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UA LOCAL 675
HAWAII - 1919

PAMCAH-UA LOCAL 675 HEALTH AND WELFARE FUND

Summary Plan Description and Plan Document

January 2020

HONOLULU, HAWAII
PAMCA
LOCAL 675

PAMCAH-UA LOCAL 675
HEALTH AND WELFARE FUND
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GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

The Fund's health care plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   - Qualified sign language interpreters
   - Written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:
   - Qualified interpreters
   - Information written in other languages

If you need these services, contact Erinn Liu, Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Erinn Liu, Civil Rights Coordinator, PAMCAH-UA Local 675 Trust Funds, 1109 Bethel Street, #403, Honolulu, Hawaii 96813, phone: (808) 466-4326, fax: (808) 524-0658, erinnliu@pamcah675.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Erinn Liu, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (808) 536-4408.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (808) 536-4408
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (808) 536-4408.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (808) 536-4408 번으로 전화해 주십시오.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
Tagalog (Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (808) 536-4408.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (808) 536-4408.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (808) 536-4408
French Creole (Haitian Creole)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (808) 536-4408.
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (808) 536-4408.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (808) 536-4408.
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (808) 536-4408.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (808) 536-4408.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (808) 536-4408.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(808) 536-4408まで、お電話にてご連絡ください。
Persian (Farsi)	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (808) 536-4408 .

PAMCAH-UA LOCAL 675
HEALTH AND WELFARE FUND

TO ALL ELIGIBLE EMPLOYEES, RETIREES, AND THEIR FAMILIES:

We are pleased to provide you with this booklet describing your health care and insurance benefits under the PAMCAH-UA Local 675 Health and Welfare Fund. The Plan as described in this document is effective January 1, 2020, and replaces all other plan documents, summary plan descriptions and applicable amendments to those documents provided to Plan participants prior to the effective date of this booklet.

Here is what you'll find inside:

- An overview of your benefits,
- Information on eligibility and enrollment,
- Chapters on the individual benefits (medical, outpatient prescription drug, dental, vision care, life insurance, accidental death and dismemberment), and
- Other important Plan information.

Making the Most of Your Benefits

You can make the most of your benefits and keep costs down by using contract health care providers. These providers have contract arrangements with the Plan to provide discounted medical benefits that are designed to lower costs without reducing the level of care available to you. Refer to the contract provider directory or contact the Fund Office for more information.

Important Information

The Board of Trustees is committed to maintaining health care coverage for employees and their families at an affordable cost. However, because future conditions cannot be predicted, the Board of Trustees has the sole and exclusive right to amend, change, or discontinue in whole or in part at any time (1) the types and amounts of benefits under this Plan and (2) the eligibility rules, including those rules providing credited or accumulated eligibility even if the eligibility has already been accumulated. Only the Board of Trustees is authorized to interpret the self-funded benefits described in this booklet, unless the Board of Trustees has delegated such authority and discretion to interpret benefit terms to a Claims Administrator as set forth in this booklet. With respect to benefits that are insured, the Board of Trustees has delegated the sole authority to determine the availability of benefits and eligibility to the applicable insurer; such insurer has the sole and exclusive authority to interpret the policy and/or certificate of coverage governing the benefit and is solely financially responsible for paying benefits. No employer, or any representative of any employer or union, is authorized to interpret this Plan on behalf of the Board of Trustees. The nature and amount of Plan benefits are subject to the actual terms of the Plan as it exists at the time the claim occurs or is incurred.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The medical, prescription drug, dental and vision benefits of the Plan are self-funded with contributions from the Employers that are held in a Trust. Independent Claims Administrators pay benefits out of Trust assets. The life, accidental death and dismemberment, Dependent life, weekly sickness and accident benefits and temporary disability insurance benefits of the Plan are fully insured with insurance companies whose names are listed on the Contacts page of this booklet.

Questions?

We encourage you to read this booklet carefully and keep it handy for future reference. If you are married, please share the booklet with your spouse. If you have questions about your benefits, contact the Fund Office, where the staff will assist you. As a courtesy to you, the Fund Office staff may respond informally to oral questions; however, any and all oral communications from the Fund Office, an employer, a Union representative, or any other person are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. You may rely only on written responses from the Fund Office staff.

