

HAWAII INSULATORS HEALTH & WELFARE TRUST



AUGUST 2015

THIS PLAN IS ADMINISTERED BY

PACIFIC ADMINISTRATORS, INC.
1440 KAPIOLANI BOULEVARD, SUITE 800
HONOLULU, HAWAII 96814

TELEPHONE: (808) 441-8600

IMPORTANT NOTICE

IF YOU HAVE ANY QUESTIONS CONCERNING THIS PLAN, SUCH AS ELIGIBILITY OR BENEFITS, PLEASE CONTACT THE HAWAII INSULATORS HEALTH AND WELFARE TRUST OFFICE AT 1440 KAPIOLANI BOULEVARD, SUITE 800, HONOLULU, HAWAII 96814, TELEPHONE: (808) 441-8600, 8:00 A.M. – 4:30 P.M., MONDAY THROUGH FRIDAY.

BENEFITS FOR ACTIVE EMPLOYEES AND RETIREES ARE NEITHER VESTED NOR GUARANTEED AND WILL BE PROVIDED ONLY AS LONG AS FUNDS ARE AVAILABLE. THE BOARD OF TRUSTEES RESERVES THE RIGHT, AT ITS SOLE DISCRETION, TO MODIFY THE PLAN WITH REGARD TO ELIGIBILITY REQUIREMENTS AND BENEFITS AVAILABLE, TO REQUIRE A CONTRIBUTION FOR THE COST OF BENEFITS, OR TERMINATE BENEFITS AT ANY TIME.

CHANGES MADE MAY AFFECT YOU AND YOUR DEPENDENTS. PLEASE READ THIS BOOKLET AND SUBSEQUENT NOTICES THAT ARE MAILED TO YOU CAREFULLY.

THIS BOOKLET SUMMARIZES THE ELIGIBILITY RULES AND BENEFITS FOR ACTIVE EMPLOYEES AND RETIREES. IF YOU ARE THINKING ABOUT RETIRING, CONTACT THE HAWAII INSULATORS HEALTH AND WELFARE TRUST OFFICE FOR ASSISTANCE.

HAWAII INSULATORS HEALTH & WELFARE TRUST

1440 Kapiolani Boulevard, Suite 800
Honolulu, Hawaii 96814
Telephone: (808) 441-8600

BOARD OF TRUSTEES

EMPLOYER TRUSTEES

Myron Nakata (Co-Chairman/Secretary)
Ross Inouye
Ronald Labanon, Jr.
Gary Silva (Alternate)

UNION TRUSTEES

Douglas Fulp (Chairman)
Ruben Aguada
Steve Fortuno, Jr.
Bernard Alvarez (Alternate)

CONTRACT ADMINISTRATOR

Pacific Administrators, Inc.

CONSULTANT

Benefit Plan Solutions, Inc.

LEGAL COUNSEL

Yee & Kawashima, LLLP

CUSTODIAN

First Hawaiian Bank

AUDITOR

Lemke, Chinen & Tanaka, CPA, Inc.

INVESTMENT MANAGER

First Hawaiian Bank/Bishop Street Capital Management

PERFORMANCE MONITOR

Wells Fargo Advisors

HAWAII INSULATORS HEALTH AND WELFARE TRUST

Several important changes have been made to 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 that have been changed, along with the page number where the complete text of the change is located, are as follows:

1. Self-Payment Program
 - A. Effective October 1, 2014, the self-payment rates were revised (page 9).
2. Dependent Coverage
 - A. Effective April 1, 2014, in accordance with the Patient Protection and Affordable Care Act of 2010, dependent coverage will be offered to children under age 26 regardless of whether they may be eligible for coverage under another employer sponsored health plan (page 16).
3. HMAA Medical and Prescription Drug Plan
 - A. Effective August 1, 2013, Hawaii Medical Assurance Association (HMAA) replaced UHA as the carrier of the Trust's PPO medical and prescription drug plan (page 21).
 - B. Effective April 1, 2014, in accordance with the Patient Protection and Affordable Care Act of 2010, there is no annual limit on the dollar amount of essential health benefits coverage for any member.
4. Kaiser Permanente Medical and Prescription Drug Plan
 - A. Effective December 1, 2014, Active participants may elect coverage under the Kaiser plan (page 85).
5. Vision Care Program (Self-Insured)
 - A. Effective January 1, 2013, the allowances for eye examinations and appliances increased (pages 104 and 126).
6. Claims and Appeals Procedures
 - A. Effective February 25, 2015, following an adverse benefit determination on appeal, beneficiaries may bring a civil action under Section 502(a) of ERISA within two years after receipt of the written notice of initial benefit determination. Any claims not brought within two years after the initial benefit determination will be deemed waived (pages 141 and 142).

If you have any questions about the plan or need additional information, please contact the Trust Office at (808) 441-8600 or write to the Trust Office at 1440 Kapiolani Boulevard, Suite 800, Honolulu, Hawaii 96814.

Sincerely,

Board of Trustees

YOU ARE URGED TO READ THIS BOOKLET CAREFULLY AND BECOME FAMILIAR WITH ALL THE BENEFITS YOU AND YOUR DEPENDENTS ARE ENTITLED TO RECEIVE. THIS BOOKLET EXPLAINS, AS BRIEFLY AS POSSIBLE, THE BENEFITS PROVIDED TO ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS. THE TRUST AGREEMENT, POLICIES, CONTRACTS OF INSURANCE, AND VARIOUS RULES AND REGULATIONS ADOPTED BY THE TRUSTEES, AS REFLECTED IN PARTICIPANT NOTICES, ARE THE FINAL AUTHORITIES IN ALL MATTERS RELATED TO THE HAWAII INSULATORS HEALTH AND WELFARE TRUST. COPIES OF THESE DOCUMENTS ARE AVAILABLE FOR INSPECTION AT THE TRUST OFFICE DURING REGULAR BUSINESS HOURS.

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

PLAN SPONSOR AND ADMINISTRATOR

Board of Trustees
Hawaii Insulators Health and Welfare Trust
1440 Kapiolani Boulevard, Suite 800
Honolulu, Hawaii 96814
Telephone: (808) 441-8600

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

IDENTIFICATION NUMBERS

Assigned by Internal Revenue Service – 99-6017123
Assigned by Plan Sponsor – Plan Number 501

TYPE OF PLAN

Welfare – medical, prescription drug, vision care, massage therapy, dental, life insurance, temporary disability insurance, and long-term care insurance benefits for actives and physician office visit, prescription drug, dental, and life insurance benefits for retirees.

TYPE OF ADMINISTRATION

The Board of Trustees has contracted Pacific Administrators, Inc., located at 1440 Kapiolani Boulevard, Suite 800, Honolulu, Hawaii 96814 to serve as Contract Administrator for the Hawaii Insulators Health and Welfare Trust.

AGENT FOR SERVICE OF LEGAL PROCESS

Mr. Alton Komori
Pacific Administrators, Inc.
1440 Kapiolani Boulevard, Suite 800
Honolulu, Hawaii 96814

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

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

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APPLICABLE COLLECTIVE BARGAINING AGREEMENT

The current Collective Bargaining Agreement between the International Association of Heat and Frost Insulators and Allied Workers, Local 132 and the Pacific Insulation Contractors Association provides for participation by signatory contractors in the Hawaii Insulators Health and Welfare Trust.

A copy of the Collective Bargaining Agreement may be obtained by participants and beneficiaries upon written request to the Contract Administrator and is available for examination by participants and beneficiaries at the Trust Office.

SOURCE OF CONTRIBUTIONS

The funds out of which all benefits and expenses are paid are contributed by 1) employers who are parties to the Collective Bargaining Agreement which requires contributions to the Health and Welfare Trust, 2) the Union on behalf of its staff employees, and 3) active and retired participants (i.e., self-payments and COBRA payments). The amount of employer contributions is calculated by multiplying the number of hours worked during the month by each covered employee by the hourly contribution rate specified in the Collective Bargaining Agreement. The self-payments and COBRA payments are set by the Trustees, from time to time, and depend on the benefits selected.

FUNDING MEDIUM

All contributions to the Health and Welfare Trust are transmitted to the Trust Department of First Hawaiian Bank in Honolulu, which serves as Custodian of the Trust. Contributions are held by First Hawaiian Bank in a custodial 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. Funds in excess of those needed for immediate requirements are invested by the Investment Manager in accordance with general investment guidelines, as determined and reviewed by the Trustees.

FISCAL YEAR

April 1 through the following March 31

AMENDMENT OR ELIMINATION OF BENEFITS AND TERMINATION OF THE PLAN AND THE TRUST

The Trust Agreement gives the Trustees the authority to terminate the Plan, amend the eligibility requirements, and amend or eliminate benefits available under the Plan, at any time. Benefits provided under the Trust Fund are not vested and may be amended or eliminated if, for example, the Trustees determine that the Trust does not have sufficient funds to pay for the benefits being provided.

If benefits under the Hawaii Insulators Health and Welfare Trust 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.

Amendments will be made to the Plan when necessary to comply with federal and/or state laws, or to ensure the tax-deductibility of contributions to the Trust, or to maintain the tax-exempt status of the Trust. The Plan may be wholly or partially terminated without terminating the Trust.

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 insurance carriers.

If the Hawaii Insulators Health and Welfare Trust is terminated, all obligations of the Trust must be satisfied first. Any remaining assets of the Trust will be used to provide benefits as set forth by the Plan, or to continue to provide benefits as allowed by ERISA, for as long as there are Trust assets.

The Trust Agreement also gives the Board of Trustees authority to transfer the assets of the Trust to the Trustees of any other trust(s) that provides benefits which are similar to the Hawaii Insulators Health and Welfare Trust.

ELIGIBILITY RULES

WHO IS ELIGIBLE

In order to qualify for benefits, you must either 1) work in the Union Local 132 bargaining unit for employers who have a signed Collective Bargaining Agreement obligating the employer to contribute to the Hawaii Insulators Health and Welfare Trust on your behalf at the negotiated contribution rate, or 2) be an employee of the Union Local 132.

ESTABLISHING ELIGIBILITY – JOURNEYMEN AND INDENTURED PROBATIONARY APPRENTICES

To establish your initial eligibility for benefits, you must work at least 100 hours within a calendar month and your employer must make the required contribution on your behalf. You will be eligible for benefits for yourself and your eligible dependents on the first day of the third consecutive calendar month following the month in which you worked at least 100 hours.

Example: You work 100 hours in January and your employer makes the required contribution in February for your work hours. You will be eligible for benefits effective April 1st (the first day of the third consecutive calendar month following the work month).

CONTINUING ELIGIBILITY – JOURNEYMEN AND APPRENTICES

Once you become eligible for benefits, your eligibility for benefits for yourself and your eligible dependents will continue on a month-to-month basis as long as you have at least 100 paid work and/or Hour Bank hours in each subsequent calendar month.

HOURLY BANK

Once you have established your initial eligibility for benefits, all paid work hours in excess of 100 hours in a calendar month will be credited to your Hour Bank. The maximum number of hours that may be accumulated in your Hour Bank is 300 hours.

Example: You work 175 hours in January and your employer makes the required contribution in February for your work hours. You will be eligible for benefits effective April 1st and 75 hours (175 hours – 100 hours = 75 hours) will be credited to your Hour Bank for future use.

If you do not earn the required 100 hours needed for eligibility in any calendar month, you may still retain eligibility by using the necessary hours from your Hour Bank so that the total number of hours equals 100. If the total number of paid work hours plus your Hour Bank hours does not equal at least 100 hours, your eligibility will terminate as of the last day of the calendar month for which you had sufficient hours for eligibility.

If you have not been eligible for benefits for a period of six (6) consecutive calendar months, any hours remaining in your Hour Bank will be lost and your Hour Bank will be reduced to zero (0). You must then work the required 100 hours in a calendar month to re-establish your eligibility.

LOSS OF ELIGIBILITY

You will continue to be eligible for benefits provided you have the required number of hours in a calendar month, either through paid work hours and/or Hour Bank hours. You will lose eligibility on the earliest of the following dates:

1. The last day of a calendar month for which you had sufficient paid work hours and/or Hour Bank hours necessary for eligibility, or
2. The date this Plan terminates.

HOW TO CONTINUE YOUR COVERAGE IF YOU LOSE ELIGIBILITY

If your eligibility for benefits under the Trust terminates and you are still a member of the bargaining unit and in good standing with the Union, or you are an employee of the Union Local 132, you may continue your coverage by electing one (1) of the following two (2) options:

1. The Self-Payment Program, or
2. The COBRA Program.

Self-Payment Program

If you become ineligible for benefits and you were eligible immediately preceding your ineligibility, you may continue your coverage for a maximum period of eighteen (18) consecutive months by making self-payments to the Trust.

After the first six (6) consecutive months of coverage under the Self-Payment Program, you may apply to the Board of Trustees for an additional six (6) months of coverage, and at the conclusion of the first six-month extension, you may apply for a second six-month extension. If approved, an extension must immediately follow a period of coverage under the Self-Payment Program and the total period of coverage under the Self-Payment Program may not exceed eighteen (18) consecutive months.

In order to qualify and remain eligible for the Self-Payment Program, you must be 1) a member of the bargaining unit and in good standing with the Union or an employee of the Union Local 132, and 2) unable to earn the necessary hours required for eligibility due to reasons beyond your control.

Effective October 1, 2014, you may continue your health and welfare benefits through the Trust by making self-payments as follows:

1. For the first six (6) months (1st through 6th months), the self-payment rate is 20% of the rate established by the Trustees.

You will be covered for full coverage as follows: medical, prescription drug, vision care, dental, and life insurance benefits.

2. If your benefits are extended, the self-payment rate is 40% of the rate established by the Trustees for the first six month extension (7th through 12th months) and 60% of the rate established by the Trustees for the second six month extension (13th through 18th months). The self-payment amount will depend on the type of coverage selected.

You must select either core coverage or full coverage as follows:

- a. Core coverage – medical and prescription drug benefits, or
- b. Full coverage – medical, prescription drug, vision care, dental, and life insurance benefits.

Your first self-payment must be received by the Trust Office by the 15th day of the first month and must include payment for the first and second months of coverage. Subsequent payments must be received by the Trust Office by the 5th day of the month **prior to** the month for which payment is being made. If your payments are not received by the required due dates, your coverage under the Self-Payment Program will be terminated.

If you choose to continue your benefits under the Self-Payment Program, you give up your right to continue your coverage under the COBRA Program described in the following section. When you have exhausted the maximum period of coverage available under the Self-Payment Program, you may not continue your coverage under the COBRA Program even though you may still be ineligible for benefits.

Any participant who applies for coverage under the Self-Payment Program or who is currently making self-payments shall provide the Trustees with such information as they may request in order to establish proof of eligibility for self-payments. Failure to provide adequate responses to information requested by the Trustees shall result in ineligibility for self-payments.

COBRA Program

The Hawaii Insulators 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.

“Qualified Beneficiary”: Under the law, a Qualified Beneficiary is any employee or the spouse or dependent child of an employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA continuation coverage. A child who becomes a dependent child by birth, adoption, or placement for adoption with the covered Qualified Beneficiary during a period of COBRA continuation coverage is also a Qualified Beneficiary.

- A child of the covered employee, who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO) during the employee’s period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
- A person who becomes the new spouse of an existing COBRA participant during a period of COBRA continuation coverage may be added to the COBRA coverage of the existing COBRA participant but is **not** a “Qualified Beneficiary.” This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new spouse is not entitled to elect COBRA for him/herself.

“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 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. If the disability extension applies with respect to a Qualifying Event, it applies with respect to each Qualified Beneficiary entitled to COBRA continuation coverage because of that Qualifying Event. Thus, for example, the 29-month maximum coverage period applies to each Qualified Beneficiary who is not disabled as well as to the Qualified Beneficiary who is disabled and it applies independently with respect to each of the Qualified Beneficiaries.

** 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

You, your spouse, or your dependent children are responsible for notifying the Trust Office, in writing, within 60 days in the event of divorce, legal separation, or if a dependent child ceases to be an eligible dependent under the Plan.

That written notice should be sent to the Trust Office located at 1440 Kapiolani Boulevard, Suite 800, Honolulu, Hawaii 96814, phone (808) 441-8600. 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 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, active employees may choose to be covered for only core benefits (medical and prescription drug benefits) or core plus non-core benefits (medical, prescription drug, vision, and dental benefits). Life insurance, temporary disability insurance and long-term care insurance benefits are not available under the COBRA Program. Once an election 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 coverage is terminated under the Trust through the date that COBRA election is made. Subsequent payments must be received by the Trust Office within 30 days after the first day of the period covered by the payment.

Addition of Newly Acquired Dependents

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

Loss of Other Group Health Plan Coverage

If, while you (the employee) are enrolled for COBRA continuation coverage, your spouse or dependent 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 for 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 termination of the other coverage or within 60 days after the termination of coverage under Medicaid or CHIP in accordance with Federal law. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA continuation coverage.

When COBRA Ends

If COBRA is elected, the continued coverage will begin on the date that coverage under the Hawaii Insulators 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, or
2. The date the Trust no longer provides health coverage, or
3. The first day 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), or
4. The first day on which the Qualified Beneficiary becomes entitled to Medicare, or
5. The first day on which the Qualified Beneficiary becomes covered under another employer's group health plan. (Exception – If the group plan contains an exclusion or limitation with respect to any pre-existing condition, COBRA may be continued until the end of the exclusion or limitation period.)

When you have exhausted the maximum period of coverage available under the COBRA Program, you may not continue coverage under the Self-Payment Program even though you may still be ineligible for benefits.

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

IF YOU BECOME DISABLED

If, while eligible for benefits you become disabled and unable to work, you will be eligible to receive a maximum of 32 ½ hours of disability credits for each week of disability, up to a maximum of 100 hours for each calendar month. The maximum number of disability credit hours that you may receive in any consecutive 12-month period is 600 hours. When you exhaust your disability credit hours, you may elect to continue coverage under the Self-Payment Program or the COBRA Program, if applicable. If you become disabled while you are making self-payments or COBRA payments, you will not be eligible to receive any credit for the disability.

In the event you become disabled, you must notify the Trust Office, in writing, no later than 30 days after the disability occurs. The Trust Office will let you know what information is required in order for you to receive credit for time lost from work as a result of a disability.

Any participant who applies for or is receiving disability credits shall provide the Trustees with such information as they may request in order to establish proof of eligibility to receive disability credits. Failure to provide adequate responses to information requested by the Trustees shall result in ineligibility for disability credits.

IF YOU ENTER THE ARMED FORCES

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

If you elect to continue coverage and the length of your leave is at least 31 days, you have two (2) options to continue coverage.

1. The first option is to use any hours remaining in your Hour Bank. Once the hours in your Hour Bank are no longer sufficient for coverage, you can either:
 - Self-pay an amount for benefits that you enrolled in, not to exceed 102% of the actual cost of the benefits as determined by the Board of Trustees; or
 - Self-pay for medical and prescription drug benefits only at 20% of the rate established by the Board of Trustees within the first twelve (12) months of losing coverage. For the next twelve (12) months, you must self-pay an amount not to exceed 102% of the actual cost of medical and prescription drug benefits, as determined by the Board of Trustees.

The maximum amount of time that coverage may be continued through a combination of your Hour Bank hours and self-payments is a total of twenty-four (24) months.

2. The second option is to have any hours remaining in your Hour Bank frozen until you have been discharged and return to covered employment. If you select this option, you can either:
 - Self-pay an amount for benefits that you enrolled in, not to exceed 102% of the actual cost of the benefits as determined by the Board of Trustees; or
 - Self-pay for medical and prescription drug benefits only at 20% of the rate established by the Board of Trustees within the first twelve (12) months of losing coverage. For the next twelve (12) months, you must self-pay an amount not to exceed 102% of the actual cost of medical and prescription drug benefits, as determined by the Board of Trustees.

The maximum amount of time that coverage may be continued through self-payments if you freeze your Hour Bank is twenty-four (24) months.

Your coverage under either of the above-mentioned options will continue until your discharge from military service or twenty-four (24) months, whichever occurs first.

Upon returning to work, health coverage for you and your eligible dependents will be reinstated on the first day of the month following the day you return to work, whether or not you elected to continue coverage during your leave. You will not be subject to any exclusion or waiting period imposed by the Trust that would not have applied had your coverage not been terminated as a result of your military service.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Hawaii Insulators 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) 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 benefits and you are eligible, your coverage will continue under the Hawaii Insulators Health and Welfare Trust **provided your employer continues to make the required contributions to the Trust on your behalf.**

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

GENERAL INFORMATION

ENROLLMENT FORMS

In order to be covered for benefits, you and your eligible dependents must have a current Trust enrollment form and all other applicable insurance carrier enrollment forms on file at the Hawaii Insulators Health and Welfare Trust Office. If you have not done so already, you should complete the enrollment forms, listing your beneficiaries and all your eligible dependents. If you are married, you must submit a copy of your marriage certificate. If you have dependent children, you must submit a copy of their birth certificates or adoption papers.

Newly hired employees and employees of employers who have just signed the Collective Bargaining Agreement should obtain their enrollment forms from the Local 132 Union Office or the Trust Office.

Return the completed enrollment forms to the Trust Office. The Trust Office will process the insurance carrier enrollment forms and retain the Trust enrollment form.

No premiums will be paid until the Trust enrollment form and all insurance carrier enrollment forms are completed and filed with the Hawaii Insulators Health and Welfare Trust Office. No retroactive enrollment will be made.

It is important to keep the Trust Office informed of any changes in your personal or family situation or mailing address. Let the Trust Office know, within 30 days, if:

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

ELIGIBLE DEPENDENTS

Prior to April 1, 2014, Eligible Dependents included your legal spouse and children under 26 years of age who were not eligible to enroll in another employer sponsored health plan other than the group health plan of a parent.

Effective April 1, 2014, Eligible Dependents include your legal spouse and **all** children under 26 years of age. The term “children” includes your natural child, stepchild, legally adopted child, and a child placed with you for adoption. Coverage will be afforded to such eligible dependent children without regard to marital status, dependency upon you (or anyone else) for financial support, residency with you, full-time student status, or eligibility to enroll in another employer-sponsored health plan.

NOTE: This dependent eligibility rule does not apply to dependent eligibility for life insurance. Please refer to the Life Insurance Benefits section on page 114 for coverage of eligible dependents.

The Board of Trustees may require any information necessary to determine the eligibility of a dependent under this section.

In order to add a spouse or dependent child, you must notify the Trust Office within 30 days of the date of marriage, birth, adoption, or placement for adoption. Coverage will begin as follows, provided proper notification is given and the required documentation is submitted to the Trust Office:

- For a new spouse and dependent children obtained through marriage – the first day of the month following the date of marriage,
- For newborns – the date of birth,
- For legally adopted children and children placed for adoption – the date the child is legally adopted or placed with you for adoption.

If you do not notify the Trust Office within this 30-day period, retroactive coverage will not be made. Instead, coverage for your new dependent will be effective on the first day of the month following the date of notification and submittal of the required documentation.

If the adoption does not become final, coverage of that child will terminate as of the date you no longer had a legal obligation to support that child.

For purposes of this section, the documents required to be submitted are as follows:

- Legal Spouse – Copy of certified marriage certificate or executed marriage license signed by the marriage performer.
- Natural Children – Copy of certified birth certificate or hospital birth acknowledgment.
- Stepchildren – Copy of certified birth certificate or hospital birth acknowledgment.
- Adopted Children – Adoption Decree or new certified birth certificate.

A dependent child who, upon attaining age 26 has a mental or physical disability which was incurred prior to age 19 and which renders him or her 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; provided that the child was covered under the Plan prior to age 26. You must, however, submit satisfactory proof to the Trust of the child's incapacity within 31 days of the child attaining age 26 and periodically, thereafter, when requested. Coverage for such child shall terminate upon the earliest of the following: 1) his or her marriage, 2) he or she becoming capable of self-support, 3) failure to provide proof of continued disability when requested, or 4) termination of your eligibility.

Restrictions on the eligibility of dependents:

1. An eligible person may be covered under the Trust as either an employee, or the dependent of an employee, but not both.
2. If both parents are covered as employees under the Trust, either parent (but not both) may cover their children as dependents.
3. If an employee wants to cover his or her dependents under the Trust, all of his or her eligible dependents must be enrolled.

SPECIAL ENROLLMENT PERIODS

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Hawaii Insulators Health and Welfare Trust may allow enrollment during a special enrollment period if you qualify under one (1) of the following Special Enrollment rules:

1. If you declined coverage under this Plan for yourself and/or your dependents because of coverage under another group health plan, you may enroll yourself and/or your eligible dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards that other coverage) provided you request enrollment within 30 days after your coverage under the other health plan ends (or after the employer stops contributing toward the other coverage). If you fail to request enrollment during this special 30-day period, you must wait until the next open enrollment period.
2. If you obtain a new dependent through marriage, birth, adoption, or placement for adoption, you may enroll yourself and/or your new dependent in this Plan provided you request enrollment within 30 days after the date of marriage, birth, adoption, or placement for adoption. If you fail to request enrollment during this special 30-day period, retroactive coverage will not be made. Instead, coverage for yourself and/or your dependents will be effective on the first day of the month following

the date of notification to the Trust Office and submission of the required documentation, in accordance with Plan rules.

3. If you declined coverage under this Plan for yourself or for an eligible dependent because of coverage under Medicaid or a state children's health insurance program (CHIP), you may enroll yourself and/or your eligible dependents in this Plan within 60 days after coverage under Medicaid or CHIP ends. If you fail to request enrollment during this special 60-day period, you must wait until the next open enrollment period.
4. 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 within 60 days after you or your dependents become eligible for such assistance. If you fail to request enrollment during this special 60-day period, you must wait until the next open enrollment period.

To request special enrollment, contact the Trust Office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Hawaii Insulators Health and Welfare Trust is required to provide benefits in accordance with the applicable requirements of a "qualified medical child support order." A "qualified medical child support order" is a judgment, decree, or order (including a court's approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that requires a group health plan to provide coverage to the children of a plan participant pursuant to a 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 Office. In order to be "qualified," the order must clearly specify:

1. The name and last known address of the participant and each alternate recipient,
2. A reasonable description of the type of coverage to be provided by the group health plan, or the manner in which that coverage is to be determined,
3. The period for which coverage must be provided, and
4. Each plan to which the order applies.

In addition, the medical child support order cannot require the Trust to provide any type or form of benefit, or benefit option, that the Trust does not already offer (except to the extent required by law).

All medical child support orders shall be delivered to the Contract Administrator of the 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 will notify the participant and alternate recipient(s) of such determination. An alternate recipient is any child of a participant who is recognized as being entitled to coverage under the participant's group health plan with respect to such participant.

For further information, contact the Trust Office.

MEDICAL BENEFITS

CHOICE OF PLANS

You may choose one of the following medical plans:

1. The Hawaii Medical Assurance Association (HMAA) Plan which is available on all islands, or
2. The Kaiser Permanente Plan which is available on Oahu, Maui, Molokai, Lanai, Kauai, and the island of Hawaii.

Please note: If you reside outside the Kaiser Hawaii service area for more than 90 days, you are not eligible to enroll in the Kaiser Permanente Plan. If you enroll in the Kaiser Permanente Plan and subsequently move outside the Kaiser Hawaii service area for more than 90 days, you will not be allowed to continue coverage under the Kaiser Permanente Plan and must enroll in the HMAA Plan.

The principal benefit provisions of the HMAA Plan and the Kaiser Permanente Plan are summarized in this booklet.

OPEN ENROLLMENT PERIOD

If you wish to make a change in your benefit election, you may do so during the Open Enrollment Period by notifying the Trust Office, in writing, during the month of November of any year. The change will become effective on December 1st. **No change in benefit election may be made at any other time unless you qualify for Special Enrollment.**

HOW TO SECURE BENEFITS

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

You must show your member ID card to the provider of service whenever you seek medical care. If you do not have your member ID card available when obtaining services, ask the doctor or facility rendering services to contact the Trust Office to confirm your eligibility.

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, health plans and insurance issuers may not, under Federal law, require that a provider obtain authorization from the health plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

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

You will be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, become entitled to COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request a certificate before losing coverage or up to 24 months after losing coverage.

Any certificates that you receive should be kept in a safe place. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion in your coverage for up to 12 months (18 months for late enrollees) after your enrollment date in a new plan.

Please note: Due to the prohibition of preexisting condition exclusions under the Patient Protection and Affordable Care Act of 2010, certificates of creditable coverage will no longer be issued after December 31, 2014.

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

In compliance with the Women's Health and Cancer Rights Act, mastectomy-related benefits include coverage 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.

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

Under the Mental Health Parity and Addiction Equity Act of 2008, group health plans and health insurance issuers generally may not impose a financial requirement or a quantitative treatment limitation on mental health or substance abuse disorder benefits that is more restrictive than the financial requirements or treatment limitations that apply to medical and surgical benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

Effective April 1, 2010, the following provisions apply to the Hawaii Insulators 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.

