptumRx toll free at 1 888-869-4600. If you are not satisfied with the response you receive and wish to pursue a claim for coverage, you may file an appeal with the Trust Fund as provided in the CLAIMS AND APPEALS PROCEDURES section of this booklet.

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

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

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

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

The Board of Trustees has appointed the Benefits and Appeals Committee to hear all requests for review of denied claims. Please refer to the Appeals section on pages 127 - 129 for further details on appealing a denied claim to the Board of Trustees.

PRESCRIPTION DRUG BENEFITS FOR UHA 600 MEDICAL PLAN MEMBERS

UHA Plan members have four 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 OptumRx 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 Pharmacy Benefits Manager at 1 (888) 869-4600.

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

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

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

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

Prescriptions obtained from a nonparticipating pharmacy are NOT covered under the Point of Service Program. You are responsible for paying the entire cost of the prescription at the nonparticipating pharmacy and filing a claim for reimbursement under the Direct Member Reimbursement Program.

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

CENTRAL FILL PROGRAM (through designated Central Fill pharmacies)

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

To use the Central Fill Program:

Step 1: Obtain a prescription from your doctor.

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

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

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

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

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

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

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

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

MAIL ORDER PROGRAM (through designated Mail Order providers)

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

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

[1] 15-day initial fill required.

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

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

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

DIRECT MEMBER REIMBURSEMENT PROGRAM

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

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

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

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

Limitations

All prescription drugs are limited to 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.

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

PRESCRIPTION DRUG BENEFITS FOR HMO PLAN MEMBERS

HMO Medical Plan members have three options for obtaining covered prescription drugs:

1. The Point of Service Program,
2. The Mail Order Program, and
3. The Direct Member Reimbursement Program (when you have a medical emergency outside the State of Hawaii).

To obtain services through the Point of Service Program, you must use participating or designated pharmacies and present your HMA/OptumRx 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.

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

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

	Participating Pharmacy
For each prescription or refill when the quantity does not exceed:	
15-day consecutive supply (Acute medications/initial fill)	$12.00 copayment or the cost of the drug, whichever is less[2]
30-day consecutive supply[1] (Maintenance medications)	$14.00 copayment or the cost of the drug, whichever is less[2]
For covered drugs or items that can only be dispensed in unbreakable packages, the day supply limit shall be equivalent to the package size day supply, with a single copayment of $14 or the cost of the drug, whichever is less, charged to the member.	
60-day consecutive supply[1] **(**Maintenance medications)	$28.00 copayment or the cost of the drug, whichever is less[2]
90-day consecutive supply[1] (**Maintenance medications**)	$42.00 copayment or the cost of the drug, whichever is less[2]
For covered drugs or items that can only be dispensed in unbreakable packages, the day supply limit shall be equivalent to the package size day supply, with a single copayment of $42 or the cost of the drug, whichever is less, charged to the member	
Preventive Health Care medications[1]	No copayment[3]

[1] 15-day initial fill required.

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

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

MAIL ORDER PROGRAM (through designated Mail Order providers)

If you use the Mail Order Program for your maintenance prescription drugs, you pay the copayments listed below:

	Mail Order Pharmacy
For each prescription or refill when the quantity does not exceed:	
30-day consecutive supply[1] (Maintenance medications)	$14.00 copayment or the cost of the drug, whichever is less[2]
For covered drugs or items that can only be dispensed in unbreakable packages, the day supply limit shall be equivalent to the package size day supply, with a single copayment of $14 or the cost of the drug, whichever is less, charged to the member.	
90-day consecutive supply[1] (Maintenance medications)	$28.00 copayment or the cost of the drug, whichever is less[2]
Preventive Health Care medications[1] (Maintenance medications)	No copayment[3]

[1] 15-day initial fill required.

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

[3] There is no copayment for generic Preventive Health Care medications. If a generic equivalent is not available or not medically appropriate for you, a brand name drug will be provided without charge. If a generic equivalent is available but you request brand name only, you will be responsible for the applicable 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 reimbursement for covered prescription drugs provided in conjunction with medical services rendered outside the State of Hawaii for an emergent or urgent medical condition or under an authorized referral. You are responsible for paying the entire cost of the prescription and filing a claim with the Pharmacy Benefits Manager. For eligible and medically necessary prescription drugs provided outside the State of Hawaii, the Trust Fund will pay benefits as provided under the Point of Service Program, but in no event will the Eligible Charge for such prescription drugs exceed the Eligible Charge for the same prescription drugs provided within the State of Hawaii.

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.

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 Plan benefits described in this booklet is insured by any contract of insurance and there is no liability on the part of the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Trust collected and available for such purpose. No participant or dependent shall have accrued or vested rights to benefits under this Plan.