Sincerely,
BOARD OF TRUSTEES

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED FOR COORDINATION OF BENEFITS WITH MEDICARE

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, You must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) or tax payer identification number (TIN) of Your Eligible Dependents for whom You have elected, or are electing, Plan coverage, and information on whether You or any of suchDependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when You first enroll for Plan coverage but may also be requested at a later date. Failure to provide the SSN or complete the CMS model form (form is available from the Fund Office or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals cannot be processed.

Contacts

FUND OFFICE	
• Employer Contributions • Eligibility information • Enrollment forms • Benefits questions • COBRA Administration • Contribution Accounting and Collection • Summaries of Benefits and Coverage • Medicare Part D Notice of Creditable Coverage	1109 Bethel Street, Room 403 Honolulu, HI 96813 Phone: (808) 536-4408 Fax: (808) 524-0658

HAWAII MEDICAL SERVICE ASSOCIATION (HMSA)	
• Help finding Contract Providers • Medicare Supplemental Coverage • Precertification of Admissions and Medical Services • Second and Third Opinions • Case Management • Hemophilia Medication Network Pharmacies • Appeal of Utilization Management Decisions • Claim forms (medical) • Claims for Out-of-Network Hemophilia Clotting Factor Medications • Medical/Behavioral Health Claims and Appeals	818 Keeaumoku Street Honolulu, HI 96808 Oahu: (808) 948-6111 Hilo: (808) 935-5441 Kona: (808) 329-5291 Kauai: (808) 245-3393 Maui: (808) 871-6295 Precertification: (808) 948-6464 or (800) 344-6122 www.hmsa.com

OPTUMRX	
• Outpatient Prescription drug benefit questions • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug ID Card • Prescription Drug Claims and Appeals • Specialty drugs • Precertification of certain drugs	Attn: Member Services P.O. Box 3410 Lisle, IL 60532 Phone: (844) 265-1718 TTY: 711 Fax: (866) 235-3171

HAWAII DENTAL SERVICE (HDS) (a member of the Delta Dental Plans Association)	
• Dental benefits • HDS Contract Provider Directory • Delta Dental Contract Provider Directory • Dental Claims and Appeals	700 Bishop Street, Suite 700 Honolulu, HI 96813 Oahu: (808) 521-1431 Neighbor Islands: (800) 232-2533 www.HawaiiDentalService.com

VISION SERVICE PLAN (VSP)	
• Vision benefits • Vision Network and Provider Directory • Vision Claims and Appeals	1003 Bishop Street, Pauahi Tower Suite 890 Honolulu, HI 96813 Phone: (800) 877-7195 www.vsp.com

PACIFIC GUARDIAN LIFE INSURANCE COMPANY (PGL)	
• Life Insurance – fully insured • Accidental Death and Dismemberment – fully insured • Weekly Sickness and Accident benefits – fully insured • Temporary Disability Insurance – fully insured	1440 Kapiolani Blvd., Suite 1700 Honolulu, HI 96814 Phone: (800) 432-3306 www.pacificguardian.com

HIPAA PRIVACY OFFICER AND HIPAA SECURITY OFFICER	
• HIPAA Notice of Privacy Practices	Erinn L. Liu 1109 Bethel Street, Room 403 Honolulu, HI 96813 Phone: (808) 536-4408 Fax: (808) 524-0658

CONTENTS

Chapter 1: Overview

In this chapter you'll find:

- An overview of your benefits
- Information on ID Cards
- Privacy of health information
- Information on filing claims