HAWAII MEDICAL ASSURANCE ASSOCIATION (HMAA)

MEDICAL AND PRESCRIPTION DRUG PLAN

Effective August 1, 2013, the Hawaii Medical Assurance Association (HMAA) replaced University Health Alliance (UHA) as the carrier of the Trust's PPO medical and prescription drug plan. The Hawaii Insulators Health and Welfare Trust believes that the PPO Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010 (PPACA or Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Office at 1440 Kapiolani Boulevard, Suite 800, Honolulu, Hawaii 96814, telephone: (808) 441-8600. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The principal benefit provisions of the HMAA Plan are summarized in this section. For information and assistance you may contact HMAA's Customer Service Center by phone during business hours, Monday through Friday from 8:00 a.m. to 4:00 p.m., or visit their website at www.hmaa.com and access **Online for Members** 24 hours a day, 7 days a week.

<p>HMAA Customer Service On Oahu (808) 941-4622 Toll-Free (888) 941-4622 737 Bishop Street, Suite 1200 Honolulu, Hawaii 96813</p>

CHAPTER 1: IMPORTANT INFORMATION

About Your PPO Program

Your health care coverage is a **Preferred Provider Organization**. This means you have medical benefits for your health care needs including office visits, inpatient facility services, outpatient facility services, and other provider services. This coverage offers you flexibility in the way you get medical benefits. Your opportunity to take an active role in your health care decisions makes this coverage special. In general, to get the best benefits possible, you should seek services from HMAA **Participating Providers**.

HMAA Participating Providers have agreed to render required services at negotiated rates. The member is not responsible for the difference between the negotiated rate and the billed charges, except for copayments, coinsurance and non-covered items. Benefits shall be automatically assigned for Participating Providers. Services rendered by **Non-Participating Providers** will be paid directly to the Member with all non-covered charges being the responsibility of the Member.

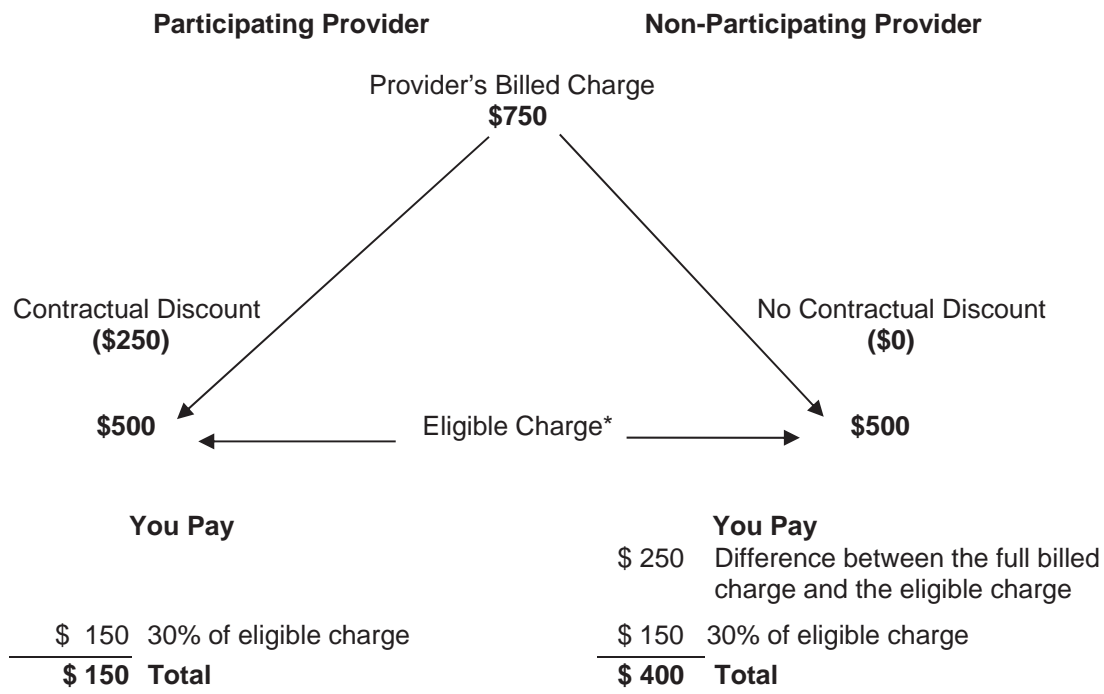
The Plan pays benefits at two levels: (1) a higher level for Participating Providers and (2) a lower level for Non-Participating Providers. **By using participating providers, you are assured of receiving the maximum benefits of the plan.**

Before you visit your doctor or receive other healthcare services, please verify whether your provider is participating with HMAA through one of the following:

- Ask your provider's office
- View our provider directory at hmaa.com
- Download the HMAA iPhone application
- Contact our Customer Service Center at 941-4622, toll-free at 888-941-4622, or via e-mail at CustomerService@hmaa.com

Pay Less by Choosing a Participating Provider

The following illustrates an example of your out-of-pocket expense if you receive services from a participating vs. non-participating provider.



* The eligible charge is not equal to the billed charge. The eligible charge is based on a fee schedule for non-participating providers. The eligible charges shown above are for illustration purposes only. Such charges may vary, depending on the provider and type of service performed. Taxes are not covered and are the sole responsibility of the member. Payment may vary by health plan.

As illustrated, using a non-participating provider or facility will result in substantially higher out-of-pocket expenses. You will be responsible for all non-covered charges, copayments, coinsurance and any remaining balances over the eligible charge, up to the full billed amount. As a result, your out-of-pocket expense could be substantial.

The provider or facility may require you to pay the entire bill at the time you receive services, and to file your claim directly with us. Payment will always be made directly to the member, regardless of whether assignment of benefits is requested (in other words, regardless of whether you ask us to pay your provider directly).

Terminology

The terms **You** and **Your** mean you and your family members eligible for this coverage. **We**, **Us**, and **Our** refer to HMAA.

The term **Provider** means an approved physician or other practitioner who provides you with health care services. Your provider may also be the place where you get services, such as a hospital or skilled nursing facility. Also, your provider may be a supplier of health care products, such as a home or durable medical equipment supplier.

Definitions

Throughout this Summary Plan Description (SPD), terms appear in ***Bold Italics*** the first time they are defined.

Questions

If you have any questions, please call us. More details about plan benefits will be provided free of charge. We list our telephone numbers on page 21 of this SPD.

Summary of Provider Categories

This chart shows how the various provider categories impact your benefits.

	HMAA Participating Provider	Mainland Participating Provider	Centers of Excellence Provider	Non-Participating Provider (in or out-of-state)
Does your provider contract with HMAA's networks?	Yes	No, contracts with PHCS or Multiplan	Yes, contracts with HMAA for transplant services	No, does not contract with HMAA, PHCS or Multiplan networks.
Does your provider always file claims for you?	Yes	Yes	Yes	No, you may have to file your own claims.
Does your provider accept eligible charge as payment in full? If so, you do not pay for any difference between actual charge and eligible charge.	Yes	Yes	Yes	No, you pay the difference between the actual charge and the eligible charge. See <i>From what Provider Category Did You Receive Care?</i> later in this chapter.
Do you pay the provider deductibles, copayments and coinsurance? If so, we send benefit payment directly to the provider.	Yes	Yes	Yes	No, you pay the provider in full. We send benefit payments to you.
Is your coinsurance percentage lower?	Yes	Yes	Yes	No, your coinsurance percentage is higher except for coinsurance for emergency services which are the same as for services provided by participating providers.
Does your provider get precertification approvals for you?	Yes	No, you are responsible for getting approval.	Yes	No, you are responsible for getting approval.

Care While You Are Away From Home

Participating Providers Outside Hawaii

We provide access to medical services on the U.S. Mainland by participating with the PHCS Healthy Directions and MultiPlan Complementary Networks. This enables members to obtain medical services from participating providers while traveling outside our service area, the state of Hawaii. If you obtain services from a PHCS Healthy Directions or MultiPlan Network provider, you enjoy advantages similar to those available when you receive health care from participating providers in Hawaii.

Please note that the Mainland network is not available for dental or alternative care services (chiropractic, naturopathic, and acupuncture). Further, we do not guarantee the availability of Mainland participating providers, including emergency care providers, in all areas.

Whenever you access covered healthcare services outside Hawaii and the claim is processed through PHCS or MultiPlan, the amount you pay for covered healthcare services is based on the negotiated price that PHCS/MultiPlan makes available to HMAA.

Finding Participating Providers

PHCS Healthy Directions and Multiplan Complementary networks can provide you with information on participating providers outside the state of Hawaii. To locate a medical provider on the Mainland, call PHCS toll-free at 1-888-721-7427 Monday to Friday, 6 am to 5 pm PST, visit www.multipan.com, or contact our Customer Service Center at the phone numbers listed on page 21 of this SPD.

Non-Participating Providers Outside Hawaii

When covered healthcare services are provided outside of Hawaii by non-participating healthcare providers, the amount you pay for such services will generally be based on either the non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you will be liable for the difference between the amount the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount we will pay for services rendered by non-participating healthcare providers. In these situations, you will be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for covered services as set forth in this paragraph.

Benefit payments for covered emergency services provided by non-participating providers are a "reasonable amount" as defined by federal law at 45 CFR§ 147.138(b).

Carry Your Member Card

Always carry your HMAA Member Card. Your member card ensures that you receive all the conveniences you're used to when you get medical services at home in Hawaii. The card tells participating providers which Plan you belong to. It also includes information the provider needs to file your claim for you.

Questions We Ask When You Receive Care

Is the Care Covered?

To receive benefits, the care you receive must be a covered treatment, service, or supply. See *Chapter 4: Description of Benefits* for a listing of covered treatment, services and supplies.

Does the Care Meet Payment Determination Criteria?

All care you receive must meet all of the following Payment Determination Criteria:

- For the purpose of treating a medical condition.
- The most appropriate delivery or level of service, considering potential benefits and harm to the patient.
- Known to be effective in improving health outcomes; provided that:
 - Effectiveness is determined first by scientific evidence;
 - If no scientific evidence exists, then by professional standards of care; and
 - If no professional standards of care exists or if they exist but are outdated or contradictory, then by expert opinion; and
- 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.

Services that are not known to be effective in improving health outcomes include, but are not limited to, services that are experimental or investigational.

Definitions of terms and more information regarding application of this Payment Determination Criteria are contained in the Patient's Bill of Rights and Responsibilities, Hawaii Revised Statutes § 432E-1.4. The current language of this statutory provision will be provided upon request. Requests should be submitted to HMAA's Customer Service Center.

The fact that a physician may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets Payment Determination Criteria, even if it is listed as a covered service.

Participating providers may not bill or collect charges for services or supplies that do not meet HMAA's Payment Determination Criteria unless a written acknowledgement of financial responsibility, specific to the service, is obtained from you or your legal representative prior to the time services are rendered.

Participating providers may, however, bill you for services or supplies that are excluded from coverage without getting a written acknowledgement of financial responsibility from you or your representative. See *Chapter 6: Services Not Covered*.

More than one procedure, service, or supply may be appropriate to diagnose and treat your condition. In that case, we reserve the right to approve only the least costly treatment, service, or supply.

You may ask your physician to contact us to decide if the services you need meet our Payment Determination Criteria or are excluded from coverage before you receive the care.

Is the Care Consistent with HMAA's Medical Policies?

To be covered, the care you get must be consistent with HMAA's medical policies. These are policies drafted by HMAA's Chief Medical Officer, who is a licensed physician. Each policy provides detailed coverage criteria for when a specific service, drug, or supply meets payment determination criteria. If you have questions about the policies or would like a copy of a policy related to your care, please call us at one of the telephone numbers on page 21 of this SPD.

From What Provider Category Did You Receive Care?

Your benefits may be different depending on the category of provider that you receive care from. In general, you will get the maximum benefits possible when you receive services from an HMAA participating provider.

When you see a non-participating provider you will owe any copayment and/or coinsurance that applies to the service plus the difference between HMAA's eligible charge and the provider's actual charge. Also, non-participating providers have not agreed to HMAA's payment policies and can bill you for services or other charges that HMAA does not cover. Participating providers have agreed not to charge you for these services. These amounts will be included in the non-participating provider's actual charge.

For more information on provider categories, see the sections *Summary of Provider Categories* and *Care While You are Away from Home* earlier in this chapter.

Please note: Your participating provider may refer services to a non-participating provider and you may incur a greater out-of-pocket expense.

For example, your participating provider may send a blood sample to a non-participating lab to analyze. Or, your participating provider may send you to a non-participating specialist for added care.

Is the Service or Supply Subject to a Benefit Maximum?

Benefit Maximum is the maximum benefit amount allowed for a covered service or supply. A coverage maximum may limit the dollar amount, the duration, or the number of visits. For information about benefit maximums, read *Chapter 2: Payment Information* and *Chapter 4: Description of Benefits*.

Is the Service or Supply Subject to Precertification?

Certain services require our prior approval. HMAA participating providers get approval for you, but other providers may not. If you receive services from a non-participating provider and approval for certain services is not obtained, benefits may be denied. In some cases, benefits are denied entirely. For services subject to approval, read *Chapter 5: Precertification*.

Did You Receive Care From a Provider Recognized and Approved by Us?

To determine if a provider is recognized and approved, we look at many factors including licensure, professional history, and type of practice. All participating providers and some non-participating providers are recognized and approved. To find out if your physician is a participating provider, refer to our Directory of Participating Providers. If you need a copy, call us and we will send one to you, or visit www.hmaa.com. To find out if a non-participating provider is recognized and approved, call us at one of the telephone numbers on page 21 of this SPD.

Did a Provider Order the Care?

All covered treatment, services, and supplies must be ordered by a recognized and approved provider.

What You Can Do to Maintain Good Health

Be Passionate About Your Health

Staying healthy is the best way to control your health care costs. Take care of yourself all year long. See your provider early. Don't let a minor health problem become a major one. Take advantage of your preventive care benefits.

Take Charge of your Health

You should make informed decisions about your health care and be an active partner in your care. Talk with your provider and ask questions. Understand the treatment program and any risks, benefits, and options related to it.

Take time to read and understand your **Explanation of Benefits (EOB)**. This report shows how we applied benefits. You may receive copies of your EOB through Online for Members at hmaa.com or by mail. Make sure you are billed only for those services you received.

Interpreting This Summary Plan Description

Agreement

The Agreement between us and you is made up of all of the following:

- This Summary Plan Description (SPD).
- Any riders and/or amendments.
- The enrollment form submitted to us (if applicable).
- The agreement between us and the Hawaii Insulators Health and Welfare Trust.

Our Rights to Interpret this Document

We will interpret the provisions of the Agreement and will determine all questions that arise under it. We have the administrative discretion:

- To determine if you meet our written coverage requirements.
- To determine the amount and type of benefits payable to you or your dependents according to the terms of this Agreement.
- To interpret the provisions of this Agreement as is needed to determine benefits, including decisions on medical necessity.

Our determinations and interpretations, and our decisions on these matters are subject to *de novo* review by an impartial reviewer as provided in this SPD or as allowed by law. If you do not agree with our interpretation or determination, you may appeal. See *Chapter 8: Dispute Resolution*.

No oral statement of any person shall modify or otherwise affect the benefits, limits and exclusions of this Summary Plan Description, convey or void any coverage, or increase or reduce any benefits under this Agreement.

CHAPTER 2: PAYMENT INFORMATION

Eligible Charge

Definition

For most medical services, except for emergency services provided by non-participating providers, the **Eligible Charge** is the lower of either the provider's *actual* charge or the amount we establish as the *maximum eligible fee*. HMAA's payment and your coinsurance are based on the eligible charge. Exception: For services provided by participating facilities, HMAA's payment is based on the maximum eligible fee and your coinsurance is based on the lower of the actual charge or the *maximum eligible fee*. Your copayment is a fixed dollar amount that does not change based on the eligible charge.

The eligible charge for emergency services provided by non-participating providers is calculated in accord with federal law as described at 45 CFR § 147.138(b).

Participating providers agree to accept HMAA's payment plus your copayment and/or coinsurance as payment in full for covered services. Non-participating providers generally do not. If you receive services from a non-participating provider, you are responsible for the copayment and/or coinsurance plus any difference between the actual charge and the eligible charge.

Please note: The eligible charge does not include excise or other tax. You are responsible for all taxes related to the medical care you receive.

Coinsurance

Definition

Coinsurance applies to most covered services. It is a fixed percentage of the eligible charge. Exception: For services provided at a participating facility, your coinsurance is based on the lower of the facility's actual charge or the *maximum eligible fee*. You owe coinsurance even if the facility's actual charge is less than the *maximum eligible fee*.

Please note: If you receive services from a non-participating or non-contracted provider, you are responsible for the copayment and/or coinsurance, *plus* any difference between *the actual charge and the eligible charge*.

Amount

See *Chapter 3: Summary of Benefits and Your Payment Obligations*.

Examples

Here are two examples of how coinsurance works:

Let's say you have an outpatient surgery and go to a participating physician for the service.

- The physician's bill or actual charge = \$150
- HMAA's eligible charge = \$70
- Your coinsurance = \$7 (10% of \$70)

If you go to a non-participating physician, your out-of-pocket cost will be higher.

- The physician's bill or actual charge = \$150
- HMAA's eligible charge = \$70
- Your coinsurance = \$21 (30% of \$70)
- The difference between the actual charge and the eligible charge = \$80
- You owe \$101 (your coinsurance plus the difference between the actual charge and the eligible charge).

Copayment

Definition

A **copayment** is a fixed dollar amount paid in addition to your coinsurance. All copayments apply to the Out-Of-Pocket Maximum. The copayment does not apply to all services. Please refer to *Chapter 3: Summary of Benefits and Your Payment Obligations* for details.

Please note: If you receive services from a non-participating or non-contracted provider, you are responsible for the copayment and/or coinsurance, *plus* any difference between *the actual charge and the eligible charge*.

Examples

Here are two examples of how the copayment works:

Let's say you have a sore throat and go to a participating physician to have it checked.

- The physician's bill or actual charge = \$150
- HMAA's eligible charge = \$70
- Your copayment = \$5
- Your coinsurance = \$6.50 (10% of \$65)
- You owe \$11.50 (your copayment and coinsurance)

If you go to a non-participating physician, your out-of-pocket cost will be higher.

- The physician's bill or actual charge = \$150
- HMAA's eligible charge = \$70
- Your copayment = \$10
- Your coinsurance = \$12 (20% of \$60)
- The difference between the actual charge and the eligible charge = \$80
- You owe \$102 (your copayment and coinsurance, plus the difference between the actual charge and the eligible charge).

Annual Coinsurance Maximum

Definition

The **Annual Coinsurance Maximum** is the maximum copayment and coinsurance amounts you pay in a calendar year. Once you meet the coinsurance maximum you are no longer responsible for copayment or coinsurance amounts unless otherwise noted.

Amount

\$2,500 per person

\$7,500 per family

When You Pay More

The following amounts do not apply toward meeting the coinsurance maximum. Also, you are still responsible for these amounts even after you have met the coinsurance maximum.

- Coinsurance payments for Medical Foods, Contraceptives, Prescription Drugs and Supplies.
- Payments for services subject to a maximum once you reach the maximum. See *Benefit Maximum* later in this chapter.
- The difference between the actual charge and the eligible charge that you pay when you receive services from a non-participating provider.
- Payments for non-covered services.
- Any amounts you owe in addition to your coinsurance for covered services.

Maximum Eligible Fee

Definition

The **Maximum Eligible Fee** is the maximum dollar amount paid for a covered service, supply, or treatment.

These are examples of some of the methods we use to determine the Maximum Eligible Fee:

- For most services, supplies, or procedures, we consider:
 - Increases in the cost of medical and non-medical services in Hawaii over the last year.
 - The relative difficulty of the service compared to other services.
 - Changes in technology.
 - Payment for the service under federal, state, and other private insurance programs.
 - Negotiated reimbursement levels with participating providers.
 - Prevalent negotiated reimbursement levels with non-participating providers.
- For some facility-billed services, we use a per case, per treatment, or per day fee (per diem) rather than an itemized amount (fee for service). This does not include practitioner-billed facility services. For non-participating hospitals, our maximum eligible fee for all-inclusive daily rates established by the hospital will never exceed more than if the hospital had charged separately for services.
- For services billed by participating providers outside of Hawaii, we use the negotiated price passed on to us by PHCS or Multiplan.
- For prescription drugs and supplies, we use nationally recognized pricing sources and other relevant information. The allowable fee includes a dispensing fee. Any discounts or rebates that we receive will not reduce the charges that your coinsurance is based on. We apply discounts and rebates to reduce prescription drugs and supplies coverage rates.

Benefit Maximum

Definition

A **Benefit Maximum** is a limit that applies to a specified covered service or supply. A service or supply may be limited by dollar amount, duration, or number of visits. The maximum may apply per:

- Service. For example, alternative care benefits by a participating provider are limited to 20 visits per calendar year.
- Calendar year. For example, you are eligible to receive benefits for up to 120 skilled nursing facility days each calendar year.

Where to Look for Limitations

See *Chapter 4: Description of Benefits*.

Carryover of Benefits from Previous Coverage

If you were covered by HMAA under a different group coverage just prior to this coverage, any maximums you accrued under the previous coverage carry forward. These maximums will count against the same types of maximum amounts under this coverage. Any deductible, copayment and/or coinsurance amounts you paid toward meeting your coinsurance maximum will also carry over.

If you become a member under another HMAA coverage, then you will be subject to the carryover provisions of the new coverage, and not this coverage.

CHAPTER 3: SUMMARY OF BENEFITS AND YOUR PAYMENT OBLIGATIONS

Benefit and Payment Chart

About this Chart

This benefit and payment chart:

- Is a summary of covered services and supplies.
- Tells you if a covered service or supply is subject to limits or precertification.
- Gives you the page number where you can find more information about the service or supply.
- Tells you what the coinsurance percentage or copayment fixed dollar amount is for covered services and supplies.

Please note: Special limits may apply to a service or supply listed in this benefit and payment chart. Please read the benefit information on the page referenced.

! = An exclamation point next to a service or supply means that our approval is required. If you receive care from a non-participating provider be sure and review *Chapter 5: Precertification*.

*** =** An asterisk next to a service or supply means a service dollar or visit maximum may apply. Please read the benefit information on the page referenced.

! = Approval Required * = See page 32	More info on page:	% = Coinsurance (Percentage based on eligible charge) \$ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating
Hospital and Facility Services			
Ambulatory Surgical Center (ASC)	39	10%	30%
Hospital Ancillary Services	39	10%	30%
Hospital Room and Board	39	10%	30%
Intensive Care Unit/Coronary Care Unit	40	10%	30%
Intermediate Care Unit	40	10%	30%
Isolation Care Unit	40	10%	30%
Outpatient Facility	40	10%	30%
Skilled Nursing Facility	40	10%	30%
Emergency Services			
Emergency Room	41	10%	10%
Physician Visits	41	10%	10%
All Other Services and Supplies	Varies; See, coinsurance and copayment amounts listed in this chart for the service or supply		Same as participating copayment and coinsurance for the service or supply <u>plus</u> the difference between the actual charge and HMAA's payment

! = Approval Required * = See page 32	More info on page:	% = Coinsurance (Percentage based on eligible charge) \$ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating
Physician Services			
Anesthesia	41	10%	30%
Consultation Services	41	10%	30%
Immunizations (standard)	41	None	None
Physician Visits	41	10%	30%
Surgical Services			
Assistant Surgeon Services	42	10%	30%
Colonoscopy (screening)	42	None	None
Cutting Surgery	42	10%	30%
Non-cutting Surgery	42	10%	30%
!Reconstructive Surgery	42	10%	30%
Sigmoidoscopy (screening)	43	None	None
Surgical Supplies	43	10%	30%
Testing, Laboratory and Radiology			
Allergy Testing	43	20%	30%
Allergy Treatment Materials	43	20%	30%
Diagnostic Testing — Inpatient	43	10%	30%
Diagnostic Testing — Outpatient	43	20%	30%
Diagnostic Testing within 48 Hours of Injury — Inpatient	43	10%	30%
Diagnostic Testing within 48 Hours of Injury — Outpatient	43	20%	30%
Fecal Occult Blood Test (FOBT) (screening)	43	None	None
Laboratory and Pathology — Inpatient	43	10%	30%
Laboratory and Pathology — Outpatient	43	20%	30%
Laboratory and Pathology within 48 Hours of Injury — Inpatient	43	10%	30%
Laboratory and Pathology within 48 Hours of Injury — Outpatient	43	20%	30%
Radiology — Inpatient	43	10%	30%
Radiology — Outpatient	43	20%	30%
Radiology within 48 Hours of Injury — Inpatient	43	10%	30%
Radiology within 48 Hours of Injury — Outpatient	43	20%	30%
Tuberculin Test (screening)	43	None	None

! = Approval Required * = See page 32	More info on page:	% = Coinsurance (Percentage based on eligible charge) \$ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating
Chemotherapy and Radiation Therapy			
Chemotherapy — Infusion/Injections	44	20%	30%
Radiation Therapy — Inpatient (for malignancy)	44	10%	30%
Radiation Therapy— Outpatient (for malignancy)	44	20%	30%
Radiation Therapy — Inpatient (for non-malignancy)	44	10%	30%
Radiation Therapy —Outpatient (for non-malignancy)	44	20%	30%
Other Medical Services and Supplies			
*Acupuncture, Chiropractic and Naturopathic Services	44	\$5	Charges in excess of \$20
Ambulance (air)	44	20%	30%
Ambulance (ground)	44	20%	30%
Blood and Blood Products	44	20%	30%
!Dentist, Services of	44	10%	30%
Dialysis and Supplies	44	20%	30%
!Durable Medical Equipment and Supplies	45	20%	30%
Evaluations for Hearing Aids	45	20%	30%
!Growth Hormone Therapy	45	20%	30%
Home IV Therapy	45	20%	30%
Inhalation Therapy	45	20%	30%
Injections	46	20%	30%
Medical Foods	46	20%	20%
!Orthotics and External Prosthetics	46	20%	30%
Private Duty Nursing	67	Not Covered	Not Covered
Vision and Hearing Appliances	46	20%	30%
Rehabilitation Therapy			
Cardiac Rehabilitation	47	20%	30%
Physical and Occupational Therapy— Inpatient	47	10%	30%
*Physical and Occupational Therapy— Outpatient	47	20%	30%
Speech Therapy Services —Inpatient	47	10%	30%
*Speech Therapy Services —Outpatient	47	20%	30%

! = Approval Required * = See page 32	More info on page:	% = Coinsurance (Percentage based on eligible charge) \$ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating
Special Benefits – Disease Management and Preventive Services			
Health Coaching	48	None	Not covered
Life Health Assessment	48	None	Not covered
Preventive Services — Laboratory	48	None	None
Preventive Services — Physical Exam	48	None	None
Screening Services and Preventive Counseling	48	None	30%
Special Benefits for Children			
Newborn Circumcision	49	10%	30%
Well Child Care Immunizations	49	None	None
Well Child Care Laboratory Tests	49	None	None
Well Child Care Physician Office Visits	49	None	None
Special Benefits for Men			
Erectile Dysfunction	50	Varies; See coinsurance and copayment amounts listed in this chart for the service or supply.	
Prostate Specific Antigen (PSA) Test (screening)	50	None	None
Vasectomy	50	10%	30%
Special Benefits for Women			
*Breast Pump	50	None	None
Chlamydia Screening	50	None	None
Complications of Pregnancy	50	Varies; See coinsurance and copayment amounts listed in this chart for the service or supply.	
Contraceptive Implants	50	None	20%
Contraceptive Injectables	50	None	20%
Contraceptive IUD	50	None	20%
Mammography (screening)	51	None	None
Maternity Care	51	10%	30%
Newborn Care	51	10%	30%
Pap Smears (screening)	51	None	None
Pregnancy Termination	51	10%	30%
Tubal Ligation	51	None	30%
Well Woman Exam	51	None	None
Special Benefits for Member and Covered Spouse			
!In Vitro Fertilization	52	10%	30%

! = Approval Required * = See page 32	More info on page:	% = Coinsurance (Percentage based on eligible charge) \$ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating
Special Benefits for Homebound, Terminal, or Long-Term Care			
!*Home Health Care	52	None	30%
*Hospice Services	52	None	None
Behavioral Health – Mental Health and Substance Abuse			
!Hospital and Facility Services— Inpatient	53	10%	30%
Hospital and Facility Services— Outpatient	53	10%	30%
Physician Services — Inpatient	53	10%	30%
Physician Services — Outpatient	53	10%	30%
Psychological Testing — Inpatient	53	10%	30%
Psychological Testing — Outpatient	53	20%	30%
Organ and Tissue Transplants			
You must receive services from a provider that is an approved Center of Excellence for Transplants or is under contract with us for the specific type of transplant you will receive for these benefits to apply.			
!Corneal Transplants	55	10%	30%
!Kidney Transplants	55	None	Not covered
!Organ Donor Services	54	None	30%
!Transplant Evaluation	54	None	Not covered
*Transportation, Lodging and Meal Allowance	54	Transportation, Lodging and Meal Allowance for patient and companion. The maximum daily allowance for Lodging & Meals is \$150. Maximum Benefit per Transplant from the date of the Pre-transplant Evaluation through one year of Post-Transplant Follow-up is \$7,500.	
Other Organ and Tissue Transplants			
!Heart Transplants	55	None	Not covered
!Heart and Lung Transplants	55	None	Not covered
!Liver Transplants	55	None	Not covered
!Lung Transplants	55	None	Not covered
!Pancreas Transplants	55	None	Not covered
!Simultaneous Kidney/Pancreas Transplants	55	None	Not covered
!Small Bowel and Multivisceral Transplants	55	None	Not covered
!Stem-Cell Transplants (including Bone Marrow Transplants)	55	None	Not covered

Prescription Drugs and Supplies

Copayments and Coinsurance for *Prescription Drugs and Supplies* are listed below. This plan covers prescription drugs and supplies only when approved by the FDA, prescribed by your Provider, and if you do not have an HMAA drug plan or your drug plan does not cover the drugs listed in the chart below. See *Chapter 4: Description of Benefits* for more information.