The Indemnity Prescription Drug Plan benefits are self-insured by the Hawaii Teamsters Health and Welfare Trust. The preceding is for informational purposes only and is only a summary of coverage. Its contents are subject to the provisions of the Indemnity Prescription Drug Plan document and all amendments thereto. This document is on file with the Hawaii Teamsters Health and Welfare Trust Office. Please refer to this document for specific questions about coverage.

VISION CARE BENEFITS

You are 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.

Vision Care benefits are provided through the VSP Advantage Plan. If you have any questions regarding your vision care benefits, please contact VSP's Customer Care Division.

VSP CUSTOMER CARE	
Oahu:	(808) 532-1600
Neighbor Islands:	1 (800) 522-5162 Toll Free
Nationwide (24/7):	1 (800) 877-7195 Toll Free

WHAT ARE THE VISION CARE BENEFITS?

Standard Eye Examinations and Prescription Glasses

Eye Examinations:	Once every 12 months*
Lenses:	Once every 24 months*
Frames:	Once every 24 months*

**From the date of your last service. Interim benefits for lenses are available after 12 months if the new prescription differs from the original prescription by a) at least (+) or (-) 0.50 diopter sphere or cylinder, or b) an axis change of 15 degrees or more, or c) a 0.5 prism diopter change in at least one eye.*

	PLAN PAYS	
BENEFIT	**VSP MEMBER DOCTOR**	**OUT-OF-NETWORK PROVIDER**
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
SPECTACLE LENSES		
Single Vision Lenses	100% after copayment	Up to $ 50.00
Lined Bifocal Lenses	100% after copayment	Up to $ 70.00
Lined Trifocal Lenses	100% after copayment	Up to $ 70.00
FRAMES	Up to $ 90.00 after copayment	Up to $ 40.00
CONTACT LENSES (in lieu of glasses)	Up to $110.00 (no copayment)	Up to $110.00

Elective Contact Lenses

Contact lenses may be chosen instead of glasses. Contact lens frequency is the same as spectacle lenses. If you elect contact lenses, you will not be eligible for lenses again for 24 months (interim benefits are available after 12 months as noted above), and frames for 24 months, after the last date you received contact lenses.

An allowance of $110 is provided for contact lenses and the contact lens exam (evaluation and fitting). Any costs exceeding the allowance are the responsibility of the patient. If you use a VSP Member Doctor, a 15% discount will be applied toward the doctor's professional fees for the contact lens exam. This discount is applicable for the 12 months following the covered exam from VSP doctors.

Medically Necessary Contact Lenses

Coverage for medically necessary contact lenses is subject to review and approval by VSP. When medically necessary contact lenses are prescribed by a VSP Member Doctor, they are covered in full with prior approval from VSP. Medically necessary contact lenses obtained from an Out-of-Network Provider are covered up to $110 when approved by VSP. This benefit is subject to the copayment.

Extra Discounts and Savings from VSP Member Doctors

- 20% off any frame overage in excess of the frame benefit.
- 20% off non-covered lens options such as tints, progressive lenses and anti-scratch coatings.
- 20% off additional pairs of prescription glasses and sunglasses, including lens options, within 12 months of your covered vision exam from a VSP Member Doctor**.**

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan benefits or may be subject to additional limitations. Details regarding frame brand availability may be obtained from your VSP Member Doctor or by calling VSP's Customer Care Division at 1-800-877-7195.

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

- Eye examinations or corrective eyewear required by an employer as a condition of employment
- Orthoptics or vision training and any associated supplemental testing
- Corneal Refractive Therapy (CRT)
- Orthokeratology
- Refitting of contact lenses after the initial (90-day) fitting period
- Plano lenses (lenses with refractive correction of less than $\pm$ .50 diopter)
- Two (2) pairs of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision treatment of an experimental nature
- Contact lens modification, polishing or cleaning
- Additional office visits associated with contact lens pathology
- Contact lens insurance policies or service agreements
- Services and/or materials not indicated as covered plan benefits

The Plan will not pay Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to a patient by a VSP Member Doctor or an out-of-network provider.

HOW DO I USE THE PLAN?

When you receive services from a VSP Member Doctor, you pay the doctor your copayment for the examination and materials. The VSP Member Doctor will submit the claim to VSP for payment, so there is no paperwork for you. If you select any non-covered extras (e.g., designer frames, lens tinting, scratch resistant coatings, etc.), you will be charged according to discounted usual and customary charges.

VSP Member Doctor

Step 1: Call a VSP Member Doctor of your choice to make an appointment and identify yourself as a VSP member.

Step 2: The doctor will collect a $10.00 copayment for the examination and materials.

Step 3: Ask your VSP Member Doctor to itemize the charges so you will know exactly what portion of the bill is covered under your VSP plan.

How Do I Receive Out-of-Network Reimbursement?