Overview of Benefits Available	
Benefit	**Description**
Medical Plan	You can choose any licensed providers for Hospital and outpatient services with no lifetime maximum, but your lowest cost is when you use Contract Providers. A Contract Provider feature allows you to keep your share of the costs down when you use Contract Providers.
Outpatient Prescription Drugs	The Plan covers the cost of generic and brand name prescription drugs after you pay your share of costs. A participating pharmacy feature allows you to keep your share of the costs down. The Plan also offers a mail order service for medications you take on a long-term basis.
Dental Plan	The Plan covers preventive, basic, and major restorative dental services. Retirees have a $1,500 maximum payment per person per Calendar Year, which does not apply to Dependent children under 18 years of age. A participating dentist feature allows you to keep your share of costs down. Orthodontic services are covered up to a lifetime maximum of $2,500 for Active Employees and their Dependents.
Vision Plan	The Plan pays benefits for eye exams and glasses or contact lenses. The VSP Contract Provider feature allows you to keep your share of the costs down.
Employee Life Insurance (insured)	Pays $50,000 to your beneficiary in the event of your death.
Dependent Life Insurance (insured)	Pays $10,000 to you if your spouse dies.
Accidental Death and Dismemberment (AD&D) (insured)	Pays $25,000-$50,000 to your beneficiary in the event of your death from an accident. Pays a benefit to you if you suffer the loss of certain body parts (e.g., foot, hand, eye) in an accident.
Weekly Sickness and Accident (insured)	Pays the employee the lesser of 70% of basic earnings or the weekly amount established by the State of Hawaii (limited to 52 weeks)
Temporary Disability Insurance (insured)	Pays the employee 58% of average weekly wage to current weekly maximum (limited to 26 weeks)

More detailed information on your benefits, including charts showing specific benefits, can be found in the chapters describing the individual benefits. Also see chapter 12, "Other Important Plan Information," for general provisions regarding your benefits.

How to Use this Summary Plan Description (SPD)/Plan Document

As you read this combined SPD/Plan Document, keep in mind that references to "You" and "Your" refer to both the Plan Participant, or Employee or Retiree, and eligible Dependents (except when specifically noted that a benefit is for Employees only, "You" and "Your" refer to the Employee).

At the beginning of each chapter you will find a summary of the benefits described in that chapter.

Unfamiliar Term?

If you see a word whose meaning you are unsure of, check Chapter 13. It contains the definitions of many words used throughout the document.

Medical and Outpatient Prescription Drug Benefits

Comprehensive medical benefits are self-insured by the Plan and the Claims Administrator that has been delegated the authority to interpret the applicable terms of the Plan and determine benefits is Hawaii Medical Service Association (HMSA). Outpatient Prescription drug benefits are self-insured by the Plan and the Claims Administrator is OptumRx. Medical benefits that are available during a Temporary Disability are also self-insured by the Plan. HMSA and OptumRx each have the authority and discretion to interpret the terms of the Plan governing the applicable benefit that they have contracted to administer.

Other Benefits

Life Insurance, Accidental Death & Dismemberment, Weekly Sickness and Accident and Temporary Disability Insurance benefits are fully insured by Pacific Guardian Life Insurance Company, which has the sole financial responsibility for paying claims for these benefits and has been delegated the exclusive authority to interpret the policies and/or certificates of coverage governing the applicable benefit and determine benefits.

Dental Benefits are self-insured by the Plan and the Claims Administrator Hawaii Dental Service (HDS), which administers claim processing and payments, and provides a network of contract dentists. HDS has the authority and discretion to interpret the terms of the Plan governing the dental benefit.

Vision Benefits are self-insured by the Plan through Vision Service Plan (VSP), which administers claim processing and payments, and provides a network of contract providers. VSP has the authority and discretion to interpret the terms of the Plan governing the dental benefit.

Identification Cards

When you, the Plan Participant, become eligible under the Plan, you will receive HMSA, OptumRx and HDS identification (ID) cards, which will include important information such as your identification number, your group number, your name and the names of your enrolled Dependents.

It is important that you keep your identification card with you at all times. Be sure to present it to your provider before receiving care and when filling prescriptions at a pharmacy.

If you need a new ID card simply contact HMSA, OptumRx or HDS at the numbers listed on the Contacts page at the beginning of this document. You can also contact the Fund Office if you need replacement cards. If your coverage under the Plan terminates, your identification card will no longer be valid.

Privacy of Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the privacy of your personal health information be protected.