! = Approval Required * = See page 32	More info on page:	Annual Deductible Applies?		% = Coinsurance (Percentage based on eligible charge) \$ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating	Participating	Non-Participating
Chemotherapy – Oral Drugs		If you have an HMAA or freestanding drug plan with benefits for oral chemotherapy drugs, the HMAA or freestanding drug plan benefits will apply. Outpatient medications over \$1,000 require precertification.			
Chemotherapy — Oral	56	No	No	None	None
Mail Order Chemotherapy — Oral	56	No	Not Covered	None	Not Covered
Contraceptives		If you have an HMAA or freestanding drug plan with benefits for contraceptives, the HMAA or freestanding drug plan benefits will apply.			
Contraceptive Diaphragms/Cervical Caps	56	No	No	None	30%
Contraceptive Oral (Generic)	56	No	No	None	20%
Contraceptive Oral (Preferred)	56	No	No	None	20%
Contraceptive Oral (Other Brand Name)	56	No	No	20%	30%
Contraceptive — Other Methods (Generic)	56	No	No	None	20%
Contraceptive — Other Methods (Preferred)	56	No	No	20%	20%
Contraceptive — Other Methods (Other Brand Name)	56	No	No	20%	30%
Mail Order Contraceptive Diaphragms/Cervical Caps	56	No	Not Covered	None	Not Covered
Mail Order Contraceptive Oral (Generic)	56	No	Not Covered	None	Not Covered
Mail Order Contraceptive Oral (Preferred)	56	No	Not Covered	20%	Not Covered
Mail Order Contraceptive Oral (Other Brand Name)	56	No	Not Covered	20%	Not Covered
Mail Order Contraceptive — Other Contraceptive Methods (Generic)	56	No	Not Covered	None	Not Covered
Mail Order Contraceptive — Other Contraceptive Methods (Preferred)	56	No	Not Covered	20%	Not Covered
Mail Order Contraceptive — Other Contraceptive Methods (Other Brand Name)	56	No	Not Covered	20%	Not Covered

! = Approval Required * = See page 32	More info on page:	Annual Deductible Applies?		% = Coinsurance (Percentage based on eligible charge) \$ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating	Participating	Non-Participating
Diabetic Drugs, Supplies, and Insulin		If you have an HMAA or freestanding drug plan with benefits for diabetic drugs, supplies, and insulin, the HMAA or freestanding drug plan benefits will apply.			
Diabetic Supplies — Preferred	56	No	No	None	None
Diabetic Supplies — Other Brand Name	56	No	No	20%	20%
Diabetic Drugs— Generic	56	No	No	20%	20%
Diabetic Drugs— Preferred	56	No	No	20%	20%
Diabetic Drugs — Other Brand Name	56	No	No	30%	30%
Insulin — Preferred	56	No	No	20%	20%
Insulin — Other Brand Name	56	No	No	30%	30%
Mail Order Diabetic Supplies — Preferred	56	No	Not Covered	None	Not Covered
Mail Order Diabetic Supplies — Other Brand Name	56	No	Not Covered	20%	Not Covered
Mail Order Diabetic Drugs— Generic	56	No	Not Covered	20%	Not Covered
Mail Order Diabetic Drugs— Preferred	56	No	Not Covered	20%	Not Covered
Mail Order Diabetic Drugs — Other Brand Name	56	No	Not Covered	30%	Not Covered
Mail Order Insulin — Preferred	56	No	Not Covered	20%	Not Covered
Mail Order Insulin — Other Brand Name	56	No	Not Covered	30%	Not Covered
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs		If you have an HMAA or freestanding drug plan with benefits for U.S. Preventive Services Task Force recommended drugs, the HMAA or freestanding drug plan benefits will apply. Outpatient medications over \$1,000 require precertification.			
Retail — USPSTF recommended drugs	56	No	No	None	20%
Mail Order — USPSTF recommended drugs	56	No	Not Covered	None	Not Covered

CHAPTER 4: DESCRIPTION OF BENEFITS

About This Chapter

Your health care coverage provides benefits for procedures, services or supplies that are listed in this chapter. You will note that some of the benefits have limitations. These limitations describe additional criteria, circumstances or conditions that are necessary for a procedure, service or supply to be a covered benefit. These limitations may also describe circumstances or conditions when a procedure, service or supply is not a covered benefit. These limitations and benefits should be read in conjunction with *Chapter 6: Services Not Covered*, in order to identify all items excluded from coverage.

Non-Assignment of Benefits

Benefits for covered services described in this SPD cannot be transferred or assigned to anyone. Any attempt to assign this coverage or rights to payment will be void.

Hospital and Facility Services

Review of Inpatient Hospital Care

When your condition requires you to be an inpatient, we may work with your provider to review your medical records to determine if payment determination criteria are met. Inpatient reviews take place after admission and at set intervals thereafter, until you are discharged from the facility. We also review discharge plans for after-hospital care.

If payment determination criteria are not met, our nurse reviewer will discuss your case with a physician consultant. If more information is needed, our nurse or physician consultant may contact your attending physician.

Ambulatory Surgical Center (ASC)

Covered, including operating rooms, surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics, blood transfusion services, routine lab and x-ray related to surgery. **Ambulatory Surgical Center** is an outpatient facility that provides surgical services without an overnight stay. This facility may be in a hospital or it may be a separate independent facility.

Hospital Ancillary Services

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

Hospital Room and Board

Covered, including:

- **Semi-Private Rooms.** If you are hospitalized at a participating facility, your coinsurance is based on the facility's medical/surgical semi-private room rate. If you are hospitalized at a non-participating facility, your coinsurance is based on HMAA's maximum eligible fee for semi-private rooms. Also, you owe the difference between the non-participating hospital's room charge and HMAA's maximum eligible fee for semi-private rooms.

- Private Rooms.
 - At Participating Hospitals:
 - If you are hospitalized in a participating facility with private rooms only, your coinsurance is based on HMAA's maximum eligible fee for semi-private rooms.
 - If you are hospitalized in a participating facility with semi-private and private rooms, your coinsurance is based on the facility's medical/surgical semi-private room rate. Also, you owe the difference between the facility's charges for private and semi-private rooms. Exception: If you are hospitalized for conditions identified by HMAA as conditions that require a private room, your coinsurance is based on the facility's medical/surgical private room rate. You may call HMAA for a list of these conditions.
 - At Non-Participating Hospitals:
 - If you are hospitalized in a non-participating facility, your coinsurance is based on HMAA's maximum eligible fee for semi-private rooms. Also, you owe the difference between the facility's private room charge and HMAA's maximum eligible fee for semi-private rooms. Exception: If you are hospitalized for conditions identified by HMAA as conditions that require a private room, your coinsurance is based on HMAA's maximum eligible fee for private rooms. Also, you owe the difference between the facility's private room charge and HMAA's maximum eligible fee for private rooms. You may call HMAA for a list of these conditions.
- Operating rooms.

Intensive Care Unit/Coronary Care Unit

Covered.

Intermediate Care Unit

Covered.

Isolation Care Unit

Covered.

Outpatient Facility

Covered, including but not limited to observation, labor room, and radiology room.

Skilled Nursing Facility

Room and Board is covered. Eligibility for benefits requires that all of these statements are true:

- You are admitted by your physician.
- Care is ordered and certified by your physician.
- We approve confinement.
- Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care.
- The confinement is not longer than 120 days in any one calendar year.
- The confinement is not for custodial care.

Services and supplies are covered, including routine surgical supplies, drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy benefits.

Emergency Services

Covered, but only to stabilize a medical condition which is accompanied by acute symptoms of sufficient severity (including severe pain) that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

- Serious risk to the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child).
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Examples of an emergency include chest pain or other heart attack signs, poisoning, loss of consciousness, convulsions or seizures, broken back or neck. Examples also include heavy bleeding, sudden weakness on one side, severe pain, breathing problems, drug overdose, severe allergic reaction, severe burns, and broken bones. Examples of non-emergencies are colds, flu, earaches, sore throats, and using the emergency room for your convenience or during normal physician office hours for medical conditions that can be treated in a physician's office.

If you need emergency services, call 911 or go to the nearest emergency room for care. Pre-authorization is not needed.

Please note: If you are admitted as an inpatient after a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits.

Physician Services

Anesthesia

Covered, as required by the attending physician and when appropriate for your condition. Services include:

- General Anesthesia.
- Regional Anesthesia.
- Monitored anesthesia when you meet HMAA's high-risk criteria.

Consultation Services

Covered, as needed for surgical, obstetrical, pathological, radiological, or other medical conditions when all of these statements are true:

- The attending physician must require the consultation.
- If the consultation is for inpatient services, you must be confined as a registered bed patient.
- If the consultation is for inpatient services, the consultant's report must be acceptable to us. It must also be included as a part of the record kept by the hospital or skilled nursing facility.
- The consultation must be for reasons other than to comply with requirements by the hospital or skilled nursing facility.

Immunizations (standard)

Covered, but only standard immunizations and immunizations for high-risk conditions such as Hepatitis B and other vaccines in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP). If you would like information about high-risk criteria, call our Customer Service Center and we will help you. Our phone number is listed on page 21 of this SPD. Travel immunizations are not covered.

Physician Visits

Covered, for an illness or injury, when you are inpatient or outpatient. A physician visit may be received in the physician's office, your home, or a facility setting. You are also covered for family planning counseling services.

Surgical Services

When you see a non-participating provider you will owe any copayment and coinsurance that applies to the service plus the difference between HMAA's eligible charge and the provider's actual charge. This may include services or added charges not covered by HMAA.

Approval for Certain Surgical Procedures

Certain surgical procedures must have precertification from HMAA. See *Chapter 5: Precertification*.

Please note: This list of procedures changes periodically. To ensure your surgical procedure is covered, call us or go online at www.hmaa.com and we will check if it requires approval before you receive the surgery.

If you are under the care of a:

- *Participating* physician, the physician will get approval for you.
- *Non-participating* physician, the physician may not get approval for you. Getting approval is your responsibility. See *Chapter 5: Precertification*.

Assistant Surgeon Services

Covered, but only when:

- The complexity of the surgery requires an assistant; and
- The facility does not have a resident or training program; or
- The facility has a resident or training program, but a resident or intern on staff is not available to assist the surgeon.

Colonoscopy (screening)

Covered in accord with HMAA's medical policies.

Cutting Surgery

Covered, including preoperative and postoperative care.

Please note: Non-participating providers may bill separately for preoperative care, the surgical procedure and postoperative care. In such cases, the total charge is often more than the eligible charge. You are responsible for any amount that exceeds the eligible charge.

Non-Cutting Surgery

Covered. Examples of non-cutting surgical procedures include diagnostic and endoscopic procedures; diagnostic and therapeutic injections including catheters injections into joints, muscles, and tendons. Examples also include 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, reconstruct or correct:

- Any bodily function that was lost, impaired, or damaged as a result of an illness or injury.
- Developmental abnormalities when present from birth and that severely impair or impede normal, essential bodily functions.
- The breast on which a mastectomy was performed, and surgery for the reconstruction of the other breast to produce a symmetrical appearance (including prostheses). Treatment for complications of mastectomy and reconstruction, including lymphedema, is also covered.

Complications of a non-covered cosmetic reconstructive surgery are not covered.

Sigmoidoscopy (screening)

Covered in accord with HMAA's medical policies.

Surgical Supplies

Covered.

Testing, Laboratory, and Radiology

Allergy Testing

Covered.

Allergy Treatment Materials

Covered.

Diagnostic Testing

Covered when related to an injury or illness. Examples of diagnostic tests include:

- Electroencephalograms (EEG).
- Electrocardiograms (EKG or ECG).
- Holter Monitoring.
- Stress Tests.

Fecal Occult Blood Test (FOBT) (screening)

Covered in accord with HMAA's medical policies.

Genetic Testing and Screening

Covered, but only if you meet HMAA's criteria. Call us for more information.

Please note: Certain services must have precertification. See *Chapter 5: Precertification*.

Laboratory and Pathology

Covered, when related to an illness or injury. For other routine and preventive lab services, see later in this chapter in the *Special Benefits* sections.

Radiology

Covered. Examples of radiology include:

- Computerized Tomography Scan (CT Scan).
- Diagnostic mammography.
- Nuclear Medicine.
- Ultrasound.
- X-rays.

Tuberculin Test (screening)

Covered for one tuberculin (TB) test per calendar year.

Chemotherapy and Radiation Therapy

High-Dose Limitation

Benefits for high-dose chemotherapy, high-dose radiation therapy, or related services and supplies are covered when provided in conjunction with stem-cell transplants. See later in this chapter under *Stem-Cell Transplants (including Bone Marrow Transplants)* in the section *Organ and Tissue Transplants*.

Chemotherapy — Infusion/Injections

Covered, including chemical agents and their administration to treat malignancy. Subject to the high-dose limit described above. Chemotherapy drugs must be FDA-approved.

Radiation Therapy (for malignancy)

Covered, subject to the high-dose described above.

Radiation Therapy (for non-malignancy)

Covered.

Other Medical Services and Supplies

Acupuncture, Chiropractic and Naturopathic Services

Covered, up to a combined annual maximum of \$500.

Ambulance

Covered, emergency transportation within the United States, if services are provided:

- By a professional ambulance to and from a hospital; or
- By a regularly scheduled airline, railroad, or by air ambulance or chartered aircraft if an air ambulance is not available, from the city or town in which the covered person becomes disabled, to and from the nearest hospital qualified to provide hospital treatment to such injury or illness in any one accidental bodily injury, or on account of any illness.

Blood and Blood Products

Covered, including blood costs, blood bank services, blood processing.

You are not covered for peripheral stem-cell transplants except as described in this chapter under *Stem-Cell Transplants (including Bone Marrow Transplants)*.

Dentist, Services of

Covered, but only when the dentist performs emergency or surgical services that could also be performed by a physician.

Dialysis and Supplies

Covered.

Durable Medical Equipment and Supplies

Covered, but only when prescribed by your treating provider. The equipment must meet all of the following criteria:

- FDA-approved for the purpose that it is being prescribed.
- Able to withstand repeated use.
- Primarily and customarily used to serve a medical purpose.
- Appropriate for use in the home. *Home* means the place where you live other than a hospital or skilled or intermediate nursing facility.
- Necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body part. It should not be useful to a person in the absence of illness or injury.

Durable medical equipment (DME) can be rented or purchased; however, certain items are covered only as rentals.

Supplies and accessories necessary for the effective functioning of the equipment are covered subject to certain limitations and exclusions. Please call our office listed on page 21 of this SPD for details.

Repair and replacement of DME is covered subject to certain limitations and exclusions. Please call our office listed on page 21 of this SPD.

Examples of DME include oxygen equipment, hospital beds, mobility assistive equipment (wheelchairs, walkers, power mobility devices), and insulin pumps.

Please note: Certain DME must have precertification. See *Chapter 5: Precertification*.

Evaluations for Hearing Aids

Covered, but only when you get the evaluation for the use of a hearing aid in the office of a physician or audiologist.

Growth Hormone Therapy

Covered, but only if you meet HMAA's criteria and if growth hormone is for replacement therapy services to treat:

- Hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy.
- Turner's syndrome.
- Growth failure secondary to chronic renal insufficiency awaiting renal transplant.
- AIDS-wasting or cachexia without evidence of suspected or overt malignancy and where other modes of nutritional supplements (e.g., hyperalimentation, enteral therapy) have been tried.
- Short stature.
- Neonatal hypoglycemia secondary to growth hormone deficiency.
- Prader-Willi Syndrome.
- Severe growth hormone deficiency in adults.

Please note: These services must have precertification. See *Chapter 5: Precertification*.

Home IV Therapy

Covered, for services and supplies for outpatient injections, biological therapeutics, biopharmaceuticals, or intravenous nutrient solutions needed for primary diet. Drugs must be FDA-approved.

Please note: Certain services must have precertification. See *Chapter 5: Precertification*.

Inhalation Therapy

Covered.

Injections

Covered, for outpatient services and supplies for the injection or intravenous administration of medication, biological therapeutics and biopharmaceuticals, or nutrient solutions needed for primary diet in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP). Injectable drugs must be FDA-approved.

If you have an HMAA drug plan with a similar benefit, there shall be no duplication or coordination of benefits between this plan and your HMAA drug plan.

Please note: Certain services must have precertification. See *Chapter 5: Precertification*.

Medical Foods

Covered, but only to treat inborn errors of metabolism in accord with Hawaii law and HMAA guidelines.

Orthotics and External Prosthetics

Orthotics are covered, when prescribed by your treating provider to provide therapeutic support or restore function.

Supplies necessary for the effective functioning of an orthotic are covered subject to certain limitations and exclusions. Please call our office listed on page 21 of this SPD for details.

Examples of orthotics include braces, orthopedic footwear, and shoe inserts (for diabetics only).

Foot orthotics are only covered for members with specific diabetic conditions as defined by Medicare guidelines; for partial foot amputations; if they are an integral part of a leg brace; or if they are being prescribed as part of post-surgical or post-traumatic casting care.

External prosthetics are covered when prescribed by your treating provider to replace absent or non-functioning parts of the human body with an artificial substitute.

Supplies necessary for the effective functioning of a prosthetic are covered subject to certain limitations and exclusions. Please call our office listed on page 21 of this SPD for details.

Repair and replacements are covered subject to certain limitations and exclusions. Please call our office listed on page 21 of this SPD for details.

Examples of prosthetics include artificial limbs and eyes, post-mastectomy or post-lumpectomy breast prostheses, external pacemakers and post-laryngectomy electronic speech aids.

Please note: Certain prosthetics and orthotics must have precertification. See *Chapter 5: Precertification*.

Routine Care Associated With Clinical Trials

Covered in accord with Medicare guidelines. Coverage is limited to services and supplies provided when you are enrolled in a Medicare qualified clinical trial if such services would be paid for by Medicare as routine care.

Please note: These services must have precertification. See *Chapter 5: Precertification*.

Vision and Hearing Appliances

Eyeglasses and contact lenses are covered when required because of intraocular surgery or accidental eye injury only. Please call our office listed on page 21 of this SPD for details.

Please note: Exclusions or limits apply. See *Chapter 6: Services Not Covered under Dental, Drug, and Vision and Miscellaneous Exclusions*.

Hearing aids are limited to one hearing aid per ear every 60 months. Benefit payments for hearing aids are limited to no more than the eligible charge. You are responsible for the coinsurance plus the difference between the eligible charge and the cost of the hearing aid of your choice. Fitting adjustment, repair and batteries are not covered.

Rehabilitation Therapy

Cardiac Rehabilitation

Covered when medically necessary.

Physical and Occupational Therapy

Covered, but only when all of the following are true:

- The diagnosis is established by a physician, physician's assistant or advanced practice registered nurse and the medical records document the need for skilled physical and/or occupational therapy.
- The therapy is ordered by a physician, physician's assistant or advanced practice registered nurse under an individual treatment plan.
- The therapy is provided by a qualified provider of physical or occupational therapy services. A qualified provider is one who is licensed appropriately, performs within the scope of his/her licensure and is recognized by HMAA.
- The therapy is necessary to achieve a specific diagnosis-related goal that will significantly improve neurological and/or musculoskeletal function due to a congenital anomaly, or to restore neurological and/or musculoskeletal function that was lost or impaired due to an illness, injury, or prior therapeutic intervention. (Significant is defined as a measurable and meaningful increase in the level of physical and functional abilities attained through short-term therapy as documented in the medical records).
- The therapy is short-term, generally not longer than 90 days, defined as the number of visits necessary to improve or restore neurological or musculoskeletal function required to perform normal activities of daily living, such as grooming, toileting, feeding, etc. Therapy beyond this is considered long-term and is not covered. Maintenance therapy, defined as activities that preserve present functional level and prevent regression, are not covered.
- The therapy does not duplicate services provided by another therapy or available through schools and/or government programs.
- The therapy is described as covered in HMAA's medical policies on physical and occupational therapy. Information on our policies can be found at www.hmaa.com.

Please note: Precertification is required after the 10th visit. See *Chapter 5: Precertification*.

Group exercise programs and group physical and occupational therapy exercise programs are not covered.

Physical therapy evaluations are not covered when provided by an occupational therapist.

Speech Therapy Services

Covered, for the treatment of communication impairments and swallowing disorders but only when all of the following statements are true:

- The diagnosis is established by a physician, physician's assistant, or advanced practice registered nurse and the medical records document the need for skilled speech therapy services.
- The therapy is ordered by a physician, physician's assistant, or advanced practice registered nurse.
- The therapy is necessary to treat function lost or impaired by disease, trauma, congenital anomaly (structural malformation) or prior therapeutic intervention.
- The therapy is rendered by and requires the judgment and skills of a speech language pathologist certified as clinically competent (SLP CCC) by the American Speech—Language Hearing Association (ASHA).
- The therapy is provided on a one-to-one basis.
- The therapy is used to achieve significant, functional improvement through objective goals and measurements.

- The therapy and diagnosis are covered as described in HMAA's medical policies for speech therapy services. Information on our policies can be found at www.hmaa.com.
- The therapy is not for developmental delay/developmental learning disabilities.
- The therapy does not duplicate service provided by another therapy or available through schools and/or government programs.

Speech therapy services include speech/language therapy, swallow/feeding therapy, aural rehabilitation therapy and augmentative/alternative communication therapy.

Please note: Certain services must have precertification. See *Chapter 5: Precertification*.

Special Benefits – Disease Management and Preventive Services

Health Coaching

Covered, for you and your covered dependents age 18 and older. The coaching program matches members with their own certified health coach who will help build a customized wellness plan designed to provide the motivation and support you need to meet your health goals. We encourage members to take advantage of the health coaching program.

Life Health Assessment (LHA)

Covered, for you and your covered dependents age 18 and older. LHA is an online health portal that includes a risk assessment that integrates evaluations of physical, psychosocial and work-life health. Reports and recommendations are immediately available to members after the assessment to help build awareness and promote a healthy lifestyle.

Preventive Services – Laboratory

Covered.

Preventive Services – Physical Exam

Covered.

Screening Services and Preventive Counseling

Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following:

- Preventive Counseling Services
- Screening Laboratory Services:
 - Screening for Lipid Disorders in Adults
 - Screening for Asymptomatic Bacteriuria in Adults
 - Screening for Gonorrhea
 - Screening for Hepatitis B Virus Infection Screening for HIV
 - Screening for Syphilis Infection
 - Screening for Type 2 Diabetes Mellitus in Adults
 - Screening for Iron Deficiency Anemia
 - Screening for Rh (D) Incompatibility
 - Screening for Congenital Hypothyroidism
 - Screening for Phenylketonuria (PKU)
 - Screening for Sickle Cell Disease in Newborns
- Screening Radiology Services:
 - Screening for Abdominal Aortic Aneurysm
 - Screening for Osteoporosis in Postmenopausal Women

Please Note: Benefits for other U.S. Preventive Services Task Force (USPSTF) Grade A and B recommended screenings may be found in other sections of this chapter under *Surgical Services, Testing, Laboratory, and Radiology*, and *Special Benefits for Women*.

Covered for recommended preventive services for woman developed by the Institute of Medicine (IOM) and supported by the Health Resources and Services Administration (HRSA), such as the following:

- Breastfeeding Support and Counseling – but only when received from a trained physician or midwife during pregnancy and/or in the postpartum period.
- Contraceptive Counseling.
- Gestational Diabetes Screening.
- Human Papillomavirus (HPV) DNA Testing.
- Interpersonal and Domestic Violence Screening and Counseling.

Please Note: Benefits for other IOM recommended preventive services for women may be found in this section under other sections of this chapter under *Special Benefits for Women* and *Prescription Drugs and Supplies*.

Special Benefits for Children

Newborn Circumcision

Covered.

Well Child Care

Covered, from birth through age twenty-one including office visits for history, physical exams, sensory screenings, developmental/behavioral assessments, anticipatory guidance, lab tests, and immunizations.

Well Child Care means routine and preventive care for children through age twenty-one. If your child needs medical care as the result of an illness or injury, physician visit benefits apply (and not well child care benefits). See *Physician Services* earlier in this chapter.

Well Child Care Immunizations

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

Well Child Care Laboratory Tests

Covered, in conjunction with office visits, from birth through age twenty-one. Laboratory tests are covered during the well child care period as identified on the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care, in addition to one urinalysis through age five.

Well Child Care Physician Office Visits

Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) 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
- Age three years through twenty-one years: one visit per year

Special Benefits for Men

Erectile Dysfunction

Services, supplies, prosthetic devices, and injectables approved by us are covered to treat erectile dysfunction due to organic cause as defined by HMAA.

Prostate Specific Antigen (PSA) Screening Test

Covered, for men age 50 or older. Benefits are limited to one prostate specific antigen screening test per calendar year. For diagnostic PSA tests, see earlier in this chapter under *Testing, Laboratory, and Radiology*.

Vasectomy

Covered, but only the initial surgery for a vasectomy. Benefits do not include the reversal of a vasectomy.

Special Benefits for Women

Breast Pump

Covered, up to \$250 for purchase of one device including attachments per pregnancy when purchased from any Provider or Medical Pharmacy that provides medical equipment and supplies.

Covered for the rental of a hospital-grade breast pump if the infant is unable to nurse directly on the breast due to a medical condition, such as prematurity, congenital anomaly and/or an infant is hospitalized.

Chlamydia Screening

Covered.

Complications of Pregnancy

Covered.

Contraceptive Implants

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. Coinsurance for Contraceptives does not apply toward meeting the Annual Coinsurance Maximum.

Contraceptive Injectables

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. Coinsurance for Contraceptives does not apply toward meeting the Annual Coinsurance Maximum.

Contraceptive IUDs

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. Coinsurance for Contraceptives does not apply toward meeting the Annual Coinsurance Maximum.

Mammography (screening)

Covered according to the following schedule:

- Age 35 to 39, one baseline mammogram.
- Age 40 or older, one mammogram per calendar year.

Please note: A woman of any age may receive the screening more often if she has a history of breast cancer or if her mother or sister has a history of breast cancer. For diagnostic mammography benefits, see earlier in this chapter under *Testing, Laboratory, and Radiology*.

Maternity Care

Covered for physician services, including prenatal, false labor, delivery, and postnatal services. HMAA pays physicians a global fee related to a bundle of maternity care. If benefit payments are made separately before delivery, payments will be considered an advance and we will deduct the amount from the global benefit payment for maternity care.

Other maternity-related services such as nursery care, labor room, hospital room and board, and diagnostic tests, labs and radiology are covered in other sections of this SPD.

Maternity Length of Stay

Covered, for up to:

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

Newborn Care

Covered for the baby's routine non-surgical physician services and nursery care after birth. Benefits for a sick newborn are available when you add the child to your coverage within 31 days of birth.

Pap Smears (screening)

Covered, but only one screening Pap Smear per year.

Pregnancy Termination

Covered.

Tubal Ligation

Covered, for surgery for a tubal ligation. Reversal of a tubal ligation is not covered.

Well Woman Exam

Covered, for one gynecological exam per calendar year. The well woman exam includes a pelvic exam, the collection of a specimen for Pap smear screening, and a clinical breast exam.

Special Benefits for Member and Covered Spouse

In Vitro Fertilization

Covered. Coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are an HMAA member. If you receive benefits for in vitro fertilization services under an HMAA plan, you will not be eligible for in vitro fertilization benefits under any other HMAA plan. Also, coverage is limited to members who meet the following criteria:

- The in vitro fertilization is for you or your spouse. In vitro fertilization services are not covered when a surrogate is used.
- Either of the following two statements is true:
 - You and your spouse have a history of infertility for at least five years; or
 - The infertility is related to one or more of these 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.
- You have been unable to attain a successful pregnancy through other covered infertility treatments.
- The in vitro procedures are 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.

Please note: These services must have precertification. See *Chapter 5: Precertification*.

Please note: Exclusions or limits that may relate to this benefit are described in *Chapter 6: Services Not Covered* in the section labeled *Fertility and Infertility*.

Special Benefits for Homebound, Terminal, or Long-Term Care

Home Health Care

Covered, but only when all of these statements are true:

- Services are prescribed in writing by a physician to treat an illness or injury when you are homebound. **Homebound** means that due to an illness or injury, you are unable to leave home, or if you do leave home, doing so requires a considerable and taxing effort.
- Part-time skilled health services are needed.
- Services are not more costly than alternate services that would be effective to diagnose and treat your condition.
- Without home health care, you would need inpatient hospital or skilled nursing facility care.
- Services do not exceed 150 visits per calendar year.

Hospice Services

Covered. A **Hospice Program** provides care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. We follow Medicare guidelines to determine benefits, level of care and eligibility for hospice services. Also, we cover:

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

While under hospice care, the terminally ill person is not eligible for benefits for the terminal condition except hospice services and attending physician office visits. The person is eligible for all covered benefits unrelated to the terminal condition.