If you have received services from an Out-of-Network Provider:

Step 1: Pay the full amount of your bill to the Out-of-Network Provider at the time you receive services.

Step 2: Submit a claim to VSP for reimbursement. Be sure to include itemized receipts with your claim.

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

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

- Log in to your vsp.com account.
- Complete the vsp.com online claim form following the prompts.
- Submit your itemized receipt(s) along with the claim form. You can either upload your receipts or print the claim form and submit with your receipts by mail to:

  VSP
  Attention: Claims Services
  P.O. Box 385018
  Birmingham, Alabama 35238-5018

  Mobile users can simply snap a photo and attach their receipts.

After submitting your claim, you can track the status of your claim online:

- Log in to your vsp.com account.
- Click on “Claims and Reimbursement” and select “Previous Doctor Visits & Services” to see the status of your claim.

Please allow up to ten (10) business days for VSP to process your reimbursement.

If you need assistance in filing a claim, you may call VSP Customer Care at (808) 532-1600 (Oahu) or 1-800-522-5162 (Neighbor Islands Toll Free) or 1-800-877-7195 (Nationwide Toll Free).

IMPORTANT: Out-of-network claims for reimbursement must be submitted to VSP within 12 months of the date of service.

CLAIMS APPEAL PROCESS

If your claim is denied in whole or in part, a copy of the specific rule, guideline, or protocol relied upon in making the benefit determination will be provided free of charge upon request by you or your authorized representative. A copy of VSP's claims appeal process may also be obtained from Customer Care.

If you are not satisfied with the explanation of why a service was not covered, a request for review may be sent within 180 days following denial of the claim to:

Vision Service Plan
Attn. Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741

Your request should include:

- Your name and telephone number.
- Member Identification Number.
- The name and birthdate of the covered person for whom the claim was denied.
- The date of the service denied or date of the contested action or decision.
- The provider's name and the claim number.
- A description of the facts related to your request and why you believe the claims administrator's action or decision was in error.
- Any other details about your appeal. This may include written comments, documents, and records you would like the claims administrator to review.

VSP will respond to your appeal within 30 calendar days following receipt of your request.

If you disagree with VSP's response, you have the right to a second level appeal. You may submit a second appeal to VSP along with any pertinent documentation within 60 calendar days following receipt of VSP's response to the initial appeal. VSP will communicate its final determination on your appeal within 30 calendar days.

If, after completing the appeals process, your claim was not approved in whole or in part and you disagree with the outcome, you have the right to bring a civil action under Section 502(a) of ERISA.

The preceding vision care benefits are insured under an insurance contract issued by Vision Service Plan (VSP), 3333 Quality Drive, Rancho Cordova, California 95670. The services provided by VSP include the payment of claims and the handling of claims appeals.

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

CHIROPRACTIC CARE BENEFITS

A Chiropractic Managed Care Network

(808) 621-4774 (Oahu)
1 (800) 414-8845 (Toll Free)
www.chiroplanhawaii.com

All employees and 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. 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.
2. 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.
3. 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.
4. 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.

QUESTIONS ABOUT YOUR COVERAGE

If you have any questions about your coverage, please call the ChiroPlan Hawaii office at 621-4774 or 1 (800) 414-8845 (toll free) for assistance.

CLAIMS APPEAL PROCESS

If a service is not covered, a copy of the specific rule, guideline, or protocol relied upon in making the benefit determination will be provided free of charge upon request by you or your authorized representative.

If you are not satisfied with the explanation of why a service was not covered, you have the right to appeal the decision and request reconsideration.

You or your authorized representative should submit a written request within 180 days of the date of denial to:

ChiroPlan Hawaii, Inc.
Attn. Medical Director
711 Kilani Avenue, Suite 3
Wahiawa, Hawaii 96786

Your request should include:

- Your name, phone number, and mailing address
- Patient's name
- Provider's name
- Claim number
- Service or decision being appealed
- Reason for the appeal

ChiroPlan will review your request and provide you with a written response within 30 days. If you do not agree with the response, you have the right to bring a civil action under section 502(a) of ERISA, or you may request further appeal by voluntary, binding arbitration.

If you choose arbitration, you must submit a written request for arbitration to ChiroPlan within one year of the final decision on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the issue. The arbitration is binding and the parties waive their right to a court trial and jury. ChiroPlan will pay the arbitrator's fee and other costs of the arbitration and each party must pay its attorney's or witness fees.

For further information on ChiroPlan's claims and appeals procedures, please call the ChiroPlan Hawaii office. A copy of the procedures will be provided free of charge upon request.