The Plan's Notice of Privacy Practices, distributed to all Plan Participants, explains what self-insured group health plan information is considered "Protected Health Information." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information.

Contact the Fund Office if you need another copy of the Plan's privacy notice.

Filing Claims

Information on how to file claims is included in each of the chapters describing the individual benefits.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims and Appeals Procedures" in Chapter 11.

Chapter 2: Eligibility and Enrollment

In this chapter you'll find:

- Employee eligibility
- Dependent eligibility
- Retiree eligibility
- Enrollment

ELIGIBILITY RULES FOR ACTIVE EMPLOYEES

Summary of Benefit Eligibility

Benefit	Upon meeting the Eligibility Requirements for:		
	Abbreviated Benefit	Full Benefit	Retired Employee
Medical	Employee only	Employee + Eligible Dependent(s)	Retiree + Eligible Dependent(s)
Outpatient Prescription Drug		Employee + Eligible Dependent(s)	Retiree + Eligible Dependent(s)
Dental		Employee + Eligible Dependent(s)	Retiree + Eligible Dependent(s)
Vision		Employee + Eligible Dependent(s)	Retiree + Eligible Dependent(s)
Life Insurance		Employee + Eligible Spouse	
Accidental Death & Dismemberment		Employee only	
Weekly Sickness and Accident		Employee only	
Temporary Disability	Employee* only	Employee* only	

*Temporary Disability Benefits have their own requirements for eligibility which are described on page 88, and which differ from the Abbreviated Benefit and Full Benefit eligibility requirements described in this chapter.

Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of your employment. Your receipt of this SPD also does not guarantee your eligibility for Plan benefits. No individual shall have accrued or vested rights to benefits under this Plan.

Establishment of Initial Eligibility

Abbreviated Benefit Coverage (Member Only, Medical Coverage Only)

You become eligible for medical benefit coverage effective the first day of the second calendar month following a period of not more than two months during which you worked at least 120 hours for a Contributing Employer. Coverage will not take effect until the Plan receives your timely and proper enrollment in the Plan. Employees meeting the above requirements who do not satisfy the requirements for ***full benefit coverage***, ***below***, are referred to as "New Hires" throughout this document. The Abbreviated Benefit coverage provided for New Hires will consist of Medical benefits only; Employees eligible for coverage under this provision are NOT eligible for outpatient prescription drug, dental, or vision benefits, and their dependents are not eligible for coverage.

Full Benefit Coverage (Family)

Upon the first day of the second calendar month which follows a period of three consecutive calendar months during which You worked at least 360 hours for a Contributing Employer and the Employer has made the required contributions to the Fund, you become eligible for Full Benefit Coverage, consisting of prescription drug, dental, vision, life, Accidental Death & Dismemberment, Weekly Sickness and Accident, and Temporary Disability benefits. In addition, your Eligible Dependents (described on page 8 below) become eligible for medical, prescription drug, dental, vision, and dependent life insurance (spouse only) benefits. For coverage to take effect, the Plan must receive timely and proper enrollment for you and your Dependents.

If you are disabled on the date of your eligibility, you will not become insured for Weekly Sickness and Accident Benefits until you are actively at work, or available for work.

Special Rules for Work Credit

Work Credit while Disabled (January 1, 2020 through April 30, 2020 only)

If, after meeting initial eligibility requirements, you cannot work due to Total Disability, you will be credited with 35 hours for each week of Total Disability for eligibility purposes, up to a maximum of 1,365 hours during any 12 consecutive months.

Work Credit while Disabled (Effective May 1, 2020 and following)

If, after meeting initial eligibility and applicable enrollment requirements, you cannot work due to Total Disability, you will be credited with 35 hours for each week of Total Disability for eligibility purposes, up to a maximum of 840 hours during the 6 consecutive month period that includes your period of Total Disability.

Subsequent Periods of Total Disability: If you return to covered work and later cannot work because of Total Disability, you may re-qualify for hours to be credited on your behalf during that subsequent period of Total Disability if you worked and were credited with at least 360 hours since your return from your most recent period of Total Disability. If you worked and were credited with the required 360 hours, you will be credited with 35 hours for each week of Total Disability for eligibility purposes, up to a maximum of 840 hours during the 6-consecutive month period that includes your subsequent Total Disability. You must re-qualify and work (and be credited) with at least 360 hours to be eligible for credited service for each period of Total Disability that is separated by at least one day of covered work.