The attending physician must certify in writing that the person is terminally ill and has a life expectancy of six months or less.

Integrated Case Management

Covered, when approved by us. **Integrated Case Management** is a special program to help members with certain medical conditions that need costly, long-term, care and when a hospital may not be the most appropriate setting for your care. If you meet HMAA's criteria, your coverage provides you with alternate benefits to help meet health care needs that result from extreme illness or injury (providing costs do not exceed inpatient facility costs). You, your physician, and the hospital can work with our case managers to identify and arrange alternate treatment plans to meet your special needs and to assist in preserving your health care benefits.

Conditions and treatments for which benefits management might be appropriate are: AIDS, coma, traumatic brain injury, respirator dependency, spinal cord injury, and long-term intravenous therapy.

Approval for Alternate Treatment Plans

Before benefits are available for alternate treatment plans, approval must be received. Without approval, no benefits for alternate treatment plans are available. Physicians usually contact us on your behalf to identify and arrange alternate treatment plans. If you are not sure if your provider has contacted us, you should talk with your physician, or contact us for assistance.

Behavioral Health – Mental Health and Substance Abuse

Covered, if:

- You are diagnosed with a condition found in the current Diagnostic and Statistical Manual of the American Psychiatric Association.
- The services are provided by a licensed physician, psychiatrist, psychologist, clinical social worker, marriage and family therapist, licensed mental health counselor, or advanced practice registered nurse.

Please note: Epilepsy, senility, mental retardation, or other developmental disabilities and addiction to or abuse of intoxicating substances, do not in and of themselves constitute a mental disorder.

Benefits for inpatient hospital and facility services are subject to the limits described earlier in this chapter under *Hospital Room and Board*.

Please note: All inpatient facility services require precertification. See *Chapter 5: Precertification*.

Please note: Outpatient services require precertification after 12 visits. See *Chapter 5: Precertification*.

Alcohol or Drug Dependence Treatment

You are not covered for detoxification services and educational programs to which drinking or drugged drivers are referred by the judicial system solely because you have been referred or services performed by mutual self-help groups.

Organ and Tissue Transplants

Covered, but only as described in this section and subject to all other conditions and provisions of your Agreement including that the transplant meets payment determination criteria. For a definition of payment determination criteria, see *Chapter 1: Important Information* under *Questions We Ask When You Receive Care*. Expenses related to one transplant evaluation and wait list fees at one transplant facility per approved transplant request are covered.

Also, all transplants (with the exception of corneal and kidney transplants) must:

- Receive our approval. Without approval for the specified transplants, benefits are not available. See *Chapter 5: Precertification*.
- Be received from a facility that:
 - Accepts you as a transplant candidate, and
 - Is located in the State of Hawaii and has a contract with us to perform the transplant, or
 - Is an approved Center of Excellence for Transplants. You may call HMAA for a current list of providers.

Benefits are not available for:

- Artificial (mechanical) organs, except for artificial hearts when used as a bridge to a permanent heart transplant.
- Non-human organs.
- Organ or tissue transplants not listed in this section.
- Transportation of organs or tissues.
- Organ or tissue transplants received out of country.

Transportation, Lodging and Meal Allowance benefits are only available when utilizing a participating Centers of Excellence Provider. Lodging and Meal Allowance for patient and companion is limited to a daily dollar maximum. There is also a maximum dollar Benefit per Transplant for Transportation, Lodging and Meals from Pre-transplant Evaluation through one year of follow-up following the Transplant.

Transplant Evaluations

Covered, if we approve, for heart, heart-lung, liver, lung, pancreas, simultaneous kidney/pancreas, small bowel and multivisceral, or stem-cell transplants. See *Chapter 5: Precertification*. **Transplant Evaluation** means those procedures, including lab and diagnostic tests, consultations, and psychological evaluations that a facility uses in evaluating a potential transplant candidate. This coverage is limited to one evaluation per transplant request and must be rendered either at a facility that is located in the State of Hawaii and has a contract with us to perform the transplant or is an approved Center of Excellence for Transplants. For information about donor screening benefits, see in this chapter under *Organ Donor Services*.

Organ Donor Services

Covered, when you are the recipient of the organ. No benefits are available under this coverage if you are donating an organ to someone else.

Please note: This coverage is secondary and the living donor's coverage is primary when:

- You are the recipient of an organ from a living donor; and
- The donor's health coverage provides benefits for organs donated by a living donor.

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

Corneal Transplants

Covered, but only if you meet HMAA's criteria and if we approve. See *Chapter 5: Precertification*.

Heart Transplants

Covered, but only if you meet HMAA's criteria and if we approve. See *Chapter 5: Precertification*.

Heart and Lung Transplants

Covered, but only if you meet HMAA's criteria and if we approve. See *Chapter 5: Precertification*.

Kidney Transplants

Covered, but only if you meet HMAA's criteria and if we approve. See *Chapter 5: Precertification*.

Liver Transplants

Covered, but only if you meet HMAA's criteria and if we approve. See *Chapter 5: Precertification*.

Lung Transplants

Covered, but only if you meet HMAA's criteria and if we approve. See *Chapter 5: Precertification*.

Pancreas Transplants

Covered, but only if you meet HMAA's criteria and if we approve. See *Chapter 5: Precertification*.

Simultaneous Kidney/Pancreas Transplants

Covered, but only if you meet HMAA's criteria and if we approve. See *Chapter 5: Precertification*.

Small Bowel and Multivisceral Transplants

Covered, for small bowel (small intestine) and the small bowel with liver or small bowel with multiple organs such as the liver, stomach and pancreas, but only if you meet HMAA's criteria and if we approve. See *Chapter 5: Precertification*.

Stem-Cell Transplants (including Bone Marrow Transplants)

Allogeneic stem-cell transplants, reduced intensity conditioning for allogeneic stem-cell transplants and autologous stem-cell transplants are available only for treatment prescribed in accord with HMAA's medical policies and with our approval. See *Chapter 5: Precertification*.

Prescription Drugs and Supplies

Covered, but only oral chemotherapy drugs, contraceptives, diabetic drugs, supplies and insulin, and U.S. Preventive Services Task Force Recommended Drugs. Coverage will be provided only when the Prescription Drugs and Supplies are:

- Approved by the FDA, under federal control,
- Prescribed by your Provider,
- Dispensed by a licensed pharmacy or Provider, and
- You do not have an HMAA or freestanding drug plan or your HMAA or freestanding drug plan does not cover the drug or supply covered in this section.

Please note: Some prescription drugs and supplies must have precertification. See *Chapter 5: Precertification*.

Please note: Coinsurance for Prescription Drugs and Supplies do not apply toward meeting the Annual Coinsurance Maximum.

Benefits for prescription drugs and supplies vary depending on whether the drug is a generic drug, a Preferred drug, or Other brand name drug.

Definitions

Brand name drug is one which is marketed under its distinctive trade name and which is or was at one time protected by patent laws.

Generic drugs are drugs prescribed or dispensed under their commonly used generic name rather than a brand name and which are not protected by patent, or drugs identified by HMAA as "generic."

Oral chemotherapy drug is an FDA-approved oral cancer treatment that may be delivered to the patient for self-administration under the direction or supervision of a Provider outside of a hospital, medical office, or other clinical setting.

Other brand name drugs, supplies, and insulin are brand name drugs, supplies, or insulin which are not identified as preferred on the HMAA Prescription Drug Formulary.

Over-the-counter drugs are drugs that may be purchased without a prescription.

Preferred drugs, supplies and insulin are brand name drugs, supplies or insulin identified as preferred on the HMAA Prescription Drug Formulary.

Prescription drug is a medication that is under Federal control. By Federal law, prescription drugs can only be dispensed with a prescription. Medications that are available as both a Prescription Drug and a non-prescription drug are not covered as a Prescription Drug under this plan.

Benefit Limitations

Contraceptive benefits are limited to one contraceptive method per period of effectiveness.

Diabetic supplies are limited to coverage for syringes, needles, lancets, lancet devices, test strips, acetone test tablets, insulin tubing, and calibration solutions.

Coinsurance amounts for all covered drugs or supplies are for a maximum 30-day supply or fraction thereof. A 30-day supply means a supply that will last you for a period consisting of 30 consecutive days. For example, if the prescribed drug must be taken by you only on the last five days of a one-month period, a 30-day supply would be the amount of the drug that you must take during those five days.

If you obtain more than a 30-day supply under one prescription:

- You must pay an additional coinsurance for each 30-day supply or fraction thereof, and
- Our maximum benefit payment will be limited to benefits for two additional 30-day supplies or fractions thereof.

Drugs Dispensed in Manufacturer's Original Unbreakable Package: Except for insulin, coinsurance for prescription drugs and supplies that are dispensed in a manufacturer's original unbreakable package are determined by the number of calendar days that are covered by the prescription. Coinsurance for insulin is based on the lesser of the calendar days supply and the "discard after" date on the medication. You owe one coinsurance payment for each prescription for up to 59 days, two coinsurance payments for 60-89 days, and three coinsurance payments for 90-119 days. An example of drugs that come in unbreakable packages is oral contraceptives.

Drug Benefit Management

We have arranged with Participating Providers to assist in managing the usage of certain drugs, including drugs listed in the HMAA Prescription Drug Formulary.

- We have identified certain kinds of drugs listed in the HMAA Prescription Drug Formulary that require preauthorization of HMAA. The criteria for preauthorization are that:
 - the drug is being used as part of a treatment plan,
 - there are no equally effective drug substitutes, and
 - the drug meets the "payment determination" criteria and other criteria as established by us.

A list of these drugs in the HMAA Prescription Drug Formulary has been distributed to all Participating Providers.

- Participating providers may dispense up to a 30-day supply for first time prescriptions of maintenance drugs. For subsequent refills, the participating provider may dispense up to a 90-day supply after confirming that:
 - You have tolerated the drug without adverse side effects that could cause the drug to be discontinued, and
 - Your Provider has determined that the drug is effective.

Additional Amounts You May Owe When There is a Drug Generic Equivalent

This plan requires the substitution of Generic Drugs listed on the FDA-Approved Products with Therapeutic Equivalence Evaluations for a brand name drug. Exceptions will be made when a Provider directs that substitution is not permissible. If you choose not to use the generic equivalent, we will pay only the amount that would have been paid for the generic equivalent. This provision will apply even if the generic equivalent is out-of-stock or is not available at the pharmacy.

You will be required to pay the entire cost of the brand name drug when you choose to obtain a brand name drug instead of the generic equivalent or the particular generic equivalent was out-of-stock or not available at the pharmacy. In this situation, you will be responsible for submitting a claim to us. In the event a generic equivalent is out-of-stock or not available, you may wish to purchase the generic equivalent from another pharmacy.

Refills

Except for certain drugs managed under Drug Benefit Management, refills will be paid if indicated on your original prescription and only after two-thirds of your prescription has already been used.

Mail Order Providers

Benefits for mail order prescription drugs, supplies, and insulin are only available through contracted providers. Call our office listed on page 21 of this SPD for a list of contracted providers. If you receive mail order prescription drugs and supplies from a non-participating provider, no benefits will be paid.

Coinsurance amounts are for a maximum 90-day supply or fraction thereof. A 90-day supply means a supply that will last you 90 consecutive days or a fraction thereof. You must pay a 90-day coinsurance even if the prescription is written for less than a 90-day supply or the pharmacy dispenses less than 90 doses or less than a 90-day supply. Situations in which this would occur include, but are not limited to:

- You are prescribed a drug in pill form that must be taken only on the last five days of each month. A 90-day supply would be fifteen pills, the number of pills you must take during a three-month period.
- You are prescribed a 30-day supply with two refills. The mail order pharmacy will fill the prescription in the quantity specified by the Provider, in this case 30 days, and will not send you a 90-day supply. You owe the 90-day coinsurance payment even though a 30-day supply has been dispensed.
- You are prescribed a 30-day supply of a drug that is packaged in less than 30-day quantity, for example, a 28-day supply. The pharmacy will fill the prescription by providing you a 28-day supply. You owe the 90-day coinsurance payment. If you are prescribed a 90-day supply, the pharmacy would fill the prescription by giving you three packages each containing a 28-day supply of the drug. Again, you would owe a 90-day coinsurance payment for the 84-day supply.

Drugs Dispensed in Manufacturer's Original Unbreakable Package: Except for insulin, coinsurance for prescription drugs and supplies that are dispensed in a manufacturer's original unbreakable package are determined by the number of calendar days that are covered by the prescription. Coinsurance payments for insulin are based on the lesser of the calendar days supply and the "discard after" date on the medication. You owe one coinsurance for each prescription for up to 119 days. An example of drugs that come in unbreakable packages is oral contraceptives.

Unless your Provider directs the use of a brand name drug by clearly indicating it on the prescription, your prescription will be filled with the generic equivalent when available and permissible by law.

Refills are available if indicated on your original prescription and only after two-thirds of your prescription has already been used.

Prescription Drug Plan

Your HMAA Prescription Drug Plan features a tiered copayment structure. Your copayment shown in the table below is based on the type of drug that is used to fill your prescription. The drug is subject to a mandatory generic substitution policy if a generic drug is available. By requesting generic drugs, you can reduce your costs. Speak with your physician about the drug that is appropriate for your medical condition. For more information, please contact HMAA's Customer Service Center.

BENEFITS	Days Supply	Participating Pharmacy	Non-Participating Pharmacy
NON-DIABETIC DRUGS			
Retail (Generic)	30	\$5 copay	Plan pays 80% of the E.C.*
Retail (Brand)	30	\$15 copay	Plan pays 80% of the E.C.*
Mail Order (Generic)	90	\$0	Not covered
Mail Order (Brand)	60	\$10 copay	Not covered
DIABETIC SUPPLIES			
Retail (Generic or Preferred Brand)	30	\$0	Plan pays 80% of the E.C.*
Retail (Non-Preferred Brand)	30	\$15 copay	Plan pays 80% of the E.C.*
Mail Order (Generic or Preferred Brand)	90	\$0	Not covered
Mail Order (Non-Preferred Brand)	60	\$10 copay	Not covered
INSULIN			
Generic or Brand	30	\$5 copay	Plan pays 80% of the E.C.*
Mail Order (Generic or Brand)	90	\$0	Not covered
DIABETIC DRUGS			
Generic or Preferred Brand	30	\$5 copay	Plan pays 80% of the E.C.*
Non-Preferred Brand	30	\$15 copay	Plan pays 80% of the E.C.*
Mail Order Generic or Preferred Brand	90	\$0	Not covered
Mail Order Non-Preferred Brand	60	\$10 copay	Not covered

MANDATORY GENERIC SUBSTITUTION POLICY: If a generic equivalent is available for the covered drug but a preferred or non-preferred brand name drug is obtained, the member is responsible for the generic equivalent's copayment plus the difference in eligible charge between the generic equivalent and preferred or non-preferred drug that was obtained.

The above reimbursement percentages are based on participating pharmacy negotiated charges. If you go to a non-participating pharmacy, member pays the total amount up front and is reimbursed based upon the wholesale price minus the applicable copayments. The member will be responsible for any remaining balance over the eligible charge up to the full billed amount.

***Eligible Charge (EC):** Reimbursement is based on a percentage of HMAA's eligible charges, not the billed charges. Eligible charges may be based on a procedure fee schedule, a percentage of billed charges, per day (per diem) fees, per case fees, per treatment fees, or other methods.

Benefits Covered

- A. Drugs and Related Supplies Obtained Without a Prescription are covered as follows if a physician orders them as part of the Eligible Person's treatment and sends the order to HMAA's Health Management Department for verification that they are necessary for the treatment of an illness or injury:
 - 1. Special Vitamins for specific vitamin deficiency conditions (this does not include "multiple" vitamin preparations which may be purchased with or without a physician's prescription).
 - 2. Anti-diabetic drugs, such as insulin.
 - 3. Diabetic Supplies, when purchased by an Eligible Person covered for anti-diabetic drugs.

- B. All of your initial prescriptions will be filled with up to a 30-day supply, with the following restrictions:
 - 1. When a single standard size package is dispensed even though a smaller quantity is prescribed for the following:
 - a. Fluoride, tabs and drops;
 - b. Children's vitamins with fluoride (unbreakable package): Tri Vi Flor, chews and drops; Poly Vi Flor, chews and drops; Vi Daylin F, chews and drops (and with iron); Vi Daylin F, ADC drops (and with iron); Vi Penta F chews; Adeflor, chews and drops; Luride, chews and drops;
 - c. Nitroglycerine products (unbreakable package): Generic NTG (all strengths); Nitrobid; Nitrospan; Nitrostat;
 - d. Miscellaneous: Prenatal vitamins (requiring a prescription); Creams and ointments (standard package size); Liquids (standard package size);
 - e. Diabetic Supplies (unbreakable package): Syringes, needles, test strips, lancets.
 - 2. Provided up to a sixty (60) day supply for brand name drugs (non-diabetic) or a ninety (90) day supply for generic and diabetic drugs when obtained by mail order service or a participating 31-90 day pharmacy.

- C. Drugs and Related Supplies that require Pre-Certification. Benefit is covered upon HMAA's verification that they are necessary for treatment of an illness or injury. For a list of drugs that require prior authorization, please refer to our Pre-Certification Program at www.hmaa.com.

Non-Covered Items, Exclusions, and Limitations

Under this Prescription Drug Rider, the following items are **Not Covered**:

1. Injectable drugs, except Insulin and anaphylaxis (Epinephrine) kits
2. Immunization agents
3. Fertility agents
4. Drugs used for cosmetic purposes
5. Supplies, appliances and other non-drug items, except Diabetic Supplies
6. Drugs furnished to Hospital or Skilled Nursing Facility inpatients
7. Drugs prescribed for treatment plans that are not medically necessary
8. Anti-obesity drugs
9. Sexual function drugs
10. Any drugs that may be purchased without a prescription (e.g. Over-the-Counter), except as specified herein
11. Drugs for which precertification is required but has not been obtained
12. Covered drugs in excess of the quantity specified by the Physician, or any refill dispensed more than one (1) year from the date of the Physician's most recent prescription.
13. Drugs in a therapeutic class in which a former prescription drug in that class converts to an Over-the-Counter (OTC) drug. HMAA reserves the right to provide coverage only for the former prescription drug that has converted to an OTC drug and to exclude from coverage all other drugs in that class. (For example, OTC Claritin is covered with a physician's prescription, but Allegra, Carinex, Zyrtec, and all other low-sedating antihistamines are not covered. Likewise, OTC Prilosec is covered with a physician's prescription, but Nexium, Prevacid, Protonix, Aciphex, prescription (non-OTC) Prilosec, and other similar heartburn medications are not covered.)
14. New, Federal Drug Administration (FDA)-approved drugs during the mandatory efficacy and safety evaluation period assigned by HMAA, which period will last at least four (4) months. This includes drugs regarded by the FDA to be experimental, investigational, or unproven.
15. Drugs and/or Diabetic Supplies obtained by mail order from a Non-Participating Pharmacy.

Filing a Prescription Drug Claim

1. Present Member ID card to the pharmacy or service provider.
2. Participating providers will electronically file claims on behalf of the member, and payment is made to provider.
3. When drugs are purchased from a Non-Participating Provider, the provider will complete a drug claim form and give it to the member along with the prescription. The member should mail the form to HMAA's pharmacy benefit manager. Payment will be made to the member.
4. Claims must be filed within ninety (90) days after the date the drug is purchased.

CHAPTER 5: PRECERTIFICATION

Definition

Precertification is a special approval process to make sure that certain medical treatments, procedures, or devices meet payment determination criteria before the service is rendered.

A table with a list of the treatments, procedures and devices that need precertification is available on our website at www.hmaa.com, or contact us to obtain a copy.

Changes to the List of Services and Supplies Which Require Precertification

From time to time, we need to update the list of services and supplies that require precertification. Changes are needed so that your plan benefits remain current with the way therapies are delivered. Changes may occur at any time during your plan year. If you would like to know if a treatment, procedure or device has been added or deleted, call us at the telephone number on page 21 of this SPD.

When to Request Precertification

If you are under the care of:

- An HMAA participating physician or contracting physician, he or she will:
 - Get approval for you; and
 - Accept any penalties for failure to get approval.
- A PHCS, Multiplan participating provider or non-participating provider, you are responsible for getting the approval. If you do not receive approval and receive any of the services described in this chapter, benefits may be denied.

How to Request Precertification

Ask for precertification by writing or faxing us at:

HMAA - Health Management Department	On Oahu (808) 791-7505
737 Bishop Street, Suite 1200	Toll-Free (888) 941-4622 ext. 302
Honolulu, HI 96813	Fax (808) 535-8398

If you would like to check on the status of the precertification, call us at the phone numbers shown above.

Our Response to Your Request for Precertification or Non-Urgent Care

If your request for precertification is not urgent, HMAA will respond to your request within a reasonable time that is appropriate to the medical circumstances of your case. We will respond within 15 days after we receive your request. We may extend the time once for 15 days if we cannot respond to your request within the first 15 days and if it is due to circumstances beyond our control. If this happens, we will let you know before the end of the first 15 days. We will tell you why we are extending the time and the date we expect to have our decision. If we need added details from you, we will let you know and give you at least 45 days to provide the information.

Our Response to Your Request for Precertification of Urgent Care

Your care is urgent if the time periods that apply to non-urgent care:

- Could seriously risk your life or health or your ability to regain maximum function, or
- In the opinion of your treating physician, would subject you to severe pain that cannot be adequately managed without the care that is the subject of the request for precertification.

HMAA will respond to your request for precertification of urgent care as soon as possible given the medical circumstances of your case. It will be no later than 72 hours after all information sufficient to make a determination is provided to us.

If you do not provide enough details for us to determine if or to what extent the care you request is covered, we will notify you within 72 hours after we receive your request. We will let you know what information we need to respond to your request and give you a reasonable time to respond. You will have at least 48 hours to provide the information.

Appeal of Our Precertification Decision

If you do not agree with our precertification decision, you may appeal it. See *Chapter 8: Dispute Resolution*.

CHAPTER 6: SERVICES NOT COVERED

About This Chapter

Your health care coverage does not provide benefits for certain procedures, services or supplies that are listed in this chapter or limited by this chapter or Chapter 4. We divided this chapter with category headings. These category headings will help you find what you are looking for. Actual exclusions are listed across from category headings.

Please note: Even if a service or supply is not specifically listed as an exclusion in this chapter, there are additional exclusions as described by the limitations in Chapter 4. If that service or supply is not specifically listed as an exclusion in this chapter or as a limitation exclusion in Chapter 4, it will not be covered unless it is described in *Chapter 4: Description of Benefits*, and meets all of the criteria, circumstances or conditions described, and it meets all of the criteria described in *Chapter 1: Important Information* under *Questions We Ask When You Receive Care*. If a service or supply does not meet the criteria described in Chapter 4, then it should be considered an exclusion or service that is not covered. This chapter should be read in conjunction with Chapter 4 in order to identify all items that are excluded from coverage.

If you are unsure if a specific procedure, service or supply is covered or not covered, please call us and we will help you. For your convenience, we list our telephone numbers on page 21 of this SPD.

Counseling Services

Bereavement Counseling

You are not covered for bereavement counseling or services of volunteers or clergy.

Genetic Counseling

You are not covered for genetic counseling, except as identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations.

Marriage or Family Counseling

You are not covered for marriage and family counseling or other training services.

Nutritional Counseling

You are not covered for nutritional counseling, except as identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations.

Sexual Identification Counseling

You are not covered for sexual identification counseling.

Coverage Under Other Programs or Laws

Payment Responsibility

You are not covered when someone else has the legal obligation to pay for your care, and when, in the absence of this coverage, you would not be charged.

Military

You are not covered for treatment of an illness or injury related to military service when you receive care in a hospital operated by an agency of the U.S. government. You are not covered for services or supplies that are needed to treat an illness or injury received while you are on active status in the military service.

Third Party Reimbursement

You are not covered for services or supplies for an injury or illness caused or alleged to be caused by a third party and/or you have or may have a right to receive payment or recover damages in connection with the illness or injury. You are not covered for services or supplies for an illness or injury for which you may recover damages or receive payment without regard to fault. For more information about third party reimbursement, see *Chapter 9: Coordination of Benefits and Third Party Liability*.

Dental, Drug and Vision

Dental Care

You are not covered for dental care under this health coverage except for those services listed in *Chapter 4: Description of Benefits*. Included in this exclusion are dental services that are generally provided only by dentists and not by physicians. The following exclusions apply regardless of the symptoms or illnesses being treated:

- Orthodontics.
- 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 the teeth, gums and structures supporting the teeth.
- Any services in connection with the treatment of TMJ (temporomandibular joint) problems or malocclusion of the teeth or jaws, except for services in connection with the initial visit for diagnosis.

Drugs

You are not covered for prescription drugs and supplies except as stated in *Chapter 4: Description of Benefits* under *Prescription Drugs and Supplies* and as identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations, and as stated under *Prescription Drug Plan*.

Eyeglasses and Contacts

You are not covered for:

- Sunglasses.
- Prescription inserts for diving masks or other protective eyewear.
- Non-prescription industrial safety goggles.
- Non-standard items for lenses including tinting and blending.
- Oversized lenses, and invisible bifocals or trifocals.
- Repair and replacement of frame parts and accessories.
- Eyeglass lenses and contact lenses, except as described in *Chapter 4: Description of Benefits* under *Other Medical Services and Supplies, Vision and Hearing Appliances*.
- Exams for a fitting or prescription (including vision exercises).
- Frames.

Vision Services

You are not covered for:

- Refractive eye surgery to correct visual acuity problems.
- Replacement of lost, stolen or broken lenses, contact lenses or frames.
- Vision training.
- Aniseikonic studies and prescriptions.
- Reading problem studies or other procedures determined to be special or unusual.

Fertility and Infertility

Contraceptives

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

Infertility Diagnosis

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

Infertility Treatment

Except as described in *Chapter 4: Description of Benefits* under *Special Benefits for Member and Covered Spouse*, you are not covered for services or supplies related to the treatment of infertility, including, but not limited to:

- Collection, storage and processing of semen.
- Cryopreservation of oocytes, semen and embryos.
- In vitro fertilization benefits when services of a surrogate are used.
- Cost of donor oocytes and donor semen.
- Any donor-related services, including but not limited to collection, storage and processing of donor oocytes and donor semen.
- Ovum transplants.
- Gamete intrafallopian transfer (GIFT).
- Zygote intrafallopian transfer (ZIFT).
- Services related to conception by artificial means, including prescription drugs and supplies related to such services except as described in *Chapter 4: Description of Benefits* under *Special Benefits for Member and Covered Spouse*.

Sterilization Reversal

You are not covered for the reversal of a vasectomy or tubal ligation.

Preventive and Routine

Health Appraisal

You are not covered for Health Appraisal services except as stated in *Chapter 4: Description of Benefits*.

Immunizations

You are not covered for immunizations except those described in *Chapter 4: Description of Benefits*.

Preventive Services - Physical Examination

You are not covered for physical or health exams and any associated screening procedures except as described in *Chapter 4: Description of Benefits* under the *Special Benefits* sections.

Routine Circumcision

You are not covered for routine circumcision except as stated in *Chapter 4: Description of Benefits* under the *Special Benefits for Children* section.

Routine Foot Care

You are not covered for services or supplies related to routine foot care.

Provider Type

Complementary Provider

You are not covered for services by complementary providers, including but not limited to massage therapists.

Physician Assistant

You are not covered for services and supplies received from a physician assistant unless he or she is employed by a medical group, M.D. or D.O.

Private Duty Nursing

You are not covered for private duty nursing.

Provider is an Immediate Family Member

You are not covered for professional services or supplies when furnished to you by a provider who is within your immediate family. ***Immediate Family*** is a parent, child, spouse, or yourself.

Social Worker

You are not covered for services and supplies received from a social worker. This exclusion does not apply to covered mental health or substance abuse services.

Transplants

Living Donor Transport

You are not covered for expenses of transporting a living donor.

Liver Organ Donor Services

You are not covered for organ donor services if you are the organ donor.

Mechanical or Non-Human Organs

You are not covered for mechanical or non-human organs, except for artificial hearts when used as a bridge to a permanent heart transplant.

Organ Purchase

You are not covered for the purchase of any organ.

Transplant Services or Supplies

You are not covered for transplant services or supplies or related services or supplies other than those described in *Chapter 4: Description of Benefits* under *Organ and Tissue Transplants*. **Related Transplant Supplies** are those that would not meet payment determination criteria but for your receipt of the transplant, including, and without limit, all forms of stem-cell transplants.

Transportation of Organs or Tissue

You are not covered for the transportation of organs or tissues.

Miscellaneous Exclusions

Act of War

To the extent allowed by law, you are not covered for services needed to treat an injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists.

Biofeedback

You are not covered for biofeedback and any related tests.

Blood

You are not covered for blood except as described in *Chapter 4: Description of Benefits*.

Carcinoembryonic Antigen (CEA)

You are not covered for carcinoembryonic antigen when used as a screening test.

Chemotherapy (High-Dose)

You are not covered for high-dose chemotherapy except when provided in conjunction with stem-cell transplants described in *Chapter 4: Description of Benefits* under *Stem-Cell Transplants (including Bone Marrow Transplants)*.