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 CARE BENEFITS

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

CHOICE OF PLANS

Employees may choose either the Trust Fund's self-insured fee for service dental plan provided through Hawaii Dental Service (HDS), or the prepaid dental plan offered by Dental Care Centers of Hawaii (DCCH) which is available only on Oahu. The main benefit provisions of each plan 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 DCCH Plan, you must use one of the DCCH dental providers, however, your out-of-pocket expenses are limited to a $12.00 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, print your membership card, and more!

To register:

1. Log on at ***www.HawaiiDentalService.com***
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.

Please note that HDS members 18 years and older must register for their own 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.HawaiiDentalService.com*** 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 assist HDS in processing your dental claims accurately, please notify the Hawaii Teamsters Health and Welfare Trust Office **immediately** of any of the following changes:

- 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.

HDS will 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. HawaiiDentalService.com*** 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 251,000 dentist locations.

If your job takes you out of state or your child attends school on the Mainland, HDS recommends that you and/or your dependents 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.HawaiiDentalService.com*** and click on "Members/Find a Participating Dentist." Click on the "Mainland & Puerto Rico" button to search for a 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.

- In most cases you will need to pay in full at the time of service.
- The non-participating dentist will render services and may provide you with the completed 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 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.

EOBs are available electronically and are accessible through your HDS website account. If you choose to 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.HawaiiDentalService.com.*** 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
HDS Payment
Dentist’s Approved Amount
<minus HDS Payment>

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 1-844-379-4325.

CLAIMS APPEAL PROCESS

If a service is not covered, a copy of the specific rule, guideline, or protocol relied upon in making the benefit determination will be provided free of charge upon request by you or your authorized representative. A copy of HDS's claims appeal process may be obtained from the HDS Customer Service Department.

If you are not satisfied with the explanation of why a service was not covered, you have the right to appeal the decision and request reconsideration.

You or your authorized representative should submit a request in writing within one year of the date of the service to:

Hawaii Dental Service
Attn: Appeals Manager
700 Bishop Street, Suite 700
Honolulu, Hawaii 96813

Your request should include:

- HDS Subscriber ID
- Patient name
- Contact phone number and mailing address
- Treating dentist's name
- Claim number
- Service being appealed
- Reason for appeal

HDS will review your request and provide you with a written response within 30 days. If you do not agree with the response, you have the right to bring a civil action under section 502(a) of ERISA**.**

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

Fraud and Abuse 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@HawaiiDentalService.com***

PLAN 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.
- All prescription medication.
- 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 HDS Contract for Dental Services.

SUMMARY OF DENTAL BENEFITS

BENEFIT	PLAN COVERS
PLAN MAXIMUM (per member per calendar year)	$1,700
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	
PERIODONTICS	80%
• 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%
• 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%
• Palliative treatment (for relief of pain but not to cure)	

ACCESS TO HDS INFORMATION 24/7

Visit HDS Online at *www.HawaiiDentalService.com* 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

HOW TO CONTACT HDS

CUSTOMER SERVICE REPRESENTATIVES

From Oahu:	**529-9248**	**Toll free:**	**1-844-379-4325**
Fax:	529-9366	Toll-free Fax:	1-866-590-7988

Monday through Friday, 7:30 a.m. - 4:30 p.m.

SEND WRITTEN CORRESPONDENCE TO:

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

E-mail: ***HDSCustomerService@HawaiiDentalService.com***

The preceding dental benefits are self-insured by the Hawaii Teamsters Health and Welfare Trust. The Trust has contracted Hawaii Dental Service (HDS), 700 Bishop Street, Suite 700, Honolulu, Hawaii 96813-4196 to be the Claims Administrator. 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 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 CARE CENTERS OF HAWAII (DCCH)

(Formerly Gentle Dental)

WHAT IS THE DENTAL CARE 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 $12.00 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 DCCH dental provider.

CHOOSING YOUR OWN PERSONAL DENTIST

Each dental provider 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	$12.00 per visit
Oral examinations	No charge
Full mouth x-ray	No charge
Panographic 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

SERVICES	MEMBER COPAYMENT
Crown and Bridge[1]	
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)[1]	
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

[1] ***Dental Laboratory*** *– Dental laboratory charges will apply if you have not met the eligibility requirement. After two (2) years of continuous enrollment in the DCCH 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. Orthodontic services.
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 DCCH providers 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 DCCH Plan considers the other plan the primary carrier, responsible for dental charges incurred by those members with dual coverage.

OFFICE FACILITIES

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

DCCH PROVIDER LOCATIONS

Kaizen Dental Center (Honolulu)
1136 Union Plaza, Suite 502
Honolulu, Hawaii 96813
Phone: 536-3405

Healthy Smiles Family Dental (Kapolei)
579 Farrington Highway, Suite 201
Kapolei, Hawaii 96707
Phone: 674-1400

QUESTIONS ABOUT YOUR COVERAGE

If you have any questions about your dental coverage, please call the DCCH Membership Services Department at 284-6545. The Membership Services Department is responsible for resolving any complaints or disputes relating to services provided by DCCH and any of its providers, including claims regarding the scope of coverage for dental services and denials.