Work Credit while on Leave of Absence (not FMLA)

If, after meeting initial eligibility and applicable enrollment requirements, you are granted an authorized leave of absence by a Contributing Employer, you will be credited with 35 hours for each week of absence for eligibility purposes, up to a maximum of 455 hours during any 12 consecutive months.

This provision does not apply to the Family and Medical Leave Act of 1993. If your Contributing Employer approves a leave under the terms of this Act, please refer to *Coverage during a FMLA Leave of Absence.*

Work Credit while Unemployed (January 1, 2020 through April 30, 2020 only)

If, after meeting initial eligibility requirements, you become unemployed and eligible to receive unemployment compensation benefits under the Hawaii Employment Security Law, you will be credited with 35 hours for each week of unemployment for eligibility purposes, up to a maximum of 1,820 hours during any 12 consecutive months, provided that you remain within the jurisdiction of UA Local 675 and available for dispatch from the union hall.

Work Credit while Unemployed (Effective May 1, 2020 and following)

If, after meeting initial eligibility and applicable enrollment requirements, you become unemployed and eligible to receive unemployment compensation benefits under the Hawaii Employment Security Law ("Unemployed Period"), you will be credited with 35 hours for each week of unemployment for eligibility purposes, up to a maximum of 840 hours during the 6 consecutive month period that includes your "Unemployed Period," provided that you remain within the jurisdiction of UA Local 675 and available for dispatch from UA Local 675.

Subsequent Periods of Unemployment: If you return to covered work from an Unemployed Period, and later qualify for another Unemployed Period, you may re-qualify for hours to be credited on your behalf during that subsequent period if you worked and were credited with at least 360 hours since your return from your most recent Unemployed Period. If you worked and were credited with the required 360 hours, you will be credited with 35 hours for each week of your Unemployed Period for eligibility purposes, up to a maximum of 840 hours during the 6-consecutive month period that includes your subsequent Unemployed Period. You must re-qualify and work (and be credited) with at least 360 hours to be eligible for credited service for each Unemployed Period that is separated by at least one day of covered work.

Employees of Delinquent Contributing Employers

If a Contributing Employer fails to make the required contributions for hours worked by its eligible Employees, such hours may be credited to the Employees as long as the Employer reports hours. *The failure of the Contributing Employer to report hours and make the required contributions for hours worked, however, may cause a termination of your eligibility for Plan benefits.*

Coverage during a Family and Medical Leave of Absence (FMLA)

If your Contributing Employer approves your taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), your Contributing Employer may request that you and your Eligible Dependents continue to be covered under this Plan, provided you were eligible when the leave began and your Contributing Employer makes the required contributions during your leave. Coverage may be requested to continue until the earlier of (a) the expiration of the FMLA leave; or (b) the date you give notice to your Contributing Employer that you do not intend to return to work at the end of the FMLA leave. *If you do not return to work after the end of the FMLA leave, your*

Contributing Employer may require you to reimburse the Contributing Employer for the contributions made to the Plan on your behalf during the leave.

Coverage during Military Service

The Plan intends to comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the Employee has been called to active duty in the uniformed services. USERRA protects Employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health service. Unless terms of a Collective Bargaining Agreement require otherwise, the following governs benefits required under USERRA.

- If you enter military service with the uniformed services of the United States for a period of less than 31 days, your eligibility will be continued with no payment required from you, provided you were eligible under the Plan when the military leave began.

- For military service lasting longer than 30 days, you may continue eligibility by electing USERRA coverage and making self-payments for up to 24 months from the date the military leave began. The procedures applicable for electing and paying for COBRA continuation coverage also apply for electing and self-paying for USERRA coverage. Any election of USERRA coverage you make will also be treated as an election of COBRA continuation coverage and vice versa (except, note, that because your Dependents do not have a separate right to elect USERRA coverage, you must elect USERRA coverage on their behalf). During the first 18 months of coverage, you will have the same rights as if you had elected COBRA continuation coverage, described in Chapter 3.