Complications of a Non-Covered Procedure

You are not covered for complications of a non-covered procedure, including complications of recent or past cosmetic surgeries, services or supplies.

Convenience Treatments, Services or Supplies

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 ramps, home remodeling, hot tubs, swimming pools, deluxe/upgraded items, or personal supplies such as surgical stockings and disposable underpads.

Cosmetic Services, Surgery or Supplies

You are not covered for cosmetic services or supplies that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function. You are not covered for complications of recent or past cosmetic surgeries, services or supplies.

Custodial Care

You are not covered for custodial care, sanatorium care, or rest cures. **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 nurse for a person who is not under specific medical, surgical, or psychiatric care to improve that person's condition and to enable that person to live outside a facility providing this care.

Developmental Delay

You are not covered for treatment of developmental delay or services related to developmental delay that are available through government programs or agencies.

Ductal Lavage

You are not covered for ductal lavage.

Duplicate Item

You are not covered for duplicate durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances that are intended to be used as a back-up device, for multiple residences, or for traveling, e.g., a second wheeled mobility device specifically for work or school use or a back-up manual wheelchair when a power wheelchair is the primary means of mobility.

Effective Date

You are not covered for services or supplies that you receive before the effective date of this coverage.

Electron Beam Computed Tomography (EBCT or Ultrafast CT)

You are not covered for electron beam computed tomography for coronary artery calcifications.

Enzyme-Potentiated Desensitization

You are not covered for enzyme-potentiated desensitization for asthma.

Erectile Dysfunction

You are not covered for services and supplies (including prosthetic devices) related to erectile dysfunction except if due to an organic cause. 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 us to treat erectile dysfunction due to an organic cause.

Extracorporeal Shock Wave Therapy

You are not covered for extracorporeal shock wave therapy except for the treatment of kidney stones.

False Statements

You are not covered for services and supplies if you are eligible for care only by reason of a fraudulent statement or other intentional misrepresentation that you or your employer made on an enrollment form for membership or in any claims for benefits. If we pay benefits to you or your provider before learning of any false statement, you or your employer are responsible for reimbursing us.

Foot Orthotics

You are not covered for foot orthotics except, under the following conditions:

- Foot orthotics for persons with specific diabetic conditions per Medicare guidelines;
- Foot orthotics for persons with partial foot amputations;
- Foot orthotics that are an integral part of a leg brace and are necessary for the proper functioning of the brace, and;
- Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.

Genetic Testing and Screening

You are not covered for genetic tests and screening except as stated in *Chapter 4: Description of Benefits* under *Testing, Laboratory, and Radiology* and *Special Benefits — Disease Management and Preventive Services*.

Growth Hormone Therapy

You are not covered for growth hormone therapy except as stated in *Chapter 4: Description of Benefits* under *Other Medical Services and Supplies*.

Hair Loss

You are not covered for services or supplies related to the treatment of baldness or hair loss regardless of condition. This includes hair transplants and topical medications.

Hypnotherapy

You are not covered for hypnotherapy.

Intradiscal Electro Thermal Therapy (IDET)

You are not covered for intradiscal electro thermal therapy.

Motor Vehicles

This plan does not cover the cost to buy or rent motor vehicles such as cars and vans. You are also not covered for equipment and costs related to converting a motor vehicle to accommodate a disability.

Non-Medical Items

You are not covered for durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances that are not primarily medical in nature, e.g., environmental control equipment or supplies (such as air conditioners, humidifiers, dehumidifiers, air purifiers or sterilizers, water purifiers, vacuum cleaners, or 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 educational equipment.

Radiation (High-Dose)

You are not covered for high-dose radiotherapy except when provided in conjunction with stem-cell transplants described in *Chapter 4: Description of Benefits* under *Stem-Cell Transplants (including Bone Marrow Transplants)*.

Radiation (Nonionizing)

You are not covered for treatment with nonionizing radiation.

Repair/Replacement

You are not covered for the repair or replacement of durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances covered under the manufacturer or supplier warranty or that meet the same medical need as the current item but in a more efficient manner or is more convenient, when there is no change in your medical condition.

Self-Help or Self-Cure

You are not covered for self-help and self-cure programs or equipment.

Sexual Transformation

You are not covered for services and supplies related to sexual transformation regardless of cause. This includes, but is not limited to, sexual transformation surgery.

Standby Time

You are not covered for a provider's waiting or standby time.

Supplies

You are not covered for take-home supplies or supplies billed separately by your provider when the supplies are integral to services being performed by your provider.

Thoracic Electric Bioimpedance (Outpatient/Office)

You are not covered for outpatient thoracic electric bioimpedance in an outpatient setting which includes a physician's office.

Topical Hyperbaric Oxygen Therapy

You are not covered for topical hyperbaric oxygen therapy.

Travel or Lodging Cost

You are not covered for the cost of travel or lodging except as described in *Chapter 4: Description of Benefits* under *Organ and Tissue Transplants*.

Vertebral Axial Decompression (VAX-D)

You are not covered for vertebral axial decompression.

Vitamins, Minerals, Medical Foods and Food Supplements

You are not covered for vitamins, minerals, medical foods, or food supplements except as described in *Chapter 4: Description of Benefits* under *Other Medical Services and Supplies, Prescription Drugs and Supplies, and Prescription Drug Plan*.

Weight Reduction Programs

You are not covered for weight reduction programs and supplies, whether or not weight reduction is medically appropriate. This includes dietary supplements, food, equipment, lab tests, exams, and prescription drugs and supplies.

Wigs

You are not covered for wigs and artificial hairpieces.

CHAPTER 7: FILING CLAIMS

When to File Claims

All participating and most non-participating providers in Hawaii file claims for you. If your non-participating provider does not file for you, please submit an itemized bill or receipt. The bill or receipt must be submitted within one year of the last day on which you received services. It must list the services you received. No payment will be made on any claim received by us more than one year after the last day on which you received services. If you have any questions after reading this section, please contact the Hawaii Insulators Health and Welfare Trust Office, or call us. Our telephone numbers appear on page 21 of this SPD.

How to File Claims

One Claim Per Person and Per Provider

File a separate claim for each covered family member and each provider.

You should follow the same procedure for filing a claim for services received in- or out-of-state or out-of-country.

What Information You Must File

Subscriber Identification Number (ID)

The subscriber ID number which appears on your member card.

Provider Statement

The provider statement must be from your provider. All services must be itemized. (Statements you prepare, cash register receipts, receipt of payment notices or balance due notices cannot be accepted.) Without the provider statement, claims are not eligible for benefits. It is helpful to us if the provider statement is in English on the stationery of the provider who performed the service. An accompanying English translation is acceptable.

The provider statement must include:

- Provider's full name and address.
- Patient's name.
- Date(s) you received service(s).
- Date of the injury or start of illness.
- The charge for each service in U.S. currency.
- Description of each service.
- Diagnosis or type of illness or injury.
- Where you received the service (office, outpatient, hospital, etc.).
- If applicable, information about other health coverage you may have.

Telephone Number

Please include a phone number where you can be reached during the day.

Signature

Make sure you sign the claim.

Other Claim Filing Information

Where to Send Claims

Send your claim to the address listed on page 21 of this SPD.

Keep a Copy

You should keep a copy of the information for your records. Information given to us will not be returned to you.

Explanation of Benefits

Once we receive and process your claim, a report explaining your benefits will be provided no later than 30 days after we receive a claim you submit. You may receive copies of your report online at www.hmaa.com or by mail upon request. The **Explanation of Benefits** tells you how we processed the claim. It includes services performed, the actual charge, any adjustments to the actual charge, our eligible charge, the amount we paid, and the amount you owe.

If we require more information to make a decision about your claim or are unable to make a decision due to circumstances beyond our control, we will extend the time for an additional 15 days. We will let you know within the initial 30-day period why we are extending the time and when you can expect our decision. If we require more information, you will have at least 45 days to provide us the information.

If any of your claims are denied, our report will explain the denial.

If, for any reason, you believe we wrongly denied a claim or coverage request, please call us for help. Our phone numbers appear on page 21 of this SPD. If you are not satisfied with the information you receive, and you wish to pursue a claim for coverage, you may request an appeal. See *Chapter 8: Dispute Resolution*.

Cash or Deposit any Benefit Payment in a Timely Manner

If a check is enclosed with your Explanation of Benefits, you must cash or deposit the check before the check's expiration date. If you ask us to reissue the expired check, there may be a service charge.

CHAPTER 8: DISPUTE RESOLUTION

Your Request for an Appeal

Writing Us to Request an Appeal

If you wish to dispute a decision made by HMAA related to coverage, reimbursement, this Agreement, or any other decision or action by HMAA you must ask for an appeal. Your request must be in writing unless you are asking for an expedited appeal. We must receive it within one year from the date of the action or decision you are contesting. In the case of coverage or reimbursement disputes, this is one year from the date we first informed you of the denial or limitation of your claim, or of the denial of coverage for any requested service or supply.

Send written requests to:

HMAA, Attn: Appeals Coordinator
737 Bishop Street, Suite 1200
Honolulu, HI 96813

Or, send us a fax at (808) 591-0463

And, provide the information described in the section below labeled "What Your Request Must Include." Requests that do not comply with the requirements of this chapter will not be recognized or treated as an appeal by us.

If you have any questions about appeals, please contact our Customer Service Center.

Appeal of Our Precertification Decision

We will respond to your appeal as soon as possible given the medical circumstances of your case. It will be within 30 days after we receive your appeal.

Appeal of Any Other Decision or Action

We will respond to your appeal within 60 calendar days after we receive your appeal.

Expedited Appeal

You may ask for an expedited appeal if the time periods for appeals above may:

- Seriously risk your life or health,
- Seriously risk your ability to gain maximum functioning, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

You may request expedited external review of our initial decision if you have requested an expedited internal appeal and the adverse benefit determination involves a medical condition for which the completion of an expedited internal appeal would meet the requirements above. The process for requesting an expedited external review is discussed below. You may ask for an expedited appeal by calling us at the phone number listed on page 21 of this SPD.

We will respond to your request for expedited appeal as soon as possible taking into account your medical condition. It will be no later than 72 hours after all information sufficient to make a determination is provided to us.

Who Can Request an Appeal

Either you or your authorized representative may ask for an appeal. Authorized representatives include:

- Any person you authorize to act on your behalf as long as you follow our procedures. This includes filing a form with us. To get a form to authorize a person to act on your behalf, please visit our website or call our Customer Service Center. (Requests for appeal from an authorized representative who is a physician or practitioner must be in writing unless you are asking for an expedited appeal.)
- A court-appointed guardian or an agent under a health care proxy.
- A person authorized by law to provide substituted consent for you or to make health care decisions on your behalf.
- A family member or your treating health care professional if you are unable to provide consent.

What Your Request Must Include

To be recognized as an appeal, your request must include all of this information:

- The date of your request.
- Your name and telephone number (so we may contact you).
- The date of the service we denied or date of the contested action or decision.
- For precertification for a service or supply, it is the date of our denial of coverage for the service or supply.
- The subscriber ID number from your member card.
- The provider name.
- A description of facts related to your request and why you believe our action or decision was in error.
- Any other details about your appeal. This may include written comments, documents, and records you would like us to review.

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

Information Available From Us

If your appeal relates to a claim for benefits or request for precertification, we will provide upon your request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim as defined by the Employee Retirement Income Security Act.

If our appeal decision denies your request or any part of it, we will provide an explanation, including the specific reason for denial, reference to the health plan terms on which our decision is based, a statement of your external review rights, and other information regarding our denial.

If You Disagree with Our Appeal Decision

If you are enrolled in a group plan and you would like to appeal HMAA's decision, you must do one of the following:

- Request review by an Independent Review Organization (IRO), selected by the Insurance Commissioner if you are appealing an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness; or a determination by HMAA that the service or treatment is experimental or investigational;
- For all other issues:
 - Request arbitration before a mutually selected arbitrator; or
 - File a lawsuit against HMAA under section 502(a) of ERISA.

Request Review by an Independent Review Organization (IRO) Selected by the Insurance Commissioner

If you choose review by an IRO, you must submit your request to the Insurance Commissioner within 130 days of HMAA's decision on appeal to deny or limit the service or supply.

Unless you qualify for expedited external review of our appeal decision, before requesting review, you must have exhausted HMAA's internal appeals process or show that HMAA 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 HMAA'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.

Your request must be in writing and include:

- A copy of HMAA's final internal appeal decision.
- A completed and signed authorization form releasing your medical records relevant to the subject of the IRO review. A copy of the authorization form is available on our website or by calling our Customer Service Center.
- A completed and signed conflict of interest form. Copies of the conflict of interest form are available on our website or by calling our Customer Service Center.
- A check for \$15.00 made out to the Insurance Commissioner. It will be refunded to you if the IRO overturns HMAA's decision. You are not required to pay more than \$60.00 in any calendar year.

You must send the request to the Insurance Commissioner at:

State of Hawaii Insurance Division
Attn: Health Insurance Branch — External Appeals
335 Merchant Street, Room 213
Honolulu, HI 96813
Telephone (808) 586-2804

You will be informed by the Insurance Commissioner within 14 business days if your request is eligible for external review by an IRO.

You may submit additional information to the IRO. It must be received by the IRO within 5 business days of your receipt of notice that your request is eligible. Information received after that date will be considered at the discretion of the IRO.

The IRO will issue a decision within 45 calendar days of the IRO's receipt of your request for review.

The IRO decision is final and binding except to the extent HMAA or you have other remedies available under applicable federal or state law.

Expedited IRO Review

You may request expedited IRO review if:

- You have requested an expedited internal appeal at the same time and the timeframe for completion of an expedited internal appeal would seriously jeopardize your life, health, or ability to gain 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 adverse determination;
- The timeframe for completion of a standard external review would seriously jeopardize your life, health, or ability to gain 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 adverse determination; or
- If the final adverse determination concerns an admission, availability of care, continued stay, or healthcare service for which you received emergency services; provided you have not been discharged from a facility for health care services related to the emergency services.

Expedited IRO review is not available if the treatment or supply has been provided.

The IRO will issue a decision as expeditiously as your condition requires but in no event more than 72 hours after the IRO's receipt of your request for review.

External Review of Decisions Regarding Experimental or Investigational Services

You may request IRO review of an HMAA determination that the supply or service is experimental or investigational. Your request may be oral if your treating physician certifies, in writing, that the treatment or supply would be significantly less effective if not promptly started.

Written requests for review must include, and oral requests must be promptly followed up with, the same documents described above for standard IRO review plus a certification from your physician that:

- Standard health care services or treatments have not been effective in improving your condition;
- Standard health care services or treatments are not medically appropriate for you; or
- There is no available standard health care service or treatment covered by your plan that is more beneficial than the health care service or treatment that is the subject of the adverse action.

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 your licensed, board certified or board eligible physician must certify in writing that scientifically valid studies using accepted protocols demonstrate the service that is the subject of the external review is likely to be more beneficial to you than any available standard health care services or treatment.

The IRO will issue a decision as expeditiously as your condition requires but in no event more than 7 calendar days of the IRO's receipt of your request for review.

Request Arbitration

If you choose arbitration, you must submit a written request for arbitration to HMAA, 737 Bishop Street, Suite 1200, Honolulu, Hawaii 96813. Your request for arbitration will not affect your rights to any other benefits under this plan. You must have fully complied with HMAA's appeals procedures described above and we must receive your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the issue. No other parties may be joined in the arbitration. The arbitration is binding and the parties waive their right to a court trial and jury.

Before arbitration starts, both parties (you and we) must agree on the person to be the arbitrator. If we both cannot agree within 30 days of your request for arbitration, either party may ask the First Circuit Court of the State of Hawaii to appoint an arbitrator.

The arbitration hearing shall be in Hawaii. The rules of the arbitration shall be those of the Dispute Prevention and Resolution, Inc. to the extent not inconsistent with this *Chapter 8: Dispute Resolution*. The arbitration shall be conducted in accord with the Federal Arbitration Act, 9 U.S.C. §1 et seq., and such other arbitration rules as both parties agree upon.

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

You must pay your attorney's or witness's fees, if you have any, and we must pay ours. The arbitrator will decide who will pay all other costs of the arbitration. The cost of the arbitrator's fees will be shared equally between you and HMAA, with each party paying one-half of the fees.

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

CHAPTER 9: COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

What Coordination of Benefits Means

Coverage that Provides Same or Similar Coverage

You may have other insurance coverage that provides benefits which are the same or similar to this plan.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's payment. As the secondary plan, this plan's payment will not exceed the amount this plan would have paid if it had been your only coverage. Additionally, when this plan is secondary, benefits will be paid only for those services or supplies covered under this plan.

If there is an applicable benefit maximum under this plan, the service or supply for which payment is made by either the primary or the secondary plan shall count toward that benefit maximum. For example, this plan covers one tuberculin test per calendar year, if this plan is secondary and your primary plan covers one tuberculin test per calendar year, the test covered under the primary plan will count toward the yearly benefit maximum and this plan will not provide benefits for a second test within the calendar year. However, the first twenty days of confinement to a skilled nursing facility that are paid in full by Medicare shall not count toward the benefit maximum.

What You Should Do

When you receive services, you need to let us know if you have other coverage. Other coverage includes:

- Group insurance.
- Other group benefit plans.
- Non-group insurance.
- Medicare or other governmental benefits.
- The medical benefits coverage in your automobile insurance (whether issued on a fault or no fault basis).

You should also let us know if your other coverage ends or changes.

You will receive a letter from us if we need more information. If you do not give us the details we need to coordinate your benefits, your claims may be delayed or denied. To help us coordinate your benefits, you should:

- Inform your provider by giving him or her information about the other coverage at the time services are rendered, and
- Indicate that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form.

What Will We Do

Once we have the details about your other coverage, we will coordinate benefits for you. There are certain rules we follow to help us determine which plan pays first when there is other insurance or coverage that provides the same or similar benefits as this plan.

General Coordination Rules

This section lists four common coordination rules. The complete text of our coordination of benefits rules is available on request.

No Coordination Rules

The coverage without coordination of benefits rules pays first.

Member Coverage

The coverage you have as an employee pays before the coverage you have as a spouse or dependent child.

Active Employee Coverage

The coverage you have as the result of your active employment pays before coverage you hold as a retiree or under which you are not actively employed.

Earliest Effective Date

When none of the general coordination rules apply (including those not described above), the coverage with the earliest continuous effective date pays first.

Dependent Children Coordination Rules

Birthday Rule

For a child who is covered by both parents who are not separated or divorced and have joint custody, the coverage of the parent whose birthday occurs first in a calendar year pays first.

Court Decree Stipulates

For a child who is covered by separated or divorced parents and a court decree says which parent has health insurance responsibility, that parent's coverage pays first.

Court Decree Does Not Stipulate

For a child who is covered by separated or divorced parents and a court decree does not stipulate which parent has health insurance responsibility, then 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.

Earliest Effective Date

If none of these rules apply, the parent's coverage with the earliest continuous effective date pays first.

Motor Vehicle Insurance Rules

Automobile Coverage

If your injuries or illness are due to a motor vehicle accident or other event for which we believe motor vehicle insurance coverage reasonably appears available under Hawaii Revised Statutes Chapter 431, Article 10C, then that motor vehicle coverage will pay before this coverage.

You are responsible for any cost-sharing payments required under such motor vehicle insurance coverage. We do not cover such cost-sharing payments.

Before we pay benefits under this coverage for an injury covered by motor vehicle insurance, you must give us a list of medical expenses paid by the motor vehicle insurance. The list must show the date expenses were incurred, the provider of service, and the amount paid by the motor vehicle insurance.

We will review the list of expenses to verify that the motor vehicle insurance coverage available under Hawaii Revised Statutes Chapter 431, Article 10C is exhausted. After it is verified, you are eligible for covered services in accord with this SPD.

Please note that you are also subject to the Third Party Liability Rules at the end of this chapter: (1) if your injury or illness is caused or alleged to have been caused by someone else and you have or may have a right to recover damages or receive payment in connection with the illness or injury, or (2) if you have or may have a right to recover damages or receive payment without regard to fault (other than coverage available under Hawaii Revised Statutes Chapter 431, Article 10C).

Any benefits paid by us in accord with this section or the Third Party Liability Rules, are subject to the provisions described later in this chapter under Third Party Liability Rules.

Medicare Coordination Rules

Medicare as Secondary Payer

Since 1980, Congress has passed legislation making Medicare the secondary payer and group health plans the primary payer in a variety of situations. These laws apply only if you have both Medicare and employer group health coverage, and your employer has the minimum required number of employees as described in the following paragraphs. For more information, contact your employer or the Centers for Medicare & Medicaid Services.

If You are Age 65 or Older

If your group employs 20 or more employees and if you are age 65 or older and eligible for Medicare only because of your age, the coverage described in this plan will be provided before Medicare benefits as long as your employer or group health plan 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 with Disability

If your employer or group employs 100 or more employees and if you are under age 65 and eligible for Medicare only because of a disability (and not ESRD), coverage under this plan will be provided before Medicare benefits as long as your group health plan coverage is based on your status as a current active employee or the status of your spouse as a current active employee or on the current active employment status of an individual for whom you are a dependent.

If You are Under Age 65 with End-Stage Renal Disease (ESRD)

If you are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), coverage under this plan will be provided before Medicare benefits, but only during the first 30 months of your ESRD coverage. Then, the coverage described in this plan will be reduced by the amount that Medicare pays for the same covered services.

Dual Medicare Eligibility

If you are eligible for Medicare because of ESRD and a disability, or because of ESRD and you are age 65 or older, the coverage under this plan will be provided before Medicare benefits during the first 30 months of your ESRD Medicare coverage if this plan was primary to Medicare when you became eligible for ESRD benefits.

This Plan Secondary Payer to Medicare

If you are covered under both Medicare and this plan, and Medicare is allowed by law to be the primary payer, coverage under this plan will be reduced by the amount of benefits paid by Medicare. We will coordinate benefits under this plan up to the Medicare approved charge not to exceed the amount this plan would have paid if it had been your only coverage. If you are entitled to Medicare benefits, we will begin paying benefits after all Medicare benefits (including lifetime reserve days) are exhausted.

If you receive inpatient services and have coverage under Medicare Part B only or have exhausted your Medicare Part A benefits, we will pay inpatient benefits based on our eligible charge less any payments made by Medicare for Part B benefits (i.e., for inpatient lab, diagnostic and x-ray services).

Benefits will be paid after we apply any deductible you may have under this plan.

Facilities or Providers Not Eligible or Entitled to Medicare Payment

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

Third Party Liability Rules

If You Have Coverage Under Worker's Compensation or Motor Vehicle Insurance

If you have or may have coverage under worker's compensation or motor vehicle insurance for the illness or injury, please note:

- **Worker's Compensation Insurance.** If you have or may have coverage under worker's compensation insurance, such coverage will apply instead of the coverage under this SPD. Medical expenses from injuries or illness covered under worker's compensation insurance are excluded from coverage under this SPD.
- **Motor Vehicle Insurance.** If you are or may be entitled to medical benefits from your automobile coverage, you must exhaust those benefits first, before receiving benefits from us. Please refer to the section in this Chapter entitled "Motor Vehicle Insurance Rules" for a detailed explanation of the rules that apply to your automobile coverage.

What Third Party Liability Means

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

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

In such cases, any payment made by us on your behalf in connection with such injury or illness will only be in accord with the following rules.

What You Need to Do

Your cooperation is required for us to determine our liability for coverage and to protect our rights to recover our payments. We will provide benefits in connection with the injury or illness in accord with the terms of this SPD only if you cooperate with us by doing the following:

- **Give Us Timely Notice.** You must give us timely notice in writing of each of the following: (1) your knowledge of any potential claim against any third party or other source of recovery in connection with the injury or illness; (2) any written claim or demand (including legal proceeding) against any third party or against other source of recovery in connection with the injury or illness; and (3) any recovery of damages (including any settlement, judgment, award, insurance proceeds, or other payment) against any third party or other source of recovery in connection with the injury or illness. To give timely notice, your notice must be no later than 30 calendar days after the occurrence of each of the events stated above;
- **Sign Requested Documents.** You must promptly sign and deliver to us all liens, assignments, and other documents we deem necessary to secure our rights to recover payments. You hereby authorize and direct any person or entity making or receiving any payment on account of such injury or illness to pay to us so much of such payment as needed to discharge your reimbursement obligations described above;
- **Provide Us Information.** You must promptly provide us any and all information reasonably related to our investigation of our liability for coverage and our determination of our rights to recover payments. We may ask you to complete an Injury/Illness report form, and provide us medical records and other relevant information;
- **Do Not Release Claims Without Our Consent.** You must not release, extinguish, or otherwise impair our rights to recover our payments, without our express written consent; and
- **Cooperate With Us.** You must cooperate to help protect our rights under these rules. This includes giving notice of our lien as part of any written claim or demand made against any third party or other source of recovery in connection with the illness or injury.

Any written notice required by these Rules must be sent to:

HMAA
737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813

If you do not cooperate with us as described above, your claims may be delayed or denied. We shall be entitled to reimbursement of payments made on your behalf to the extent that your failure to cooperate has resulted in erroneous payments of benefits or has prejudiced our rights to recover payments.

Payment of Benefits Subject to Our Right to Recover Our Payments

If you have complied with the rules above, we will pay benefits in connection with the injury or illness to the extent that the medical treatment would otherwise be a covered benefit payable under this SPD. However, we shall have a right to be reimbursed for any benefits we provide, from any recovery received from or on behalf of any third party or other source of recovery in connection with the injury or illness, including, but not limited to, proceeds from any:

- Settlement, judgment, or award;
- Motor vehicle insurance including liability insurance or your underinsured or uninsured motorist coverage;
- Workplace liability insurance;
- Property and casualty insurance;
- Medical malpractice coverage; or
- Other insurance.

We shall have a first lien on such recovery proceeds, up to the amount of total benefits we pay or have paid related to the injury or illness. You must reimburse us for any benefits paid, even if the recovery proceeds obtained (by settlement, judgment, award, insurance proceeds, or other payment):

- Do not specifically include medical expenses;
- Are stated to be for general damages only;
- Are for less than the actual loss or alleged loss suffered by you due to the injury or illness;
- Are obtained on your behalf by any person or entity, including your estate, legal representative, parent, or attorney;
- Are without any admission of liability, fault, or causation by the third party or payer.

Our lien will attach to and follow such recovery proceeds even if you distribute or allow the proceeds to be distributed to another person or entity. Our lien may be filed with the court, any third party or other source of recovery money, or any entity or person receiving payment regarding the illness or injury.

If we are entitled to reimbursement of payments made on your behalf under these rules, and we do not promptly receive full reimbursement pursuant to our request, we shall have a right of set-off from any future payments payable on your behalf under this SPD.

To the extent that we are not reimbursed for the total benefits we pay or have paid related to your illness or injury, we have a right of subrogation (substituting us to your rights of recovery) for all causes of action and all rights of recovery you have against any third party or other source of recovery in connection with the illness or injury.

The amount of recovery to be reimbursed or otherwise paid to HMAA is not reduced by any expenses, such as attorneys' fees, incurred in connection with the recovery. Accordingly, the common fund doctrine is not to be applied. In addition, the "make-whole" rule of insurance law, which holds that an insurance company may not enforce a right of subrogation or third-party responsibility until the insured party has been fully compensated for any injuries, also does not apply.

Our 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 we may have for reimbursement of these payments. All of these rights are preserved and may be pursued at our option against you or any other appropriate person or entity.

For any payment made by us under these rules, you are still responsible for your copayments, coinsurance, deductibles, timeliness in submission of claims, and other obligations under this SPD. Nothing in these Third Party Liability Rules shall limit our ability to coordinate benefits as described in this Chapter.

The preceding medical and prescription drug benefits are fully insured under an insurance contract issued by Hawaii Medical Assurance Association (HMAA), 737 Bishop Street, Suite 1200, Honolulu, Hawaii 96813. The services provided by HMAA 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 content is subject to the provisions of the Agreement for Group Health Plan and all amendments thereto, which contain all of the terms and conditions of membership and benefits. These documents are on file with the Hawaii Insulators Health and Welfare Trust Office. Please refer to these documents for specific questions about coverage.

KAISER FOUNDATION HEALTH PLAN, INC.



MEDICAL AND PRESCRIPTION DRUG BENEFITS

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

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

HOW TO USE THE KAISER PERMANENTE PLAN

PERSONAL DOCTOR

You obtain your medical care directly from Kaiser Permanente facilities and Physicians. You may choose your personal doctor from a staff of over 500 highly qualified Physicians representing all major specialties. Your personal Kaiser Permanente Physician is responsible for your medical care and arranges consultations with other specialists, as necessary. All care and services need to be coordinated by a Kaiser Permanente Physician. A list of providers is included in the Kaiser Permanente Member Handbook which is provided to you at no charge.

LIVE OR WORK

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

LOCATIONS

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

For detailed information on the Kaiser Permanente locations, please contact the Customer Service Center at 432-5955 (Oahu), or 1 (800) 966-5955 (neighbor islands), or visit the website at www.kaiserpermanente.org.

OFFICE VISITS

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

EMERGENCY SERVICES

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

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

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

Emergency care is available seven days a week, 24 hours a day at Kaiser Permanente's Moanalua Medical Center, 3288 Moanalua Road, Honolulu, Hawaii 96819, phone: (808) 432-0000.