If you have a grievance, you may call the Membership Services Department or fill out a complaint form which is available from your dental provider. Mail the completed form to:

Dental Care Centers of Hawaii, Inc.
Attn: Membership Services Department
P.O. Box 893896
Mililani, Hawaii 96789

DCCH will review your grievance and provide a written response within 30 days. A copy of DCCH's grievance policy may be obtained by calling the DCCH Membership Services Department.

The preceding dental benefits are insured under an insurance contract issued by Dental Care Centers of Hawaii, P. O. Box 893896, Mililani, Hawaii 96789. The services provided by Dental Care Centers of Hawaii 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

You are eligible for life insurance benefits if your employer's collective bargaining agreement requires an additional contribution to provide for the life insurance benefit.

COVERAGE

Eligible active employee members will be covered for life insurance in accordance with the following schedule:

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

Life insurance terminates upon retirement.

BENEFICIARY

On your Trust enrollment form, you may name any natural person, trust or estate as your beneficiary to receive your life insurance benefits. You may change your beneficiary designation at any time by submitting a new Trust enrollment form to the Hawaii Teamsters Health and Welfare Trust Office. The change is effective on the date you signed the form when it is received by the Trust Office. 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 life insurance proceeds will be paid to your beneficiary.

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

a) If more than one beneficiary is named, each will be paid an equal share of the proceeds.

b) If any named beneficiary dies before you, his/her share will be paid equally to 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 there is no surviving spouse, in equal shares to your surviving children; or

   iii. If there is no surviving spouse or child, in equal shares to your surviving parents; or

   iv. If there is no surviving spouse, child, or parent, in equal shares to your surviving brothers and sisters; or

   v. If none of the above survives, to 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 to Pacific Guardian Life. If the minor beneficiary does not have a legal guardian, Pacific Guardian Life will establish an account for the minor which will accrue interest until the minor attains the age of majority.

Any payment made in accordance with the preceding provisions shall release Pacific Guardian Life from further liability for the amount paid.

TOTAL DISABILITY

If you become 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 Disability" refers to disability caused by injury or sickness that disables you to the extent that you are unable to perform the duties of any occupation for which you are qualified and causes you to not be engaged in any gainful employment. The total disability must have been continuous for not less

than nine consecutive months. You must furnish written proof to Pacific Guardian Life that you are 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 calendar year thereafter upon request.

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

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.

SUICIDE CLAUSE

If you commit suicide within two years from the effective date of your life insurance, the benefit payable will be limited to the premiums paid on your behalf. The benefit payable will also be limited to the premiums paid if you commit suicide within two years from the effective date of any increase in the amount of your life insurance.

CLAIMS AND APPEALS

Claim forms and instructions are available from the Trust Office. All completed claim forms and required documentation must be submitted to the Trust Office. PGL will determine whether or not benefits are payable within 90 days from the date it receives a claim. If the claim is approved, the proceeds from your life insurance will be paid to your beneficiaries.

If a claim for benefits is wholly or partly denied, PGL will provide a written notice to the claimant containing the specific reasons for the denial, reference to the provisions upon which the denial was based, and a description of its review procedures.

The claimant may appeal to PGL for a full and fair review of any denied claim by sending a written request within 60 days following receipt of the claim denial to:

Pacific Guardian Life Insurance Company
Attn. Group Claims Department
1440 Kapiolani Boulevard, Suite 1700
Honolulu, Hawaii 96814

PGL will review your claim and notify you of its decision within 60 days of receiving your request. All decisions made by PGL shall be final and binding on participants and beneficiaries to the full extent permitted by law.

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 MEDICAL AND PRESCRIPTION DRUG CLAIMS

(HMO Medical Plan and Indemnity Prescription Drug Plan)

The Trust has the discretionary authority to determine all questions of eligibility, to determine the amount and type of benefits payable to any beneficiary or provider in accordance with the terms of the Plan and related regulations, and to interpret the provisions of the Plan as necessary to determine benefits.

If your claim is wholly or partially denied by the Claims Administrator, you will be provided with a written determination explaining the reasons for denial.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

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

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

INITIAL CLAIMS

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

Urgent Care Claims: 72 Hours

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

You will receive a decision within 48 hours from the earlier of the following events:

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

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

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

You will be notified within 15 calendar days from the receipt of your claim whether your claim is approved or denied. A pre-service claim is any claim involving a requirement or request for approval before care is rendered. Pre-service claims include prior authorization and utilization review decisions. For specific procedures on obtaining prior approvals for benefits, pre-authorizations, or utilization reviews, refer to the specific sections of the self-insured benefits described in this booklet. If you fail to follow the Plan's claims filing procedure, you will receive oral notification (or written notification, if you

request) within five days of the day the claim was received. The notification will indicate what the proper procedures are for filing claims. The five day deadline will apply only if your claim is received by the Claims Administrator and is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

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

You will be notified within 30 calendar days from the receipt of your claim if your claim is denied. A post service claim is any claim submitted after services have been provided to you.

Extensions for Pre-Service and Post-Service Claims: 15 Calendar Days

The Plan may extend the time to respond to a pre-service or post-service claim by 15 calendar days if there are circumstances beyond the Plan's control that interfere with a timely claim determination. The Plan must provide you with advance notice of the extension, identifying the circumstances which provide the basis for the extension and the date that the Plan is expected to make its decision, prior to the extension period taking effect. If the extension is necessary due to insufficient information to decide the claim, the notice of extension will indicate what additional information is needed to complete your claim. You will be given 45 days from the date you are notified to provide additional information to complete your claim.

Concurrent Care Claims: 24 Hours

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

INITIAL BENEFIT DETERMINATION

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

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

a. Identification of the claim involved including the date of service, the provider's name, and the claim amount, if applicable, and a statement that you may request, free of charge, the diagnosis code and the treatment code and their corresponding meanings.

b. The specific reason(s) for the denial, with reference(s) to the specific Plan provisions, the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.

c. A description of any additional material or information necessary to complete your claim and why the information is needed.

d. A statement that you may request, free of charge, an explanation of the clinical or scientific judgment used to make the determination applying the terms of the Plan to your medical circumstances, if the denial was based on medical necessity, experimental treatment, or similar exclusion.

e. The identification of any internal rule, guideline, protocol, or other criteria the Plan relied upon in making the determination, and a statement that such rule, guideline, protocol, or other criteria is available to you, free of charge, upon your request.

f. A description of the Plan's internal appeals and external review procedures, the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

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

APPEALS

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

An appeal may be initiated by you or your authorized representative (such as your physician). Appeals must be submitted in writing to the Board of Trustees at the following address:

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

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

You may ask for an expedited appeal by calling the Trust Administrator at (808) 523-0199 or 1 (866) 772-8989 (toll free).

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

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

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

Your Right to Information

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

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

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

Before the Benefits and Appeals Committee can issue an adverse benefit determination on your appeal based on a new or additional rationale, the Plan must provide you with the rationale, free of charge, and give you a reasonable opportunity to respond.

Appeal of an Urgent Care Claim

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

Appeal of a Pre-Service Claim

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

Appeal of a Post-Service Claim

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

Appeal of a Rescission of Coverage

If you are appealing a rescission of coverage, you must submit a written request for review. The Benefits and Appeals Committee must issue its decision no later than 60 days from the time the appeal is received.

Notification of Determination on Appeal

You will receive written notification informing you of the determination of the appeal. If your claim is denied, the notice of denial will contain the following information:

a. Identification of the claim involved including the date of service, the provider's name, and the claim amount, if applicable, and a statement that you may request, free of charge, the diagnosis code and the treatment code and their corresponding meanings.

b. The specific reason(s) for the denial, with reference(s) to the specific Plan provisions and a description of the Plan's standard, if any, that was used in denying the claim.

c. A statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim.

d. A statement that you may request, free of charge, an explanation of the clinical or scientific judgment used to make the determination applying the terms of the Plan to your medical circumstances, if the denial was based on medical necessity, experimental treatment, or similar exclusion.

e. The identification of any internal rule, guideline, protocol, or other criteria the Plan relied upon in making the determination, and a statement that such rule, guideline, protocol, or other criteria is available to you, free of charge, upon your request.

f. A description of the Plan's external review procedures and the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA.

Continued Coverage pending the Outcome of an Appeal

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

Right to Bring Civil Action

Following receipt of an adverse benefit determination on your appeal, you have the right to bring a civil action under section 502(a) of ERISA within two years after receipt of the written notice of Initial Benefit Determination.

EXTERNAL REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)

Following receipt of an adverse benefit determination on an appeal involving medical judgment or a rescission of coverage, you may request an external review by an Independent Review Organization (IRO). You must submit your request to the Plan, in writing, within 130 days after notice of the adverse benefit determination is received. Within six business days following receipt of your request, the Plan will notify you in writing whether your appeal is eligible for external review. Upon determination that the criteria for external review has been met, the Plan will assign an IRO at random from a panel of three IROs to review your appeal. The IRO will notify you of its decision within 45 days after it receives the assignment from the Plan.

Expedited External Review by an IRO

You may request an expedited external review if:

a. You have filed an expedited internal appeal and the timeframe for completion of an expedited internal appeal would seriously jeopardize your life, health, or ability to regain maximum functioning; or

b. The timeframe for completion of a standard external review would seriously jeopardize your life, health, or ability to regain maximum functioning; or

c. The internal appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services and you have not been discharged from a facility.