On the neighbor islands, emergency care is available seven days a week, 24 hours a day at these facilities:

Maui	Maui Memorial Medical Center
Hawaii	Hilo Medical Center Kona Community Hospital North Hawaii Community Hospital
Kauai	Samuel Mahelona Memorial Hospital West Kauai Medical Center Wilcox Memorial Hospital
Molokai	Molokai General Hospital
Lanai	Lanai Community Hospital

CARE RECEIVED OUTSIDE THE KAISER PERMANENTE SYSTEM

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

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

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

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

Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered. When you are temporarily traveling outside of the Hawaii service area, you may require medical services for emergent or urgent problems. Please have your ID card with you at all times. If you are admitted to a hospital, you or a family member must call the toll-free number found on the back of your ID card within 48 hours of your hospital admittance or your claim may be denied.

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

If you are relocating to another Kaiser Permanente service area or are visiting for more than 90 days, you should contact the Trust Office to discuss your plan/coverage options.

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

MEDICAL BENEFITS

SERVICES	MEMBER CHARGES
OUTPATIENT SERVICES	
Doctors' and all other health professionals' office visits	\$20.00 per visit
Preventive care office visits	No charge
<ul style="list-style-type: none"> • Well-child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months) • Preventive care visits, one per calendar year (age 2 and older) • Preventive gynecological visits, one per calendar year for female members 	
Outpatient surgery and procedures	
<ul style="list-style-type: none"> • Provided in medical office • Provided in ambulatory surgery center or hospital setting 	\$20.00 per visit 10% of applicable charges
Outpatient physical, occupational, and speech therapy	\$20.00 per visit
Dialysis	
<ul style="list-style-type: none"> • Physician and facility services • Equipment, training and medical supplies for home dialysis 	10% of applicable charges No charge
Outpatient laboratory, imaging & testing services	
<ul style="list-style-type: none"> • Basic laboratory and imaging services • Specialty laboratory and imaging services • Testing services 	\$10 per day 20% of applicable charges 20% of applicable charges
Radiation therapy	20% of applicable charges
HOSPITAL INPATIENT SERVICES	10% of applicable charges
Semiprivate, Private (when prescribed), or Intensive Care Unit, 365 days each year. The following hospital services are provided: room and board; general nursing care and special duty nursing; Physician services; surgical procedures; respiratory therapy; anesthesia; drugs, medical supplies; use of operating and recovery rooms; radiation therapy.	
Inpatient laboratory, imaging & testing services	10% of applicable charges
Inpatient physical, speech, and occupational therapy	10% of applicable charges
EXTENDED CARE SERVICES	10% of applicable charges
Up to 60 days of extended care services in a skilled nursing facility per benefit period	
EMERGENCY CARE SERVICES	
Coverage for initial emergency treatment only	
<ul style="list-style-type: none"> • At a facility in the Hawaii service area • At a facility outside the Hawaii service area 	\$100.00 per visit \$100.00 per visit

SERVICES	MEMBER CHARGES
URGENT CARE SERVICES	
Coverage for initial urgent care treatment only	
<ul style="list-style-type: none"> At a Kaiser facility in the Hawaii service area At a non-Kaiser facility outside the Hawaii service area 	<p>\$20.00 per visit</p> <p>20% of applicable charges</p>
OBSTETRICAL CARE, FAMILY PLANNING, AND INFERTILITY SERVICES	
Doctors' services after confirmation of pregnancy (routine prenatal visits and postpartum visit)	No charge
Delivery/hospital stay	10% of applicable charges
Inpatient stay and inpatient care for newborn during or after mother's hospital stay	10% of applicable charges
Interrupted pregnancy services (medically indicated and elective abortions)	
<ul style="list-style-type: none"> Provided in outpatient office visit Provided in ambulatory surgery center or hospital setting 	<p>\$20.00 per visit</p> <p>10% of applicable charges</p>
Family planning office visits	\$20.00 per visit (No charge women's health benefits required by ACA)
Involuntary infertility office visits	\$20.00 per visit
In vitro fertilization	20% of applicable charges
<ul style="list-style-type: none"> Limited to one (1) procedure per lifetime Limited to female members using spouse's sperm 	
Artificial insemination	\$20.00 per visit
Contraceptive drugs and devices (FDA approved) to prevent unwanted pregnancy	
<ul style="list-style-type: none"> Available on Health Plan formulary All other FDA approved contraceptive drugs and devices 	<p>No charge</p> <p>50% of applicable charges</p>
Voluntary sterilization for female members	No charge
MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES	
Outpatient office visits	\$20.00 per visit
Hospital inpatient care	10% of applicable charges
Specialized Facility Services provided in a specialized mental health or chemical dependence treatment unit or facility approved by Kaiser Permanente Medical Group	
<ul style="list-style-type: none"> Day treatment or partial hospitalization services Non-hospital residential services 	<p>\$20.00 per visit</p> <p>10% of applicable charges</p>

SERVICES	MEMBER CHARGES
OTHER SERVICES	
Ambulance services	20% of applicable charges
Blood and blood processing	
<ul style="list-style-type: none"> • Provided in outpatient office visit 	No charge
<ul style="list-style-type: none"> • Provided in ambulatory surgery center, hospital, or skilled nursing facility setting 	10% of applicable charges
Prescribed drugs	
<ul style="list-style-type: none"> • Drugs requiring skilled administration by medical personnel provided in outpatient office visit 	\$20 per dose
<ul style="list-style-type: none"> • Routine immunizations 	No charge
<ul style="list-style-type: none"> • Unexpected mass immunizations 	50% of applicable charges
<ul style="list-style-type: none"> • Diabetes supplies 	50% of applicable charges
<ul style="list-style-type: none"> • Tobacco cessation drugs and products 	No charge
Home health services for home-bound members when prescribed by a Kaiser Permanente Physician	
<ul style="list-style-type: none"> • Nurse and home health aide visits 	No charge
<ul style="list-style-type: none"> • Physician house calls 	\$20.00 per visit
Hospice care (in lieu of any other plan benefits for the treatment of terminal illness)	No charge (\$20.00 per visit for Physician visits)
Implanted internal prosthetics, devices and aids	
<ul style="list-style-type: none"> • Provided in outpatient office visit 	No charge
<ul style="list-style-type: none"> • Provided in ambulatory surgery center, hospital, or skilled nursing facility setting 	10% of applicable charges
Durable medical equipment	20% of applicable charges
Diabetes equipment	50% of applicable charges
Home phototherapy equipment for newborns	No charge
Breast feeding pump	No charge
External prosthetic devices and braces	20% of applicable charges
Hearing aids (standard hearing aids, limited to one per ear every three years)	60% of applicable charges
Chiropractic services for the treatment or diagnosis of neuromusculo-skeletal disorders (performed by American Specialty Health Networks participating chiropractors and limited to 12 office visits per calendar year)	\$20.00 per visit
Active and Fit Program (provided through American Specialty Health Networks)	
<ul style="list-style-type: none"> • Fitness club membership program 	\$100.00 per contract year
<ul style="list-style-type: none"> • Home fitness program 	\$10.00 per contract year

SUPPLEMENTAL CHARGES MAXIMUM

\$2,500 per member,
\$7,500 per family unit
(3 or more members),
per calendar year

Your out-of-pocket expenses are capped each year by the Supplemental Charges Maximum.

You must retain your receipts for supplemental charges and when the maximum amount has been incurred and/or paid, present these receipts to the Business Office at the Moanalua Medical Center, Honolulu Clinic, Waipio Clinic, or Wailuku Clinic, or to the cashier at other clinics, or the Patient Accounting Office at 711 Kapiolani Boulevard, Honolulu, Hawaii 96813. After verification that the Supplemental Charges Maximum has been incurred and/or paid, you will be given a card which indicates that no additional supplemental charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits to ensure that no additional supplemental charges are billed or collected for the remainder of the calendar year. **All payments are credited toward the calendar year in which the medical services were received.**

Once you have met the Supplemental Charges Maximum, please submit your proof of payment as soon as reasonably possible.

Supplemental charges for the following covered Basic Health services can be applied toward the Supplemental Charges Maximum: Essential Health Benefits, covered office visits for medical services listed in this Basic Health Services section, ambulance service, artificial insemination, blood or blood processing, braces, chemical dependency services, contraceptive drugs and devices, diabetes supplies and equipment, dialysis, drugs requiring skilled administration, durable medical equipment, emergency services, external prosthetics, family planning office visits, hearing aids, health evaluation office visits for adults, home health care, hospice, imaging (including x-rays), immunizations (excluding travel immunizations), internal prosthetics, devices, and aids, in-vitro fertilization procedure, infertility office visits, inpatient room (semi-private), interrupted pregnancy/abortion, laboratory, medical foods, mental health services, obstetrical (maternity) care, outpatient surgery and procedures, radiation and respiratory therapy, reconstructive surgery, self-administered/outpatient prescription drugs (in some cases payments for self-administered/outpatient drugs may not count toward the Supplemental Charges Maximum; members may contact Kaiser's Customer Service Center for more information), short-term physical therapy, short-term speech therapy, short-term occupational therapy, skilled nursing care, testing services, transplant procedures, and urgent care.

The following are not Basic Health Services and charges for these services/items are not applicable toward the Supplemental Charges Maximum: all services for which coverage has been exhausted, all excluded or non-covered benefits, all other services not specifically listed above as a Basic Health Service, allergy test materials, complementary alternative medical services (chiropractic, acupuncture, or massage therapy), dental services, dressings and casts, handling fees or taxes, health education services, classes or support groups, medical social services, office visits for services which are not Basic Health Services, radioactive materials, take home supplies, and travel immunizations.

COVERAGE EXCLUSIONS

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

- **Acupuncture.**
- **Alternative medical Services** not accepted by standard allopathic medical practices such as: hypnotherapy, behavior testing, sleep therapy, biofeedback, massage therapy, naturopathy, rest cure, and aromatherapy.
- **Artificial aids, corrective aids, and corrective appliances** such as orthopedic aids, corrective lenses and eyeglasses except as described in the benefits section (for example, external prosthetic devices, braces, and hearing aids are covered benefits).
- **All blood, blood products, blood derivatives, and blood components** whether of human or manufactured origin and regardless of the means of administration, except units of whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin. Donor directed units are not covered.
- **Cardiac rehabilitation.**
- **Chiropractic Services** except as described in the benefits section.
- Services for **confined members** (confined in criminal institutions, or quarantined).
- **Contraceptive foams and creams, condoms** or other non-prescription substances used individually or in conjunction with any other prescribed drug or device.
- **Cosmetic Services**, such as plastic surgery to change or maintain physical appearance, which is not likely to result in significant improvement in physical function, including treatment for complications resulting from cosmetic services. However, Kaiser Permanente physician services to correct significant disfigurement resulting from an injury or medically necessary surgery, incident to a covered mastectomy, or cosmetic service provided by a Physician in a Health Plan facility are covered.
- **Custodial Services or Services in an intermediate level care facility.**
- **Dental care Services**, including pediatric oral care, such as dental x-rays, dental implants, dental appliances, or orthodontia, and Services relating to Temporomandibular Joint Dysfunction (TMJ) or Craniomandibular Pain Syndrome.
- **Employer or government responsibility:** Services that an employer is required by law to provide or that are covered by Workers' Compensation or employer liability law; Services for any military service-connected illness, injury or condition when such Services are reasonably available to the member at a Veterans Affairs facility; Services required by law to be provided only by, or received only from, a government agency.
- **Experimental or investigational Services.**
- **Eye examinations** for contact lenses and vision therapy, including orthoptics, visual training and **eye exercises**.
- **Eye surgery** solely for the purpose of correcting refractive defects of the eye, such as Radial keratotomy (RK) and Photo-refractive keratectomy (PRK).
- **Routine foot care**, unless medically necessary.
- **Health education:** specialized health promotion classes and support groups (such as the bariatric surgery program).
- **Homemaker Services.**

- The following costs and Services for **infertility, in vitro fertilization or artificial insemination**:
 - The cost of equipment and of collection, storage, and processing of sperm.
 - In vitro fertilization using either donor sperm or donor eggs.
 - In vitro fertilization that does not meet state law requirements.
 - Services related to conception by artificial means other than artificial insemination or in vitro fertilization, such as ovum transplants, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT); including prescription drugs related to such Services and donor sperm and donor eggs used for such Services.
 - Services to reverse voluntary, surgically-induced infertility.
- **Non FDA-approved drugs and devices.**
- **Certain exams and Services.** Certain Services and related reports/paperwork in connection with third party requests such as those for: employment, participation in employee programs, sports, camp, insurance, disability, licensing, or on court-order or for parole or probation. Physical examinations that are authorized and deemed medically necessary by a Kaiser Permanente physician and are coincidentally needed by a third party are covered according to the member's benefits.
- Long-term **physical therapy, occupational therapy, speech therapy**; maintenance therapies; applied behavioral analysis services; routine vision services.
- **Services not generally and customarily available in the Hawaii service area.**
- **Services and supplies not medically necessary.** A service or item is medically necessary (in accord with medically necessary state law definitions and criteria) only if, 1) recommended by the treating Kaiser Permanente physician or treating Kaiser Permanente licensed health care practitioner, 2) is approved by Kaiser Permanente's medical director or designee, and 3) is for the purpose of treating a medical condition, is the most appropriate delivery or level of service (considering potential benefits and harms to the patient), and known to be effective in improving health outcomes. Effectiveness is determined first by scientific evidence, then by professional standards of care, then by expert opinion. Coverage is limited to the services which are cost effective and adequately meet the medical needs of the member.
- All Services, drugs, injections, equipment, supplies, and prosthetics related to treatment of **sexual dysfunction**, except evaluations and health care practitioners' services for treatment of sexual dysfunction.
- Personal comfort items, such as telephone, television, and take-home medical supplies for covered **skilled nursing care**.
- Services, drugs, prosthetics, devices or surgery related to **gender reassignment**.
- **Take-home supplies** for home use, such as bandages, gauze, tape, antiseptics, ace type bandages, drug and ostomy supplies, catheters and tubing.
- The following costs and Services for **transplants**:
 - Non-human and artificial organs and their transplantation.
 - Bone marrow transplants associated with high-dose chemotherapy for the treatment of solid tissue tumors, except for germ cell tumors and neuroblastoma in children.
- Services for injuries or illnesses caused or alleged to be caused by **third parties or in motor vehicle accidents**.
- **Transportation** (other than covered ambulance services), **lodging, and living expenses**.
- **Travel immunizations.**
- **Services for which coverage has been exhausted, Services not listed as covered, or excluded Services.**

COVERAGE LIMITATIONS

Benefits and Services are subject to the following limitations:

- Services may be curtailed because of major disaster, epidemic, or other circumstances beyond Kaiser Permanente's control such as a labor dispute or a natural disaster.
- Coverage is not provided for treatment of conditions for which a member has refused recommended treatment for personal reasons when physicians believe no professionally acceptable alternative to treatment exists. Coverage will cease at the point that the member stops following the recommended treatment.
- **Ambulance services** are those services which: 1) use of any other means of transport, regardless of availability of such other means, would result in death or serious impairment of the member's health, and 2) is for the purpose of transporting the member to receive medically necessary acute care. In addition, air ambulance must be for the purpose of transporting the member to the nearest medical facility designated by Health Plan for receipt of medically necessary acute care, and the member's condition must require the services of an air ambulance for safe transport.
- Coverage of **blood and blood processing** includes (regardless of replacement, units and processing of units) whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin. Coverage also includes collection, processing, and storage of autologous blood when prescribed by a Kaiser Permanente physician for a scheduled surgery whether or not the units are used.
- **Chemical dependency services** include coverage in a specialized alcohol or chemical dependence treatment unit or facility approved by Kaiser Permanente Medical Group. Specialized alcohol or chemical dependence treatment services include day treatment or partial hospitalization services and non-hospital residential services.
- Members are covered for **contraceptive drugs and devices** (to prevent unwanted pregnancy) only when all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) the drug is one for which a prescription is required by law, and 3) obtained from pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc.
- Up to a 30-consecutive day supply of **diabetes supplies** is provided (as described under the prescribed drugs section) if all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy designated by Kaiser.
- **Emergency services** are covered for initial emergency treatment only. Member (or member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility. Emergency Services are those medically necessary services available through the emergency department to medically screen, examine and stabilize the patient for Emergency Medical Conditions. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity that meet the prudent layperson standard and the absence of immediate medical attention will result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or place the health of the individual in serious jeopardy. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.
- When applicable, **essential health benefits (EHB)** are provided to the extent required by law and include ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services to the extent required by Health and Human Services (HHS) and EHB-benchmark plan. Pediatric oral care services are

covered only if a separate dental rider is attached. A complete list of essential health benefits is available from Kaiser's Customer Service Center. Essential health benefits are provided upon payment of the copayments listed under the appropriate benefit sections.

- When covered, the following types of **female sterilizations** and related items and services is provided: 1) sterilization surgery for women: Trans-abdominal Surgical Sterilization/Surgical Implant; 2) sterilization implant for women: Trans-cervical Surgical Sterilization Implant; 3) pre and post operative visits associated with female sterilization procedures; and 4) Hysterosalpingogram test following sterilization implant procedure.
- Coverage of **hospice care** is supportive and palliative care for a terminally ill member, as directed by a Kaiser Permanente physician. Hospice coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. The member must be certified by a Kaiser Permanente physician as terminally ill at the beginning of each period. (Hospice benefits apply in lieu of any other plan benefits for treatment of terminal illness.) Hospice includes services such as: 1) nursing care (excluding private duty nursing), 2) medical social services, 3) home health aide services, 4) medical supplies, 5) physician services, 6) counseling and coordination of bereavement services, 7) services of volunteers, and 8) physical therapy, occupational therapy, or speech language pathology.
- **Hospital inpatient care** (for acute care registered bed patients) includes services such as: 1) room and board, 2) general nursing care and special duty nursing, 3) physician services, 4) surgical procedures, 5) respiratory therapy, 6) anesthesia, 7) medical supplies, 8) use of operating and recovery rooms, 9) intensive care room, 10) laboratory services, 11) imaging services, 12) testing services, and 13) and radiation therapy.
- Specialty **imaging services** are services such as CT, interventional radiology, MRI, nuclear medicine, and ultrasound. General radiology includes services such as x-rays and diagnostic mammography.
- Coverage of **in vitro fertilization** is limited to: 1) a one-time only benefit at Kaiser Permanente, and 2) female members using spouse's sperm. Please see Coverage Exclusions for services and items not covered.
- **Internal prosthetics, devices, and aids** (such as pacemakers, hip joints, surgical mesh, stents, bone cement, bolts, screws, and rods) must be prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan. Internal prosthetics, devices, and aids are those which meet all of the following: 1) are required to replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ, 2) are used consistently with accepted medical practice and approved for general use by the Federal Food and Drug Administration (FDA), 3) were in general use on March 1 of the year immediately preceding the year in which this Plan's Service Agreement became effective or was last renewed, and 4) are not excluded from coverage by Medicare, and if covered by Medicare, meet the coverage definitions, criteria and guidelines established by Medicare at the time the device is prescribed. Fitting and adjustment of these devices, including repairs and replacement other than due to misuse or loss, is included in coverage. The following are excluded from coverage: a) all implanted internal prosthetics and devices and internally implanted aids related to an excluded or non covered service/benefit, and b) prosthetics, devices, and aids related to sexual dysfunction. Coverage is limited to the standard prosthetic model that adequately meets the medical needs of the member. Convenience and luxury items and features are not covered.
- The following **interrupted pregnancies** are included: 1) medically indicated abortions, and 2) elective abortions (including abortion drugs such as RU-486). Elective abortions are limited to two per member per lifetime.
- Specialty **laboratory services** include tissue samples, cell studies, chromosome studies, and testing for genetic diseases. All other laboratory services are considered basic lab services.

- **Mental health services** include coverage in a specialized mental health treatment unit or facility approved by Kaiser Permanente Medical Group. Specialized mental health treatment services include day treatment or partial hospitalization services and non-hospital residential services.
- **Office visits** are limited to one or more of the following services: exam, history, and/or medical decision making. Office visits also include: 1) eye examinations for eyeglasses (see also Coverage Exclusions for more information on eye examinations), and 2) ear examinations to determine the need for hearing correction. Members choice of primary care providers and access to specialty care allow for the following: 1) Member may choose any primary care physician available to accept Member, 2) parents may choose a pediatrician as the primary care physician for their child, 3) Members do not need a referral or prior authorization for certain specialty care, such as obstetrical or gynecological care, and 4) the physician may have to get prior authorization for certain services.
- Short-term **physical, occupational, and speech therapy** services (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply) means medical services provided for those conditions which meet all of the following criteria: 1) the therapy is ordered by a Physician under an individual treatment plan; 2) in the judgment of a Physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy; 3) the therapy is provided by or under the supervision of a Physician-designated licensed physical, speech, or occupational therapist, as appropriate; and 4) as determined by a Physician, the therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury. Neurological and/or musculoskeletal function is sufficient when one of the following first occurs: a) neurological and/or musculoskeletal function is the level of the average healthy person of the same age, b) further significant gain is unlikely, or 3) the frequency and duration of therapy for a specific medical condition as specified in the Kaiser Permanente Hawaii Clinical Practice Guidelines has been reached. Occupational therapy is limited to hand rehabilitation services, and medical services to achieve improved self-care and other customary activities of daily living. Speech-language pathology is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin.
- **Prescribed drugs that require skilled administration by medical personnel** must meet all of the following: 1) prescribed by a Kaiser Permanente licensed prescriber, 2) on the Health Plan formulary and used in accordance with formulary guidelines or restrictions, and 3) prescription is required by law.
- In accordance with **routine obstetrical (maternity) care**, if member is discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), the member's Kaiser Permanente physician may order a follow-up visit for the member and newborn to take place within 48 hours after discharge.
- Covered **skilled nursing care** in an approved facility (such as a hospital or skilled nursing facility) per Benefit Period, include the following services: 1) nursing care, 2) room and board, 3) medical social services, 4) medical supplies, and 5) durable medical equipment ordinarily provided by a skilled nursing facility. In addition to Health Plan criteria, Medicare guidelines are used to determine when skilled nursing services are covered, except that a prior three-day stay in an acute care hospital is not required.
- Up to a 30-consecutive day supply of **tobacco cessation drugs and products** is provided when all of the following criteria are met: 1) provided by a licensed Prescriber, 2) available on the Health Plan formulary's Tobacco Cessation list of approved drugs and products, including over-the-counter drugs and products, and used in accordance with formulary criteria, guidelines or restrictions, 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc., or a pharmacy designated by Kaiser, and 4) Member meets Health Plan-approved program-defined requirements for smoking cessation classes or counseling (tobacco cessation classes and counseling sessions are provided at no charge).

- **Tuberculin skin test** is limited to one (1) per calendar year unless medically necessary.
- **Transplant services for transplant donors.** Health Plan will pay for medical services for living organ and tissue donors and prospective donors if the medical services meet all of the following requirements. Health Plan pays for these medical services as a courtesy to donors and prospective donors, and this document does not give donors and prospective donors any of the rights of Kaiser Permanente Members.
 - Regardless whether the donor is a Kaiser Permanente member or not, the terms, conditions, and supplemental charges of the transplant-recipient Kaiser Permanente member will apply. Supplemental charges for medical services provided to transplant donors are the responsibility of the transplant-recipient Kaiser Permanente member to pay, and count toward the transplant-recipient Kaiser Permanente member's limit on supplemental charges.
 - The medical services required are directly related to a covered transplant for a Kaiser Permanente member and required for a) screening of potential donors, b) harvesting the organ or tissue, or c) treatment of complications resulting from the donation.
 - For medical services to treat complications, the donor receives the medical services from Kaiser Permanente practitioners inside a Health Plan Region or Group Health service area.
 - Health Plan will pay for emergency services directly related to the covered transplant that a donor receives from non-Kaiser Permanente practitioners to treat complications.
 - The medical services are provided not later than three months after donation.
 - The medical services are provided while the transplant recipient is still a Kaiser Permanente member, except that this limitation will not apply if membership terminates because he or she dies.
 - Health Plan will not pay for travel or lodging for donors or prospective donors.
 - Health Plan will not pay for medical services if the donor or prospective donor is not a Kaiser Permanente member and is a member under another health insurance plan, or has access to other sources of payment.

The above policy does not apply to blood donors.

- **Urgent care services** are covered for initial urgent care treatment only. "Urgent Care Services" means medically necessary services for a condition that requires prompt medical attention but is not an Emergency Medical Condition. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.

THIRD PARTY LIABILITY, MOTOR VEHICLE ACCIDENTS AND SURROGACY HEALTH SERVICES

Kaiser Permanente has the right to recover the cost of care for a Member's injury or illness caused by another person or in an auto accident from a judgment, settlement, or other payment paid to the Member by an insurance company, individual, or other third party.

Kaiser Permanente has the right to recover the cost of care for Surrogacy Health Services. Surrogacy Health Services are services the Member receives related to conception, pregnancy, or delivery in connection with a Surrogacy Arrangement. The Member must reimburse Kaiser Permanente for the costs of Surrogacy Health Services out of the compensation the Member or the Member's payee is entitled to receive under the Surrogacy Arrangement.

BINDING ARBITRATION

Except for certain situations outlined in your Group Medical and Hospital Service Agreement, all claims, disputes, or causes of action arising out of, or related to your Group Medical and Hospital Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, are subject to binding arbitration. **For all claims subject to binding arbitration, all parties give up the right to jury or court trial.** For a complete description of arbitration procedures, please refer to your Group Medical and Hospital Service Agreement, which you may obtain from the Trust Fund Office. After exhausting Kaiser Permanente's internal appeals process, in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) members have the option of choosing binding arbitration or filing a lawsuit.

PRESCRIPTION DRUG BENEFITS

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

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

BENEFITS	MEMBER COPAYMENT
<p>For each prescription, when the quantity does not exceed:</p> <ul style="list-style-type: none"> • a 30-day consecutive supply of a prescribed drug, or • an amount as determined by the formulary. <p>Self-administered drugs are covered only when all of the following criteria are met:</p> <ul style="list-style-type: none"> • prescribed by a Kaiser Permanente Physician/ licensed prescriber, or a prescriber designated by Kaiser Permanente, • on the Kaiser Permanente Hawaii Drug Formulary. Drugs must be used in accordance with formulary criteria, guidelines or restrictions, • the drug is one for which a prescription is required by law, • obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc., or pharmacies designated by Kaiser Permanente, and • drug does not require administration by nor observation by medical personnel. <p>Maintenance drugs are those which are used to treat chronic conditions, such as asthma, hypertension, diabetes, hyperlipidemia, cardiovascular disease, and mental health.</p>	<p>\$5 per prescription for generic Maintenance drugs</p> <p>\$15 per prescription for all other generic drugs</p> <p>\$50 per prescription for brand name drugs</p>
<p>Insulin</p>	<p>\$15 per prescription for generic</p> <p>\$50 per prescription for brand name</p>
<p>Diabetes supplies</p>	<p>50% of applicable charges</p>
<p>WellRx Program Members who are eligible for and enroll in the WellRx Program may receive their 30-day consecutive supply of a chronic disease drug or diabetes supply without charge. Only certain drugs are available as part of this program.</p>	<p>No charge (Member must meet program requirements)</p>

Your Kaiser Permanente membership contract entitles you to a maximum one-month's supply per prescription. However, as a convenience to you, Kaiser Permanente pharmacies will dispense up to a three-month's supply of certain prescriptions upon request (you will be responsible for three copayment amounts). Dispensing a three-month's supply is done in good faith, presuming you will remain a Kaiser Permanente member for the next three-months. **If you terminate your membership with Kaiser Permanente before the end of the three-month period, you will be billed the retail price for your remaining drugs.** For example, if you end your membership after two months, you will be billed for the remaining one-month's supply. Unless otherwise directed by a Kaiser Permanente physician, refills may be allowed when 75% of the current prescription supply is taken/administered according to the prescriber's directions.

MAIL ORDER SERVICE

Members may request refills of maintenance drugs through the mail order service, in which members are entitled to a 90-day supply for two copayments. The Mail Order program does not apply to the delivery of certain pharmaceuticals such as narcotics, tranquilizers, bulky items, medication affected by temperature, and injectables. Mail order drugs will not be sent to addresses outside the Hawaii Service Area.

ORDERING REFILLS

You can order your refills at your convenience, 24/7, using one of the following methods:

- For the quickest turnaround time, order online at kp.org.
- Order via the automated prescription refill service by calling 432-7979 (Oahu) or 1-888-867-2118 (Neighbor Islands). You'll have the following options:
 - To check your order status, press 1.
 - To order refills, press 2. You will be asked to enter your medical record number and prescription number. Then you'll have the option of receiving your refills via mail order (by pressing 1) or picking up your refills at a Kaiser pharmacy (by pressing 2)
 - To listen to detailed instructions, press 3.
- Order by using a mail order envelope, available at all Kaiser Permanente clinic locations.
- Order via the Pharmacy Refill Center at 432-5510 (Oahu), or toll free 1-866-250-1805 (Neighbor Islands), Monday to Friday, 8:30 a.m. to 5:00 p.m. TTY users may call 1-877-447-5990.

Place your refill order when you've used two-thirds of your existing supply of prescription medications.