Upon determination that you meet the above criteria, the Plan will assign an IRO at random from a panel of three IROs to review your appeal. The IRO will notify you of its decision as expeditiously as your condition or circumstances require but in no event more than 72 hours after it receives the assignment from the Plan.

SELF-INSURED DENTAL CLAIMS

Participants may obtain information concerning claims and appeals procedures for self-insured dental claims administered by Hawaii Dental Service by referring to the HDS Plan section of this booklet or by contacting the Claims Administrator at the address listed below.

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

INSURED CLAIMS

Participants may obtain information concerning claims and appeals procedures for the following insured benefits by referring to the applicable benefit section of this booklet or by contacting the insurance carrier at the address listed below.

Medical Benefits:

UHA
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813
Attn: Appeals Coordinator

Chiropractic Care Benefits:

CHIROPLAN HAWAII, INC.
711 Kilani Avenue, Room 3
Wahiawa, Hawaii 96786
ATTN: Medical Director

Dental Care Benefits:

DENTAL CARE CENTERS OF HAWAII, INC.
P.O. Box 893896
Mililani, Hawaii 96789
ATTN: Membership Services Department

Vision Care Benefits:

VISION SERVICE PLAN
P.O. Box 2350
Rancho Cordova, California 95741
ATTN: Member Appeals

Life Insurance Benefits:

PACIFIC GUARDIAN LIFE
1440 Kapiolani Boulevard, Suite 1700
Honolulu, Hawaii 96814
ATTN: Group Claims Department

DISABILITY CLAIMS

A disability claim is any claim for which the Plan must make a determination of disability in order for the beneficiary to receive the benefit. Examples include the continuation of your benefits when you become disabled and unable to work, and the continuation of benefits for a disabled dependent child beyond age 26.

Effective on and after April 1, 2018, any claim for a disability benefit shall be subject to the following claims and appeal procedures. Exception: When the Plan provides a benefit that is conditioned on a finding of a disability made by a party other than the Plan (e.g., the Social Security Administration), then a claim for such benefits is not treated as a disability claim under this section.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

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

INITIAL CLAIMS

Upon the filing of a claim for disability benefits with the Administrator, and all necessary information required to make a determination on your claim, a decision will be made within 45 days. This period may be extended by the Plan for up to 30 days if the Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you prior to expiration of the initial 45-day period of the circumstances requiring the extension and the date by which the Plan expects to make a decision. If, prior to the end of the first extension period, the Administrator determines that due to matters beyond the control of the Plan a decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Plan notifies you prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date by which the Plan expects to make a decision.

In the case of any extension, the notice of extension shall explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You will be given 45 days from the date you are notified to provide the specified information to complete your claim.

INITIAL BENEFIT DETERMINATION

If your claim is approved by the Administrator, you will receive a notice informing you of the approval.

If your claim is denied by the Administrator, you will be provided written notice of the denial at no cost to you. Examples of a denied claim include a determination to reduce or terminate a benefit, or a failure to make whole or partial payment of a benefit by the Plan. The notice of denial will contain the following information:

a. The specific reason(s) for the denial, with reference(s) to the specific Plan provisions on which the determination is based.

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

c. A description of the Plan's review procedures, the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal. The statement of your right to bring an action under section 502(a) of ERISA shall also describe any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

d. Identification of any internal rule, guideline, protocol, or other criteria the Plan relied upon in making the determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

e. A statement that you may request, free of charge, an explanation of the clinical or scientific judgment used to make the determination applying the terms of the Plan to your medical circumstances, if the denial was based on medical necessity, experimental treatment, or similar exclusion.

f. A discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following: (a) the views of health care professionals who treated you or vocational professionals who evaluated you; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan without regard to whether the advice was relied upon in making the benefit determination; (c) a disability determination made by the Social Security Administration.

g. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

h. A statement that if you are not proficient in English and have questions about the claim denial, you should contact the Trust Office to find out if language assistance is available.

APPEAL OF A DENIED CLAIM

If your disability claim is denied in whole or in part or you disagree with the decision made on a claim, you may ask for a review (appeal the decision).

An appeal may be initiated by you or your authorized representative. Appeals must be submitted in writing to the Board of Trustees at the following address:

Board of Trustees
Hawaii Teamsters Health & Welfare Trust
560 North Nimitz Highway, Suite 209
Honolulu, Hawaii 96817

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

If you wish to appeal the denial of any disability claim by the Administrator, you have 180 days following your receipt of an adverse benefit determination to file an appeal with the Board of Trustees.