For mail orders, allow one to two weeks to receive your medication for refillable orders.

If you must pick up your prescriptions at a clinic pharmacy, refillable prescriptions are usually ready for pickup at the designated pharmacy in one business day. Prescriptions requiring a physician's approval are usually ready in two business days. Call the pharmacy or Kaiser's automated prescription refill line in advance to make sure that your prescription is ready. Orders not picked up within 7 days are returned to stock.

EXCLUSIONS

The following are excluded from coverage under the Kaiser Permanente Prescription Drug Plan:

- Drugs for which a prescription is not required by law (e.g., over-the-counter drugs) including condoms, contraceptive foams and creams, or other non-prescription substances used individually or in conjunction with any other prescribed drug or device. This exclusion does not apply to tobacco cessation drugs and products as described in the prescribed drug section of the Medical Plan.
- Drugs and their associated dosage strengths and forms in the same therapeutic category as a non-prescription drug that have the same indication as the non-prescription drug.
- Drugs obtained from a non-Kaiser Permanente pharmacy.
- Non-prescription vitamins.
- Drugs when used primarily for cosmetic purposes.
- Medical supplies such as dressings and antiseptics.
- Reusable devices such as blood glucose monitors and lancet cartridges (covered under Medical Plan).
- Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente Physician/licensed prescriber or prescriber designated by Kaiser Permanente.
- Brand name drugs requested by a member when there is a generic equivalent.
- Prescribed drugs that are necessary for or associated with excluded or non-covered services.
- Drugs related to sexual dysfunction.
- Drugs to shorten the duration of a common cold.
- Drugs related to enhancing athletic performance (such as weight training and bodybuilding).
- Any packaging other than the dispensing pharmacy's standard packaging.
- Immunizations, including travel immunizations.
- Contraceptive devices and drugs to prevent unwanted pregnancies (covered under Medical Plan).
- Abortion Drugs such as RU-486.
- Replacement of lost, stolen or damaged drugs.

ADDITIONAL KAISER PERMANENTE INFORMATION

CUSTOMER SERVICE

When you need help, ask the Customer Service Center:

- Oahu: (808) 432-5955
- Neighbor Islands and outside the Hawaii service area: 1 (800) 966-5955
- TTY hearing/speech impaired: 1 (877) 447-5990
- Phone line hours:
8:00 a.m. – 4:30 p.m. (Monday through Friday)
8:00 a.m. – 12:00 p.m. (Saturday)

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

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

YOUR IDENTIFICATION CARD

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

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

YOUR CURRENT ADDRESS

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

CLAIMS FOR BENEFITS

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

CONVERSION PRIVILEGE

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

IMPORTANT PHONE NUMBERS

Kaiser Foundation Health Plan Office

Contract and policy interpretations 432-5127

Customer Service

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

Membership Accounting

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

Patient Accounting

Industrial, No-Fault, Tri-care, and filing other insurances 432-5340

Mainland Kaiser Facilities

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

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

The preceding information is only a summary of coverage. Its contents are subject to provisions of the Group Medical and Hospital Service Agreement and Face Sheet, Kaiser Permanente Group Plan Benefit Schedule and applicable Riders, which contain all the terms and conditions of membership and benefits. These documents are on file with the Hawaii Insulators Health and Welfare Trust Office. Please refer to these documents for specific questions about coverage.

VISION CARE BENEFITS

(Self-Insured)

Vision care benefits are paid for directly by the Hawaii Insulators Health and Welfare Trust. All eligible active employees and their covered dependents are eligible for vision care benefits.

WHAT ARE THE VISION CARE BENEFITS?

You and your eligible dependents are eligible for one (1) eye examination and one (1) pair of lenses and frame, or one (1) pair of contact lenses every calendar year. In no event will the Trust make allowances for more than one (1) eye examination and one (1) pair of lenses and frame, or one (1) pair of contact lenses during any calendar year for each eligible employee or dependent. For covered services and appliances, the Trust will pay up to the following amounts:

	Allowances
Eye Examination	
Ophthalmologist (M.D.)	\$ 50.00
Optometrist (O.D.)	\$ 45.00
Appliances	
Single vision lenses and frame	\$105.00
Multi-focal lenses and frame	\$125.00
Contact lenses	\$130.00
Frame only	\$ 50.00

If lenses are replaced without furnishing a new frame, the total allowance for both lenses and frame may be used toward the cost of the lenses, if required.

EXCLUSIONS

- Repair or replacement of frame parts and accessories
- Sunglasses
- Prescription inserts for diving masks
- Non-prescription industrial safety goggles or glasses
- Non-standard items

Payments will be made by the Trust only when services are rendered in connection with an eye examination for the correction of a visual defect and when the lenses and/or frame are required as a result of such examination.

HOW ARE THE VISION CARE SERVICES PROVIDED?

You may go to any licensed ophthalmologist (M.D.), optometrist (O.D.), or other vision care provider of your choice. You should choose a provider who can help you obtain the vision care you need at a reasonable cost. Your choice of vision care provider can make a difference in how much you will owe after vision care benefit payments have been made.

The Hawaii Insulators Health and Welfare Trust contracts with certain vision care providers in the State of Hawaii. A list of these participating providers will be provided to you at no charge. When you go to one of the participating providers, payment for the services and/or supplies is sent directly to the provider. The only copayment you will be required to pay will be for trifocal and progressive multi-focal lenses, the balance of charges for frames not within a selected group of frames available at no charge, contact lenses, and non-covered items.

If you go to a non-participating provider, payment for the services and/or supplies is made directly to you. You will then owe the provider the total charge for the services and/or supplies.

HOW TO FILE A VISION CARE CLAIM

If you go to a participating provider:

1. Obtain a claim form from the provider.
2. Complete Part I of the claim form.
3. Have the provider complete Part II and/or Part III of the claim form.
4. The provider will send the completed claim form to the Trust Office.
5. Payment will be made directly to the provider. However, you must arrange to pay the provider for any copayments that may be required.

If you go to a nonparticipating provider:

1. Obtain a claim form from the Trust Office.
2. Complete Part I of the claim form.
3. Have the provider complete Part II and/or Part III of the claim form.
4. Send the completed claim form with the itemized bills to the Trust Office.
5. Your reimbursement check, together with a statement showing the charges and amounts paid, will be mailed to you. You must arrange to pay the provider the total charge for the services and/or supplies.

All claims must be filed within 90 days from the date of service.

Vision care benefits are self-insured by the Hawaii Insulators Health and Welfare Trust. The preceding is for informational purposes and is only a summary of coverage. Its content is subject to the provisions of the Vision Care Plan document and all amendments thereto. These documents are on file with the Hawaii Insulators Health and Welfare Trust Office. Please refer to these documents for specific questions about coverage.

MASSAGE THERAPY BENEFITS (Self-Insured)

Massage Therapy benefits are paid for directly by the Hawaii Insulators Health and Welfare Trust. All eligible active employees and their covered spouses are eligible for massage therapy benefits. Dependent children are not eligible for this benefit.

WHAT ARE THE MASSAGE THERAPY BENEFITS?

You and your spouse are eligible for twelve (12) office visits per calendar year for massage therapy services provided by licensed Massage Therapists in Shiatsu, Kiate Nerve Therapy, or Therapeutic Structural Integration. The Trust will pay up to a maximum of \$25.00 per office visit.

You must arrange to pay the provider the total charge for the services and file a claim with the Trust for reimbursement. The Trust will reimburse you up to the maximum benefit amount for each covered office visit.

HOW ARE SERVICES PROVIDED?

You may receive massage therapy services from preferred providers designated by the Trust. A list of these preferred providers may be obtained, free of charge, from the Trust Office.

HOW TO FILE A CLAIM

1. Have the provider complete a universal claim form (also known as a CMS 1500 claim form).
2. Mail the completed claim form and itemized bills to the Hawaii Insulators Health and Welfare Trust Office.
3. Your reimbursement check, together with a statement showing the charges and amounts paid, will be mailed to you. You must arrange to pay the provider the total charge for the services.

<p>All claims must be filed within 90 days from the date of service.</p>

Massage therapy benefits are self-insured by the Hawaii Insulators Health and Welfare Trust. The preceding is for informational purposes and is only a summary of coverage. Its content is subject to the provisions of the Massage Therapy Benefit plan document. This document is on file with the Hawaii Insulators Health and Welfare Trust Office. Please refer to this document for specific questions about coverage.

DENTAL BENEFITS

Eligible active employees and their covered dependents are eligible for dental benefits provided through Hawaii Dental Service (HDS). Details of the HDS dental plan are outlined below.



Getting Started

Register for Online Member Information

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

To register, go to www.HawaiiDentalService.com and click on "New User?" Complete the Member Registration form and click on "Register User." HDS will then send you an e-mail. Please click on the link in the e-mail to activate your online account.

Effective Date of Eligibility

If you are a new HDS member enrolling in this plan, the Hawaii Insulators Health and Welfare Trust will let you know the start date (effective date) of your dental coverage. An HDS membership card will be mailed to you after HDS is notified of your start date.

- 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 Web site at www.HawaiiDentalService.com or you may ask your dentist to confirm your eligibility with HDS prior to receiving services.

Eligible Persons

Eligible dependents include your legal spouse and dependent children as described in the General Information section of this booklet (See "ELIGIBLE DEPENDENTS"). Check with the Hawaii Insulators Health and Welfare Trust to determine who is eligible to be covered as your dependent(s) under your plan.

Updating Information

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

- Name change
- Address change
- Add/remove dependent(s)

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 after 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. To obtain a current listing of HDS participating dentists, visit the HDS Web site 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 292,000 dentist locations.

If your job takes you out of state or your child attends school on the Mainland, we recommend 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 Web site at www.HawaiiDentalService.com and click on "Members/Find a Participating Dentist." Click on the link at the bottom of the page to search for a Mainland dentist. Select "Delta Dental Premier" as your plan type. Or you may call the HDS Customer Service department.

Visiting a Delta Dental Participating Dentist

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

Visiting a Non-Participating Dentist

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

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

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

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

- HDS Payment will be based on the HDS non-participating dentist fee schedule and a reimbursement check will be sent to you along with your Explanation of Benefits (EOB) report.

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

Helping You Manage Your Costs

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

Your participating dentist may submit a preauthorization 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 preauthorization 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.

Questions on Your Claims

If you have any questions or concerns about your dental claims, please call the HDS Customer Service Department at 529-9248 on Oahu or toll-free at 1-800-232-2533 extension 248. A copy of HDS's claims appeal process may be obtained from Customer Service.

HDS Reports and Payments

Explanation of Benefits (EOB) Report

You will receive an HDS Explanation of Benefits (EOB) report through the mail which provides payment information about the services you received from your dentist.

You can choose to go paperless and receive the EOB reports electronically by registering yourself as a user on the HDS Web site at www.HawaiiDentalService.com. Select "New User" and complete the "Member Registration" form. If you are a registered user, login and select "Edit My Profile," then select "yes" under "Request Electronic EOB."

It is important to note that the EOB report 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 at right). HDS will pay the “% plan covers” amount. You are responsible for the balance owed to your participating dentist and any applicable deductible amount and taxes. Participating dentists are paid based upon their Allowed Amount.

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

Dual Coverage/Coordination of Benefits

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

Fraud and Abuse Program

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

Confidential Fraud Hotline

From Oahu: (808) 529-9227
Toll-free: 1-866-505-9227
E-mail: HDSCompliance@HawaiiDentalService.com

How to Contact HDS

Customer Service Representatives

From Oahu: 529-9248
Toll-free: 1-800-232-2533 ext. 248

Fax: 529-9366
Toll-free fax: 1-866-590-7988

Monday through Friday
7:30 a.m. – 4:30 p.m. (Hawaii Standard Time)

Send Written Correspondence to:

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

E-mail: HDSCustomerService@HawaiiDentalService.com

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 in the Mainland, Guam or Saipan

VIEW

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

DOWNLOAD & PRINT

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

REQUEST

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

Visit HDS DenTel

From Oahu: 545-7711

Toll-free 1-800-272-7204

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

- Find out when they are eligible for coverage for their next dental visit
- Obtain claims information
- Have a summary of their plan benefits faxed or mailed to them

Simply follow the prompts on the phone.

SUMMARY OF DENTAL BENEFITS

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per calendar year	\$2,500
DEDUCTIBLE per calendar year – does not apply to Diagnostic and Preventive services (except space maintainers)	\$25/person \$50/family
DIAGNOSTIC	
<ul style="list-style-type: none"> • Examinations – twice per calendar year • Bitewing X-rays – twice per calendar year • Other X-rays – full mouth X-rays limited to once every three years 	80% 80% 80%
PREVENTIVE	
<ul style="list-style-type: none"> • Cleanings – twice per calendar year • Topical fluoride – twice per calendar year through age 17 • Space maintainers – through age 17 	80% 80% 80%
RESTORATIVE	
<ul style="list-style-type: none"> • 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 <p>NOTE: Composite (white) restorations 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</p>	80% 80% 80%
ENDODONTICS	80%
<ul style="list-style-type: none"> • Pulpal therapy • Root canal treatment, retreatment, apexification, apicoectomy 	
PERIODONTICS	80%
<ul style="list-style-type: none"> • Periodontal scaling and root planing – once every two years • Gingivectomy, flap curettage and osseous surgery – once every three years • Periodontal Maintenance – twice per calendar year – after qualifying periodontal treatment 	
PROSTHODONTICS	80%
<ul style="list-style-type: none"> • Fixed bridges – once every five years; age 16 and over • Removable dentures – complete and partial; once every five years; age 16 and over • Repairs and adjustments • Relines and rebase 	
ORAL SURGERY	80%
<ul style="list-style-type: none"> • Extractions • Other oral surgery procedures to supplement medical care plan 	

BENEFIT	PLAN COVERS
ADJUNCTIVE GENERAL SERVICES <ul style="list-style-type: none"> • Palliative treatment (for relief of pain but not to cure) 	80%
ORTHODONTICS <ul style="list-style-type: none"> • \$3,000 lifetime maximum amount per case, per eligible dependent child and paid in eight quarterly payments. • \$25 deductible per eligible dependent child <p><i>Orthodontic services are not covered if services were started prior to the date the patient became eligible under the Hawaii Insulators Health and Welfare Trust plan. If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. If the Trust elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.</i></p>	100%

Benefit Exclusions

The following are general exclusions not covered by the plan:

- Services for injuries and conditions that are covered under Workers' Compensation or Employer's Liability Laws; services provided by any federal or state government agency or those provided without cost to the eligible person by the government or any agency or instrumentality of the government.
- Congenital malformations, medically related problems, cosmetic surgery or dentistry for cosmetic reasons.
- Procedures, appliances or restorations other than those for replacement of structure loss from cavities that are necessary to alter, restore or maintain occlusion.
- 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 are not covered.
- Other exclusions are listed in the Schedule of Benefits, which is included in the Hawaii Insulators Health and Welfare Trust dental contract.

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

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

LIFE INSURANCE BENEFITS

PACIFIC GUARDIAN LIFE

COVERAGE

Eligible active employees and their eligible dependents are covered for life insurance in accordance with the following schedule:

BENEFIT SCHEDULE

	Benefit Amount
Active Employees	
Under age 65	\$30,000
Age 65 through 69	\$19,500
Age 70 through 74	\$13,500
Age 75 through 79	\$ 9,000
Age 80 and over	\$ 6,000
Dependents	
Spouse	\$10,000
Children*	
• Less than 14 days old	\$ 0
• At least 14 days old but under age 6 months	\$ 100
• At least 6 months old but under age 19, or under age 25 if attending an educational institution, or to any age, if handicapped	\$ 3,000

*Dependent children means each unmarried natural child, stepchild, legally adopted child, or child placed in the home in anticipation of adoption who is dependent upon you for support as attested by income tax information and lives with you in a regular parent-child relationship, within the limiting ages shown on the Benefit Schedule. An unmarried child's insurance may be kept in force past the date it would have ended due to age if prior to reaching that age, the child is not able to work due to mental or physical handicap and remains dependent on you for more than 50% of his or her support, and acceptable proof of the handicap is received by the Trust Fund or Pacific Guardian Life within 31 days after the date the dependent life insurance would otherwise have ceased. Any insurance for such child will terminate when the handicap ceases or it would terminate for reasons other than the child's age.

ACCIDENTAL DEATH, DISMEMBERMENT & LOSS OF SIGHT BENEFITS

You, the active employee, are also covered for non-occupational Accidental Death, Dismemberment and Loss of Sight benefits (AD & D). If you die in an accident off the job, AD & D will pay an additional amount. See the following Table of Losses.

TABLE OF LOSSES

In the event of loss of:

Life	Full Amount
Both hands or feet	Full Amount
Sight of both eyes	Full Amount
Any two or more (of one foot, one hand, sight of one eye)	Full Amount
One hand	One-Half Full Amount
One foot	One-Half Full Amount
Sight of one eye	One-Half Full Amount

“Loss of a hand or foot” means that it is completely cut off at or above the wrist or ankle joint.

“Loss of hand” may also mean the severance of four fingers of one hand.

“Loss of sight” means total and permanent blindness.

“Full Amount” is the same as your group life benefit.

The total amount payable for all injuries of any one accident will not be more than the “Full Amount”.

AD & D EXCLUSIONS

AD & D does not cover losses caused by the following:

- bodily or mental infirmity;
- disease, ptomaine or bacterial infection;
- medical or surgical treatment;
- suicide or any attempt thereat, or self-inflicted injury;
- war or any act of war;
- participating in a riot;
- committing an assault or felony;
- operating, riding in or descending from an aircraft if the insured is a pilot, officer or crew member or is giving or receiving training or instruction or has duties upon such aircraft or as a participant in a sporting event or hobby; or
- the intentional taking of any drug not prescribed by a physician.

BENEFICIARY

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

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

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

1. If more than one beneficiary is named, each will be paid an equal share.
2. If any named beneficiary dies before you, his/her share will be divided equally among the named beneficiaries who survive you.
3. 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:
 - a. All to your surviving spouse; or
 - b. If your spouse does not survive you, in equal shares to your surviving children; or
 - c. If no child survives you, in equal shares to your surviving parents; or
 - d. If no parent survives you, in equal shares to your surviving brothers and sisters; or
 - e. If no brother or sister survives you, to the executors or administrators of your estate.

The life insurance on your spouse and children is payable to you in the event of their death. If you do not survive your dependent, Pacific Guardian Life will pay the executors or administrators of your estate.

If the insurance proceeds are payable to a minor or mentally incompetent person, a Letter of Guardianship of the Property for the minor or incompetent beneficiary 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.

CONVERSION RIGHTS

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

During this 31-day period, you and your dependents 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 and your dependents were covered under the group policy. You must apply and pay for the first premium within 31 days after your insurance terminates.

The preceding life insurance benefits are fully 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 is for informational purposes and is only a summary of the life insurance coverage. Its content is 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 Insulators Health and Welfare Trust Office. Please refer to these documents for specific questions about coverage.

TEMPORARY DISABILITY INSURANCE

PACIFIC GUARDIAN LIFE

Only you, the active employee, are eligible for temporary disability insurance benefits.

When a non-occupational accidental injury or sickness wholly and continuously disables you and prevents you from engaging in your occupation and requires the regular care and attendance of a legally qualified physician or surgeon, you will be paid a weekly benefit of 70% of your average weekly wage, up to the maximum established by the T.D.I. statutes, provided that the disability commenced while you were eligible for temporary disability insurance benefits.

Benefits commence with the first day of disability due to accident or sickness, if hospitalized, or the eighth day of disability due to sickness, if not hospitalized. The maximum number of weeks for which benefits are payable for any one (1) disability is 26 weeks.

Successive periods of disability due to the same or related cause will be considered one (1) period of disability unless they are separated by at least 14 calendar days of active work. Successive periods of disability due to different or unrelated causes will be considered as separate periods of disability provided they are separated by at least one (1) day of active work.

Benefits are not payable for any disability 1) for which you are covered by any workers' compensation or occupational disease law, or 2) arising from or sustained in the course of any employment for compensation, profit or gain.

The preceding temporary disability benefits are fully 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 is for informational purposes and is only a summary of the temporary disability insurance coverage. Its content is subject to the provisions of the temporary disability insurance policy with Pacific Guardian Life, and all amendments thereto, which contain all of the terms and conditions governing temporary disability insurance benefits. These documents are on file with the Hawaii Insulators Health and Welfare Trust Office. Please refer to these documents for specific questions about coverage.

LONG TERM CARE INSURANCE BENEFITS

UNUM LIFE INSURANCE COMPANY OF AMERICA

ELIGIBILITY

Eligible active participants are covered for long-term care insurance benefits provided through UNUM Life Insurance Company of America.

Long-term care insurance provides benefits when an individual becomes disabled and is no longer able to independently care for himself. Disability is defined as the loss of two or more “Activities of Daily Living” (ADLs) or severe cognitive impairment such as Alzheimer’s disease.

Activities of Daily Living (ADLs) are:

1. BATHING Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower with or without equipment or adaptive devices.
2. DRESSING Putting on and taking off all items of clothing, any necessary braces, fasteners, or artificial limbs.
3. TOILETING Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
4. TRANSFERRING Moving into or out of bed, chair, or wheelchair with or without equipment such as canes, walkers, crutches or grab bars or other supportive devices including mechanical or motorized devices.
5. CONTINENCE The ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
6. EATING Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table), by a feeding tube or intravenously.

The UNUM policy provides coverage in the form of a fixed dollar indemnity benefit. To receive benefits, you must be receiving qualified long term care services and satisfy a 90-day Elimination Period. A Licensed Health Care Practitioner must also certify that you are unable to perform two or more Activities of Daily Living (ADLs) without substantial assistance from another individual, or that you require substantial supervision by another individual due to severe cognitive impairment.

BASE PLAN COVERAGE

The Base Plan coverage, which is provided at no cost to you, is as follows:

- Elimination (Waiting) Period* 90 accumulated days
**The Elimination Period must be satisfied within a period of 730 consecutive days. Benefits begin the day after the Elimination Period is completed.*
- Monthly Benefit Maximums
 - Long Term Care Facility \$2,000.00 per month
 - Professional Home Care Services \$1,000.00 per month
(50% of Facility Benefit)
- Facility Benefit Duration 3 years
- Lifetime Benefit Maximum..... \$72,000

ADDITIONAL BUY UP COVERAGE OPTIONS

In addition to the Base Plan coverage, you may also apply for Additional Buy-Up coverage; however, you are responsible for the cost of any additional benefits that you select.

Additional Buy-Up coverage options are as follows:

1. Increase the Monthly Benefit Maximum

Long Term Care Facility BenefitAdditional \$1,000 increments
(Up to a Total Monthly Benefit
Maximum of \$6,000 per month)

Your Professional Home Care Services Monthly Benefit Maximum will be 50% of the Long Term Care Facility Monthly Benefit.

2. Increase the Duration of Coverage from 3 years up to 6 years.

3. Add Total Home Care at 50% of the Facility Benefit. If you choose this option, those services covered under Professional Home Care Services may also be provided by an informal caregiver, such as a friend or relative.

4. Add 5% Annual Simple Inflation Protection.

CHANGES IN COVERAGE

You can apply at any time to increase your coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance. Your request is subject to approval by UNUM.

ELIGIBILITY FOR FAMILY MEMBERS

As long as you are eligible for coverage under the Long Term Care plan, your family members may also apply for coverage. Eligible family members include your spouse, adult children, siblings, parents and grandparents, and your spouse's siblings, parents and grandparents, who are between 18 and 80 years of age and reside in the United States of America.

Family members must apply for coverage and are subject to acceptance by UNUM. You or your family member is responsible for the entire cost of any family member coverage.

CONTINUATION OF BASE PLAN BENEFITS

As long as you remain eligible for health and welfare benefits, you will continue to be covered for Base Plan long-term care benefits at no cost to you. If you become ineligible for coverage under the Hawaii Insulators Health and Welfare Trust, your coverage for Base Plan benefits will terminate. However, you may elect to continue your Base Plan coverage on a direct billed basis by making the required premium payment directly to UNUM. Election for continued coverage must be made within 60 days of the date your coverage would otherwise end.

HOW TO FILE A CLAIM

If you become disabled, you or your authorized representative must notify UNUM within 30 days, or as soon as reasonably possible, and complete a Long Term Care claim form available from UNUM or the Hawaii Insulators Health and Welfare Trust Office. You must submit your proof of claim no later than 90 days after the date you become disabled, or as soon as it is reasonably possible to do so, but in no event later than 15 months after the time that proof is otherwise required.

The proof of claim must include:

1. The date your disability began;
2. The cause of your disability;
3. The extent of your disability, including restrictions and limitations preventing you from performing ADLs;
4. A Licensed Health Care Practitioner's Certification of your disability;
5. A copy of your plan of care;
6. A Physician's statement and/or copies of relevant medical records from any Physician or health care provider involved in your care;
7. The name and address of the hospital or institution where you received treatment and/or the name and address of the health care provider who treated you; and
8. Verification of the care or services provided.

You will be required to give UNUM information on your continued disability, when requested. UNUM may also require a claims assessment, which is a review done by UNUM to evaluate your disability. A face-to-face interview or examination by a Physician may also be required. If required, however, UNUM will pay the cost of the interview or examination.

EXCLUSIONS

Coverage is not provided for:

- Disability caused by war or any act of war, whether declared or undeclared;
- Disability caused by intentionally self-inflicted injuries or attempted suicide, while sane;
- Disability caused by the participation in a felony, riot, or insurrection;
- Disability caused by alcoholism and drug addiction;
- Any period in which you are confined in a hospital other than if you are confined in a long term care facility that is a distinctly separate part of a hospital (this exclusion does not apply to those periods covered under the Bed Reservation Benefit).

The preceding long-term care benefits are fully insured under an insurance contract issued by the UNUM Life Insurance Company of America, 2211 Congress Street, Portland, ME 04122. The services provided by UNUM 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 content is subject to the provisions of the group insurance policy with UNUM Life Insurance Company of America, and all amendments thereto, which contain all the terms and conditions governing long term care benefits. These documents are on file with the Hawaii Insulators Health and Welfare Trust Office. If the terms of this summary description or your certificate differ from the group insurance policy, the policy will govern. Please refer to the group insurance policy for specific questions about coverage.

BENEFITS FOR RETIRED EMPLOYEES

When you retire on a pension from the Hawaii Insulators Supplemental Pension Plan or the Hawaii Insulators Local Union Officers and Employees Pension Plan and meet the requirements described below, you will be eligible for physician office visit, prescription drug, vision care, dental care, and life insurance benefits from the Hawaii Insulators Health and Welfare Trust. Benefits will be provided as long as the Trust's Post Retirement Benefit Account has the necessary funds to provide the benefits. Benefits are neither vested nor guaranteed for the life of the retiree. The Board of Trustees, at its sole discretion, reserves the right to modify benefits, to require a retiree contribution for the cost of benefits, or terminate benefits at any time.

Health and welfare benefits from the Hawaii Insulators Health and Welfare Trust are available only to eligible retirees who reside in the United States of America. Spouses and dependents of retirees are not eligible for benefits.

ELIGIBILITY RULES FOR RETIREMENTS BEFORE AUGUST 1, 1999

If you retired before August 1, 1999, you will be eligible for physician office visit, Medicare Part D premium reimbursement, vision care, dental care, and life insurance benefits from the Hawaii Insulators Health and Welfare Trust if you meet all of the following eligibility requirements:

1. Retired on a pension from the Hawaii Insulators Supplemental Pension Plan and are receiving a monthly pension payment; **and**
2. Must be enrolled in both Medicare Part A and Part B; **and**
3. Reside in the United States of America.

To be covered for retiree benefits, you must turn in your completed enrollment form as required by the Trust Office.

ELIGIBILITY RULES FOR RETIREMENTS ON OR AFTER AUGUST 1, 1999

If you retire on or after August 1, 1999, you will be eligible for physician office visit, Medicare Part D premium reimbursement, vision care, dental care, and life insurance benefits from the Hawaii Insulators Health and Welfare Trust. You are eligible, provided you were covered for health and welfare benefits under the Hawaii Insulators Health and Welfare Trust as a result of 1) work hours, 2) an authorized leave of absence, 3) an authorized disability leave, 4) the Self-Payment Program, 5) the COBRA Program, or 6) any combination of the preceding, for twelve (12) consecutive months immediately preceding your retirement, **and** meet all of the following eligibility requirements:

1. Retired on a pension from the Hawaii Insulators Supplemental Pension Plan or the Hawaii Insulators Local Union Officers and Employees Pension Plan and are receiving a monthly pension payment; **and**
2. Must be enrolled in both Medicare Part A and Part B; **and**
3. Reside in the United States of America.

EXCEPTIONS:

1. If you last worked in employment covered by a multi-employer pension fund (a pension fund to which more than one (1) employer contributes in accordance with a collective bargaining agreement(s) with a union) in the construction industry in the State of Hawaii, other than the Hawaii Insulators Supplemental Pension Plan, and retire on a pension from that pension fund, you will not be eligible for any benefits through the Hawaii Insulators Health and Welfare Trust even though you meet the eligibility requirements listed above.