The appeal will be conducted by the Board of Trustees (or a subcommittee thereof) without any preferential treatment given to the determination of the initial claim. The determination on appeal will be made by individuals who were not involved in the determination of the initial claim and who are not subordinates of anyone involved in the initial claim determination.

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

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

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

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

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

Before the Plan can issue an adverse benefit determination on your appeal or before the Plan can issue an adverse benefit determination based on a new or additional rationale, you will be provided, free of charge, any new or additional rationale or evidence considered, relied upon, or generated by the Plan in connection with your claim for benefits. Such rationale or evidence will be provided in advance of the date on which the notice of determination on appeal is required and you will be given a reasonable opportunity to respond prior to that date.

The Board of Trustees meets quarterly. The Board of Trustees (or a subcommittee thereof) will review your appeal and make its benefit determination no later than the date of the Board meeting that immediately follows the Plan's receipt of your request for an appeal. However, if your request for appeal is filed within 30 calendar days preceding the date of the next Board meeting, the Board's benefit determination may be made no later than the date of the second meeting following the Plan's receipt of your request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered no later than the third meeting of the Board following the Plan's receipt of your request for an appeal. If such an extension is necessary, the Plan will provide you with a Notice of Extension describing the special circumstances and date by which the benefit determination will be made. The Administrator will notify you of the benefit determination no later than five days after the benefit determination is made at the Board meeting.

OTHER APPEALS

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

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

Upon receipt of your written request for review, the Board of Trustees (or a sub-committee thereof) will review your case and take into account all evidence submitted by you (or your authorized representative), without regard to whether such evidence was submitted or considered in the initial benefit determination. 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 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.

GENERAL PROVISIONS

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator (the Board of Trustees) or its delegate, other Plan fiduciaries, and the insurers or administrators of each program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ELIMINATION OF CONFLICT OF INTEREST

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

FACILITY OF PAYMENT

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, nor the Board of Trustees, appropriate claims administrator, or any other designee of the Plan Administrator will be required to see to the application of the money so paid.

EXHAUSTION OF ADMINISTRATIVE REMEDIES / LIMITATION ON TIME TO FILE A LAWSUIT

You or any other claimant may not file a lawsuit to claim Plan benefits until all administrative remedies have been exhausted including this Plan's claim appeal review procedures. In the event your claim is denied, you must commence any lawsuit under Section 502(a) of ERISA respecting such claim not later than two years after receipt of the written notice of Initial Benefit Determination denying such claim.

For disability claims filed on or after April 1, 2018, the foregoing appeals procedures will not be deemed exhausted if the Plan's violation was de minimis and did not cause, and is not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and that the violation occurred in the context of an ongoing, good faith exchange of information with the claimant. This exception is not available if the violation is part of a pattern or practice of violations. The Plan must provide a written explanation of the violation within ten days of receipt of a request.

The preceding is for informational purposes only and is a summary of the Trust's claims and appeals procedures. This summary is subject to the provisions of the Plan Documents, certificates of insurance, and all amendments made thereto, which are on file with the Hawaii Teamsters Health and Welfare Trust Office. In the event of a conflict between the information contained in this booklet and the Plan Documents or certificates of insurance, the Plan Documents or applicable insurance certificate will control. Please refer to these documents for specific questions about claims and appeals procedure.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The Hawaii Teamsters Health and Welfare Trust is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, to maintain the privacy of your health information. The Trust and its business associates may use or disclose your health information for the following purposes:

- Treatment;
- Payment;
- Health plan operations and plan administration; and
- As permitted or required by law.

Other than for the purposes stated above, your health information will not be used or disclosed without your written authorization. If you authorize the Trust to use or disclose your health information, you may revoke that authorization at any time in writing.

Under HIPAA, you have the following rights regarding your health information. You have the right to:

- Request restrictions on certain uses and disclosures of your health information;
- Receive confidential communications of your health information;
- Inspect and copy your health information;
- Request amendment of your health information if you believe your health records are inaccurate or incomplete; 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:

UHA Medical Plan

Privacy Officer
UHA
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813
Phone: 532-4000 (Member Services)

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

Privacy Office
OptumRx
17900 Von Karman Avenue
M/S: CA016-0203
Irvine, California 92614
Phone: 1 (877) 598-3646
Fax: 1 (888) 905-9490

ChiroPlan Hawaii, Inc. Chiropractic Plan

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

HDS Dental Plan

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

DCCH Dental Plan

Membership Services Department
Dental Care Centers of Hawaii, Inc.
P.O. Box 893896
Mililani, Hawaii 96789
Phone: 284-6545 (Plan Administrator)

VSP Vision Care Plan

Privacy Specialist
Vision Service Plan
3333 Quality Drive
MS-163
Rancho Cordova, California 95670
Phone: 1 (916) 858-7432

STATEMENT OF ERISA RIGHTS

As a participant in the 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.