2. If, after you retire on a pension from the Hawaii Insulators Supplemental Pension Plan or the Hawaii Insulators Local Union Officers and Employees Pension Plan, you are employed for 20 or more hours per week for four (4) consecutive weeks, you will not be eligible for retiree benefits from the Hawaii Insulators Health and Welfare Trust while you are employed. Upon the termination of employment, you will have the option to re-enroll in the Hawaii Insulators Health and Welfare Trust as a retiree if you re-enroll within 30 days of the termination of employment. If you fail to re-enroll within this 30-day period, you will no longer be eligible for retiree benefits under the Hawaii Insulators Health and Welfare Trust.

If you return to employment, you must provide written notification to the Trust Office within 21 days of your return to employment. If you fail to provide such written notification, your retiree benefits may be permanently terminated.

DATE OF RETIREMENT

For purposes of this plan, your retirement date is the date you receive the first pension benefit payment from the Hawaii Insulators Supplemental Pension Plan or the Hawaii Insulators Local Union Officers and Employees Pension Plan or, if applicable, the date of your first pension benefit payment under the Hawaii Insulators Supplemental Pension Plan or the Hawaii Insulators Local Union Officers and Employees Pension Plan following the suspension of benefits.

HOW TO SECURE MEDICARE COVERAGE

All retirees who are eligible for Medicare must enroll in Medicare Part A and Part B, when eligible, in order to receive retiree benefits. Failure to secure Medicare coverage will result in the denial of retiree benefits under the Hawaii Insulators Health and Welfare Trust. **Benefits under the Trust will begin once the necessary Medicare coverage has been obtained.**

When you become eligible for Medicare benefits provided under the Social Security Law, you should contact your local Social Security office and arrange for both Part A and Part B coverage. Part A covers hospital care while Part B covers physician services. You will be covered by Medicare as soon as you reach the age at which you are eligible only if you apply during the three-month period just before you reach your eligible age. If you fail to apply during the 90-day period prior to your eligible age, you may still apply during the first three (3) months of any later calendar year. However, you may lose some Medicare benefits during the period that you are not enrolled.

RESIDENCY REQUIREMENT

Supplemental physician office visit, prescription drug, vision care, dental care, and life insurance benefits are available only to eligible retirees who reside in the United States of America. Retirees who reside outside the United States of America are not eligible for benefits. Retiree benefits will be terminated once a retiree resides outside the United States of America for more than 90 days. If a retiree moves back to the United States of America and re-establishes residency, retiree benefits will be reinstated prospectively only if the retiree re-enrolls with the Trust Office within 90 days from the date residency is re-established.

SELF-PAYMENT PROGRAM FOR EARLY RETIREES

Effective October 1, 2007, the Hawaii Insulators Health and Welfare Trust implemented a self-payment program for early retirees, ages 62 through 64, who retire on or after October 1, 2007. Under the Retiree Self-Payment Program, you may continue health and welfare benefit coverage through the Trust, for yourself and your eligible dependents by making self-payments to the Trust.

You are eligible to participate in the Retiree Self-Payment Program if you were covered for health and welfare benefits under the Hawaii Insulators Health and Welfare Trust as a result of 1) work hours, 2) an authorized leave of absence, 3) an authorized disability leave, 4) the Self-Payment Program, 5) the COBRA Program, or 6) any combination of the preceding, for twelve (12) consecutive months immediately preceding your retirement, and meet all of the following eligibility requirements:

1. Retire on or after October 1, 2007; **and**
2. Retire on a pension from the Hawaii Insulators Supplemental Pension Plan or the Hawaii Insulators Local Union Officers and Employees Pension Plan, and are receiving a monthly pension payment; **and**
3. Reside in the United States of America.

Under the Retiree Self-Payment Program, you and your eligible dependents will be eligible for Medical and Prescription Drug benefits provided through HMAA as described on pages 21 - 84; Vision Care benefits provided through the Trust as described on pages 104 - 105; Dental benefits provided through HDS as described on pages 107 - 113; and Life Insurance benefits provided through PGL as described on page 136. If you choose to continue your benefits under the Retiree Self-Payment Program, you give up your right to continue your benefits under the COBRA Program.

The amount you must self-pay each month is established by the Board of Trustees. Your payment must be received by the Trust Office by the 5th day of the month prior to the month for which payment is being made. If your payments are not received by the required due date, your coverage under the Retiree Self-Payment Program will be terminated.

SPECIAL ENROLLMENT PERIOD

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Hawaii Insulators Health and Welfare Trust may allow enrollment during a special enrollment period if you qualify under one (1) of the Special Enrollment rules described on pages 17 - 18. To request special enrollment, contact the Trust Office.

NOTE: RETIREE BENEFITS ARE NEITHER VESTED NOR GUARANTEED FOR THE LIFE OF THE RETIREE AND WILL BE PROVIDED ONLY AS LONG AS FUNDS ARE AVAILABLE. THE BOARD OF TRUSTEES RESERVES THE RIGHT, AT ITS SOLE DISCRETION, TO MODIFY THE PLAN WITH REGARD TO ELIGIBILITY REQUIREMENTS AND BENEFITS AVAILABLE, TO REQUIRE A RETIREE CONTRIBUTION FOR THE COST OF BENEFITS, OR TERMINATE BENEFITS AT ANY TIME.

PHYSICIAN OFFICE VISIT BENEFITS FOR MEDICARE RETIRED EMPLOYEES (Self-Insured)

PHYSICIAN OFFICE VISIT BENEFITS

Your plan has been designed to provide coverage for physician office visits that are medically necessary for the diagnosis or treatment of an illness or injury. For such physician office visits, the plan will pay 80% of submitted charges. For the purpose of this plan, a physician is a properly licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.). Since the Trust does not have a contract with any physician, the benefit payment will be sent directly to you.

There is no coverage under this plan for medical services other than physician office visits as described above. Medical services such as: physician services performed in a non-office setting; hospital or other facility services; surgery; diagnostic laboratory, x-ray, and therapy services; injections, immunizations, drugs and supplies; are not covered. A list of exclusions is provided below.

Choice of Physician

You are free to go to any licensed physician of your choice and receive benefits under this plan. However, you owe the physician the total charge and any applicable tax for the office visit. **You should therefore, discuss charges with your physician before receiving services.**

Medical Necessity

This plan pays benefits only for physician office visits that are medically necessary for an illness or injury.

ANNUAL MAXIMUM

The annual maximum benefit payable per eligible retiree for physician office visit and vision care benefits combined is \$1,000 per calendar year.

EXCLUSIONS

Any service that is not a medically necessary physician office visit for the diagnosis or treatment of an illness or injury is not a covered service. The following services are specifically excluded and are not covered:

- Ambulance services
- Blood and blood products
- Cosmetic services (services that may improve physical appearance but do not restore or materially improve a bodily function)
- Dental services
- Diagnostic laboratory and x-ray services (including those done in association with a physician's office visit)
- Dialysis
- Home health services
- Hospice services
- Hospital inpatient and outpatient services
- Injections, drugs, medications, allergy testing, and immunizations
- Medical equipment, appliances, and supplies

- Physician visits in a home, hospital, or emergency room
- Radiotherapy and chemotherapy
- Rehabilitation, physical, and speech therapy
- Routine physical examinations, screens, or checkups (even if performed by a physician in a physician's office)
- Services by non-physicians, including visits by a psychologist
- Services not medically necessary
- Surgical and anesthesiology services
- Taxes or administrative fees

HOW TO FILE A PHYSICIAN OFFICE VISIT CLAIM

1. Have your physician complete a universal claim form (also known as a CMS 1500 claim form). Mail the completed claim form and itemized bills to the Trust Office at:

Hawaii Insulators Health & Welfare Trust
1440 Kapiolani Boulevard, Suite 800
Honolulu, Hawaii 96814

2. Your reimbursement check, together with a statement showing the charges and amounts paid, will be mailed directly to you. You must arrange to pay the provider the total charge for the services.

All claims must be filed within 180 days from the date of service.

Physician office visit benefits for Medicare Retired Employees are self-insured by the Hawaii Insulators Health and Welfare Trust.

The preceding is for informational purposes and is only a summary of coverage. Its content is subject to the provisions of the Physician Office Visit plan document and all amendments thereto. These documents are on file with the Hawaii Insulators Health and Welfare Trust Office. Please refer to these documents for specific questions about coverage.

VISION CARE BENEFITS FOR MEDICARE RETIRED EMPLOYEES (Self-Insured)

VISION CARE BENEFITS

You are eligible for one (1) eye examination and one (1) pair of lenses and frame or one (1) pair of contact lenses every calendar year. In no event will the Trust make allowances for more than one (1) eye examination and one (1) pair of lenses and frame or one (1) pair of contact lenses during any calendar year for each eligible retiree beneficiary. For covered services and appliances, the plan will pay up to the following amounts:

	Allowances
Eye Examination	
Ophthalmologist (M.D.)	\$ 50.00
Optometrist (O.D.)	\$ 45.00
Appliances	
Single vision lenses and frame	\$ 105.00
Multifocal lenses and frame	\$125.00
Contact lenses	\$130.00
Frame only	\$ 50.00

If lenses are replaced without furnishing a new frame, the total allowance for both lenses and frame may be used toward the cost of the lenses, if required.

Payments will be made to you only when services are rendered in connection with an eye examination for the correction of a visual defect and when the lenses and/or frame are required as a result of such examination.

EXCLUSIONS

- Repair or replacement of frame parts and accessories
- Sunglasses
- Prescription inserts for diving masks
- Non-prescription industrial safety goggles or glasses
- Non-standard items

ANNUAL MAXIMUM

The annual maximum benefit payable per eligible retiree for physician office visit and vision care benefits combined is \$1,000 per calendar year.

HOW THE VISION CARE SERVICES ARE PROVIDED

You may go to any licensed ophthalmologist (M.D.), optometrist (O.D.), or other vision care provider of your choice. You should choose a provider who can help you obtain the vision care you need at a reasonable cost. Your choice of vision care provider can make a difference in how much you will owe after vision care benefit payments have been made.

The Hawaii Insulators Health and Welfare Trust contracts with certain vision care providers in the State of Hawaii. A list of these participating providers may be obtained, free of charge, by contacting the Trust Office.

When you go to one of the participating providers, payment for the services and/or supplies is sent directly to the provider. The only copayment you will be required to pay will be for trifocal and progressive multifocal lenses, the balance of charges for frames not within a selected group of frames available at no charge, contact lenses, and non-covered items.

If you go to a nonparticipating provider, payment for the services and/or supplies is made directly to you. You will then owe the provider the total charge for the services and/or supplies.

HOW TO FILE A VISION CARE CLAIM

If you go to a participating provider:

1. Obtain a claim form from the provider.
2. Complete Part I of the claim form.
3. Have the provider complete Part II and/or Part III of the claim form.
4. The provider will send the completed claim form to the Trust Office.
5. Payment will be made directly to the provider. However, you must arrange to pay the provider for any copayments that may be required.

If you go to a non-participating provider:

1. Obtain a claim form from the Trust Office.
2. Complete Part I of the claim form.
3. Have the provider complete Part II and/or Part III of the claim form.
4. Mail the completed claim form and the itemized bills to the Trust Office at:

Hawaii Insulators Health and Welfare Trust
1440 Kapiolani Boulevard, Suite 800
Honolulu, Hawaii 96814
5. Your reimbursement check, together with a statement showing the charges and amounts paid, will be mailed directly to you. You must arrange to pay the provider the total charge for the services and/or supplies.

All claims must be filed within 90 days from the date of service.
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Vision care benefits for Medicare Retired Employees are self-insured by the Hawaii Insulators Health and Welfare Trust.

The preceding is for informational purposes and is only a summary of coverage. Its content is subject to the provisions of the Vision Care plan document and all amendments thereto. These documents are on file with the Hawaii Insulators Health and Welfare Trust Office. Please refer to these documents for specific questions about coverage.

PRESCRIPTION DRUG BENEFITS FOR MEDICARE RETIRED EMPLOYEES (Self-Insured)

MEDICARE ELIGIBLE RETIREES - Medicare Part D Premium Reimbursement

Effective January 1, 2009, retired participants who are eligible for Medicare must enroll in a Medicare Part D drug plan to receive prescription drug benefits through the Trust. The Trust will reimburse you for your Medicare Part D premium, on a quarterly basis, up to the Medicare Part D National Base Beneficiary Premium.

In order to receive this reimbursement, you must submit to the Trust Office:

1. A completed Application for Medicare Part D Premium Reimbursement (available from the Trust Office);
2. Proof of your monthly premium amount; and
3. Proof of your monthly premium payments.

The Trust will not issue reimbursement unless you submit all of the required information.

**Claims for reimbursement of Medicare Part D premiums must be filed
with the Trust Office within 1 year from the date of service.**

Prescription drug benefits for Medicare Retired Employees are self-insured by the Hawaii Insulators Health and Welfare Trust.

The preceding is for informational purposes and is only a summary of coverage. Its content is subject to the rules and regulations adopted by the Board of Trustees, as reflected in the Participant Notices. These documents are on file with the Hawaii Insulators Health and Welfare Trust Office. Please refer to these documents for specific questions about coverage.

DENTAL BENEFITS FOR MEDICARE RETIRED EMPLOYEES



Getting Started

Register for Online Member Information

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

To register, go to www.HawaiiDentalService.com and click on "New User?" Complete the Member Registration form and click on "Register User." HDS will then send you an e-mail. Please click on the link in the e-mail to activate your online account.

Effective Date of Eligibility

If you are a new HDS member enrolling in this plan, the Hawaii Insulators Health and Welfare Trust will let you know the start date (effective date) of your dental coverage. An HDS membership card will be mailed to you after HDS is notified of your start date.

- 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 Web site at www.HawaiiDentalService.com or you may ask your dentist to confirm your eligibility with HDS prior to receiving services.

Updating Information

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

- Name change
- Address change

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 after 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. To obtain a current listing of HDS participating dentists, visit the HDS Web site 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 292,000 dentist locations.

If you reside out of state or travel to the Mainland, we recommend that you 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 Web site at www.HawaiiDentalService.com and click on "Members/Find a Participating Dentist." Click on the link at the bottom of the page to search for a Mainland dentist. Select "Delta Dental Premier" as your plan type. Or you may call the HDS Customer Service department.

Visiting a Delta Dental Participating Dentist

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

Visiting a Non-Participating Dentist

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

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

- On your first visit, advise the non-participating dentist that you have an HDS dental plan and present your HDS membership card.
- In most cases you will need to pay in full at the time of service.

- The non-participating dentist will render services and may send you the completed claim form (universal ADA claim form) to submit to HDS. Mail the completed claim form for processing to:

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

- HDS Payment will be based on the HDS non-participating dentist fee schedule and a reimbursement check will be sent to you along with your Explanation of Benefits (EOB) report.

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

Helping You Manage Your Costs

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

Your participating dentist may submit a preauthorization 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 preauthorization 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.

Questions on Your Claims

If you have any questions or concerns about your dental claims, please call the HDS Customer Service Department at 529-9248 on Oahu or toll-free at 1-800-232-2533 extension 248. A copy of HDS’s claims appeal process may be obtained from Customer Service.

HDS Reports and Payments

Explanation of Benefits (EOB) Report

You will receive an HDS Explanation of Benefits (EOB) report through the mail which provides payment information about the services you received from your dentist.

You can choose to go paperless and receive the EOB reports electronically by registering yourself as a user on the HDS Web site at www.HawaiiDentalService.com. Select “New User” and complete the “Member Registration” form. If you are a registered user, login and select “Edit My Profile,” then select “yes” under “Request Electronic EOB.”

It is important to note that the EOB report 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 at right). HDS will pay the “% plan covers” amount. You are responsible for the balance owed to your participating dentist and any applicable deductible amount and taxes. Participating dentists are paid based upon their Allowed Amount.

Dentist’s Allowed Amount X % plan covers
<hr/>
HDS Payment
Dentist’s Approved Amount <minus HDS Payment>
<hr/>
Patient Share

Dual Coverage/Coordination of Benefits

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

Fraud and Abuse Program

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

Confidential Fraud Hotline

From Oahu: (808) 529-9227

Toll-free: 1-866-505-9227

E-mail: HDSCompliance@HawaiiDentalService.com

How to Contact HDS

Customer Service Representatives

From Oahu: 529-9248

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

Fax: 529-9366

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

Monday through Friday

7:30 a.m. – 4:30 p.m. (Hawaii Standard Time)

Send Written Correspondence to:

Hawaii Dental Service

Attn: Customer Service

700 Bishop Street, Suite 700

Honolulu, HI 96813-4196

E-mail: HDSCustomerService@HawaiiDentalService.com

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 in the Mainland, Guam or Saipan

VIEW

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

DOWNLOAD & PRINT

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

REQUEST

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

Visit HDS DenTel

From Oahu: 545-7711

Toll-free 1-800-272-7204

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

- Find out when they are eligible for coverage for their next dental visit
- Obtain claims information
- Have a summary of their plan benefits faxed or mailed to them

Simply follow the prompts on the phone.

SUMMARY OF DENTAL BENEFITS FOR MEDICARE RETIRED EMPLOYEES

BENEFITS	PLAN COVERS
PLAN MAXIMUM per person per calendar year	\$2,000
DIAGNOSTIC <ul style="list-style-type: none"> • Examination – once per calendar year • Bitewing X-rays – twice per calendar year • Other X-rays – full mouth X-rays limited to once every three years 	80% 80% 80%
PREVENTIVE <ul style="list-style-type: none"> • Cleanings – twice per calendar year 	80%
RESTORATIVE <ul style="list-style-type: none"> • 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 <p>NOTE: Composite (white) restorations 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</p>	60% 60% 60%
ENDODONTICS <ul style="list-style-type: none"> • Pulpal therapy • Root canal treatment, retreatment, apexification, apicoectomy 	60%
PERIODONTICS <ul style="list-style-type: none"> • Periodontal scaling and root planing – once every two years • Gingivectomy, flap curettage and osseous surgery – once every three years • Periodontal Maintenance – twice per calendar year – after qualifying periodontal treatment 	60%
PROSTHODONTICS <ul style="list-style-type: none"> • Fixed bridges – once every five years; age 16 and over • Removable dentures – complete and partial; once every five years; age 16 and over • Repairs and adjustments • Relines and rebase 	60%
ORAL SURGERY <ul style="list-style-type: none"> • Extractions • Other oral surgery procedures to supplement medical care plan 	60%
ADJUNCTIVE GENERAL SERVICES <ul style="list-style-type: none"> • Palliative treatment (for relief of pain but not to cure) 	60%

Benefit Exclusions

The following are general exclusions not covered by the plan:

- Services for injuries and conditions that are covered under Workers' Compensation or Employer's Liability Laws; services provided by any federal or state government agency or those provided without cost to the eligible person by the government or any agency or instrumentality of the government.
- Congenital malformations, medically related problems, cosmetic surgery or dentistry for cosmetic reasons.
- Procedures, appliances or restorations other than those for replacement of structure loss from cavities that are necessary to alter, restore or maintain occlusion.
- 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 are not covered.
- Other exclusions are listed in the Schedule of Benefits, which is included in the Hawaii Insulators Health and Welfare Trust dental contract.

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

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

LIFE INSURANCE BENEFITS FOR RETIRED EMPLOYEES PACIFIC GUARDIAN LIFE

COVERAGE

All eligible retired employees are covered for a life insurance benefit of \$1,000.

BENEFICIARY

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

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

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

1. If more than one beneficiary is named, each will be paid an equal share.
2. If any named beneficiary dies before you, his/her share will be divided equally among the named beneficiaries who survive you.
3. 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:
 - a. All to your surviving spouse; or
 - b. If your spouse does not survive you, in equal shares to your surviving children; or
 - c. If no child survives you, in equal shares to your surviving parents; or
 - d. If no parent survives you, in equal shares to your surviving brothers and sisters; or
 - e. If no brother or sister survives you, to the executors or administrators of your estate.

If the insurance proceeds are payable to a minor or mentally incompetent person, a Letter of Guardianship of the Property for the minor or incompetent beneficiary 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.

CONVERSION RIGHTS

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

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

The preceding life insurance benefits for Retired Employees are fully 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 is for informational purposes and is only a summary of the life insurance coverage. Its content is 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 Insulators Health and Welfare Trust Office. Please refer to these documents for specific questions about coverage.

CLAIMS AND APPEALS PROCEDURES

SELF-INSURED CLAIMS FOR BENEFITS PROVIDED DIRECTLY FROM THE HAWAII INSULATORS HEALTH AND WELFARE TRUST

(i.e., Vision Care and Massage Therapy Benefits for Active Employees and Physician Office Visit, Vision Care and Prescription Drug Benefits for Medicare Retired Employees)

CLAIMS

The Trust has the discretionary authority to determine all questions of eligibility, to determine the amount and type of benefits payable to any beneficiary or provider in accordance with the terms of the Plan and related regulations, and to interpret provisions of this Plan as necessary to determine benefits.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

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

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

INITIAL CLAIMS

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

- **Urgent Care Claims: 72 Hours**

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

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

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

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

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

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

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

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

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

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

- **Concurrent Care Claims**

If you are currently receiving ongoing treatment under the Plan, you will receive advance notice of any determination to terminate or reduce your treatment. The notice will be provided to you, in advance, to allow you to appeal the determination and have a decision rendered prior to the termination or reduction of your treatment. Any claim involving both urgent care and a request to extend a course of treatment previously approved by the Plan, must be decided as soon as possible, given the urgency of the medical conditions involved. You will receive notification within 24 hours after the receipt of your urgent and concurrent care claim provided your claim is received at least 24 hours prior to the expiration of your treatment. If your claim is received less than 24 hours prior to the expiration of treatment, you will be notified of the decision within 72 hours 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, you will be provided written notice of the denial at no cost to you. Examples of a denied claim include a determination to reduce or terminate a benefit, or a failure to make whole or partial payment of a benefit by the Plan. In the case of urgent care claims, the Plan may first notify you orally, with a written notice to follow in three (3) days. The notice of denial, whether oral or written, will contain the following information:

1. The specific reason(s) for the denial, with reference(s) to the specific Plan provisions;
2. A description of any additional material or information necessary to complete your claim and why the information is needed;
3. A statement that you may request, free of charge, an explanation of the clinical or scientific judgment used to make the determination applying the terms of the Plan to your medical circumstances, if the denial was based on medical necessity, experimental treatment, or similar exclusion;

4. The identification of any internal rule, guideline, protocol, or other criteria the Plan relied upon in making the determination, and a statement that such rule, guideline, protocol, or other criteria is available to you, free of charge, upon your request;
5. A description of the Plan's review procedures, the applicable time limits, and a statement of your right to bring civil action under Section 502(a) of ERISA to appeal a denial based on the review of an earlier decision; and
6. A description of the expedited review process applicable to the claim, if the denial involved a claim for urgent care.

APPEALS

SELF-INSURED CLAIMS

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

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

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

Appeal of an Urgent Care Claim

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

Appeal of a Pre-Service Claim

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

Appeal of a Post-Service Claim

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

Notification of Determination on Appeal

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

If after you appeal, you are still not satisfied, you have a legal 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. Any claims not brought within two years of the Initial Benefit Determination will be deemed waived.

INSURED CLAIMS

Actives – Medical and prescription drug benefits are provided through HMAA and Kaiser Foundation Health Plan, Inc. Dental benefits are provided through Hawaii Dental Service. Temporary disability insurance and life insurance benefits are provided through Pacific Guardian Life. Long Term Care insurance benefits are provided through UNUM Life Insurance Company of America.

Retirees – Medicare Retiree dental benefits are provided through Hawaii Dental Service. Life insurance benefits are provided through Pacific Guardian Life.

You may obtain information regarding the claims and appeals procedures for these insurance plans by contacting the respective carrier at the address listed below.

HAWAII MEDICAL ASSURANCE ASSOCIATION (HMAA)
700 Bishop Street, Suite 1200
Honolulu, Hawaii 96813-4100
Attn: Appeals

KAISER FOUNDATION HEALTH PLAN, INC.
711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Attn: Customer Service

HAWAII DENTAL SERVICE (HDS)
700 Bishop Street, Suite 700
Honolulu, Hawaii 96813-4196
Attn: Customer Service Manager

For temporary disability insurance benefit claims and appeals:

PACIFIC GUARDIAN LIFE
1440 Kapiolani Boulevard, Suite 1700
Honolulu, Hawaii 96814
Attn: TDI Claims Department

For life insurance benefits:

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

For long term care insurance benefits:

UNUM LIFE INSURANCE COMPANY OF AMERICA
2211 Congress Street
Portland, Maine 04122

OTHER APPEALS

The Trust Office serves as the Administrator of the Hawaii Insulators Health and Welfare Trust and maintains the records regarding your eligibility for benefits. Questions concerning enrollment, change in employee status, or change in dependent coverage should be directed to the Trust Office. Any disagreement regarding your eligibility status or the status of a 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 receipt of the Administrator's decision and describe your version of the facts and reasons why you feel that the decision was not proper. You should also submit any documents, records, and other information in support of your claim not already furnished to the Plan. If you wish, you (or your authorized representative) may review and obtain copies of all Plan documents, records, and other information relevant to your claim, free of charge.

Upon receipt of your written request for review, the Board of Trustees (or a subcommittee thereof) will review your case and take into account all evidence submitted by you (or your authorized representative), without regard to whether such evidence was submitted or considered in the initial benefit determination. The Board of Trustees (or a subcommittee thereof) will determine whether or not a hearing will be held on your case. If a hearing is to be held, you will be notified of the time and place of the hearing at least two (2) weeks in advance 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 decision of the Board of Trustees (or a subcommittee thereof) will be made within 60 days after receipt of your written request for review, unless special circumstances require an extension of time for reviewing your case, in which event the decision will be rendered as soon as possible, but no later than 120 days after receipt of your written request. 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 a subcommittee thereof) will be written in clear, easily understood language and will explain the reasons for their decision and refer to the specific Plan provisions that support it. You are entitled to review and receive, upon request and free of charge, copies of all Plan documents, records, and other information relevant to your claim.

If after you appeal, you are still not satisfied, you have a legal 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. Any claims not brought within two years of the initial benefit determination will be deemed waived.

The preceding is for informational purposes only and is a summary of the Trust's claims and appeals procedures. This summary is subject to the provisions of the Plan documents and all amendments made thereto, which are on file with the Hawaii Insulators Health and Welfare Trust Office. In the event of a conflict between the information contained in this booklet and the Plan documents, the Plan documents will control. Please refer to these documents for specific questions about claims and appeals procedures.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The HAWAII INSULATORS 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 disclosure 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 Insulators Health and Welfare Trust, 1440 Kapiolani Boulevard, Suite 800, Honolulu, Hawaii 96814*. You will not be retaliated against, in any way, for filing a complaint.

The Trust has designated Pacific Administrators, Inc. as the Trust's Privacy Officer and as 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 *1440 Kapiolani Boulevard, Suite 800, Honolulu, Hawaii 96814, phone: (808) 441-8600 (Oahu) or 1 (888) 256-3573 (neighbor islands), Monday through Friday, 8:00 a.m. to 4:30 p.m.*

FOR BENEFITS PROVIDED DIRECTLY BY THE TRUST

For questions or complaints regarding your health information and privacy rights related to the self-funded benefits provided through the Trust (Vision Care and Massage Therapy benefits for active employees and Physician Office Visit, Vision Care and Prescription Drug benefits for Medicare retirees), contact the Trust's Privacy Officer.

FOR BENEFITS PROVIDED THROUGH CARRIERS

For questions or complaints regarding your health information and privacy rights related to the insured benefits provided through the plans listed below, contact the following:

HMAA Plan

Privacy Officer
HAWAII MEDICAL ASSURANCE ASSOCIATION (HMAA)
700 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
Phone: 941-4622 (Customer Service)
Toll-free: 1 (888) 941-4622

Kaiser Permanente Plan

Privacy Officer
KAISER FOUNDATION HEALTH PLAN, INC.
711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Phone: 432-5090

HDS Dental Plan

Privacy Officer
HAWAII DENTAL SERVICE (HDS)
700 Bishop Street, Suite 700
Honolulu, Hawaii 96813
Phone: 529-9248 (Customer Service)
Toll-free: 1 (800) 232-2533, ext. 248

STATEMENT OF ERISA RIGHTS

As a participant in the Hawaii Insulators 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 loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 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 court 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: You may examine the following documents at the Trust Office during regular business hours, Monday through Friday, except holidays:

- a. Trust Agreement,
- b. Collective Bargaining Agreements,
- c. Insurance contracts,
- d. Annual Report Form 5500 filed with the Internal Revenue Service and Department of Labor, and
- e. A list of contributing Employers.

You may also obtain copies of the document by written request and by paying the reasonable cost of duplication. You should find out what the charges will be before requesting copies. If you prefer, you can arrange to examine the documents, during business hours, at your union office or at your Employer's establishment, if at least 50 Plan participants are employed there.

To make such arrangements, call or write the Trust Office. A summary of the annual report which gives details of the financial information about the Fund's operation is furnished annually to all participants free of charge.

IMPORTANT INFORMATION

NOTE

**RETAIN YOUR PAY STUBS
AS PROOFS OF RECORD**

CHANGE-OF-ADDRESS NOTIFICATION

**Keep your records current
by notifying the Trust Office
of any changes.**

CHANGE-OF-BENEFICIARY NOTIFICATION

**Be sure that you have named
your selected Beneficiary
in writing and that it is on file
at the Trust Office.**