Requirement to Notify Fund Office of Military Leave

You must notify the Fund Office verbally or in writing of your entry into military service as soon as possible, but no later than 60 days after your military service begins. If notice is provided verbally, the Fund Office will send written confirmation of receipt of this verbal notice, and You must acknowledge receipt of this confirmation to the Fund Office. If any of the information or details in the confirmation are incorrectly stated, you must also contact the Fund Office to indicate the incorrect statement of the written confirmation within 10 days of receipt.

Once the Fund Office has received your notice, you will be offered the right to elect USERRA coverage for you and any eligible Dependents covered under the Plan on the day the leave started. Unlike COBRA Continuation Coverage, if you do not elect USERRA for your Dependents, those Dependents cannot elect USERRA separately (your Dependents may elect COBRA Continuation Coverage, however). Additionally, you and any eligible Dependents covered under the Plan on the day the leave started may also be eligible to elect COBRA continuation coverage. Note that USERRA is an alternative to COBRA. Therefore, either COBRA or USERRA Continuation Coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Fund Office in the same timeframes as is permitted under COBRA.

After You Return From Military Service

If you return to work or become available for work for a Contributing Employer after discharge from military service, eligibility will be reinstated provided you give written notice to the Fund Office within the following time frames:

- 90 days after discharge from military service if your service lasted more than 180 days, or
- 14 days after discharge from military service if your service lasted 31 to 180 days, or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits may be extended up to two years.

An Employee who is reemployed with a Contributing Employer will be entitled to all rights and benefits under the Plan that the Employee would have attained if the Employee had remained continuously employed with a Contributing Employer. The Contributing Employer will provide through contributions to the Plan any seniority based benefits of the Plan to which an Employee is entitled due to the provisions of the Act.

Reciprocity

This Plan has entered into Reciprocal Agreements covering plumbers, pipefitters and related employee classifications who work within the jurisdictions of both Local Union 675 and other Local Union areas. If you are an employee who may be subject to one of these Reciprocal Agreements, please notify this Plan's Fund Office and the other Local Union's fund office so that proper determination is made as to which plan covers you. Contact your Local Union office if you have any questions on the operations of the Reciprocal Agreements or need a complete listing of these agreements.

ELIGIBILITY RULES FOR DEPENDENTS

Establishment of Initial Eligibility

Subject to applicable enrollment requirements, coverage for eligible Dependents becomes effective at the same time an Active Employee or Retired Employee becomes eligible for Full Benefit Coverage or the date the Dependent is acquired (such as through birth, adoption, or marriage), if later, provided the Employee is eligible on that date. Newborn eligible Dependents will be considered eligible from the date of birth for benefits under the Plan. Dependents must be enrolled in accordance with the Plan's procedures within 31 days of the date of initial eligibility. Receipt of this document does not guarantee eligibility for Plan benefits. No individual shall have accrued or vested rights to any benefit under this Plan.

Your eligible Dependents are:

- The spouse of an Active or Retired Employee
- Children of an Active or Retired Employee if they are:
    - Natural children younger than 26 years of age; or
    - Legally adopted children younger than 26 years of age, from the date of adoption or placement for adoption; or
    - Stepchildren or foster children younger than 26 years of age; or
    - Children under the age of 26 who are required to be covered by the eligible Active or Retired Employee by a Qualified Medical Child Support Order (QMCSO).

Eligible children will be covered through the end of the month in which they turn age 26. Other dependents, such as but not limited to grandchildren, or domestic partners, or a spouse of a Dependent child (the Participant's son-in-law/daughter-in-law), are not Eligible Dependents under this plan. A child of a Dependent child (Participant's grandchild) is not eligible for coverage under the Plan except for limited newborn care provided in the hospital immediately after birth when the mother is a covered Dependent.

Coordination of Benefits if Your Spouse Works

If a spouse is offered the opportunity to enroll in another group plan sponsored by the spouse's employer and elects not to enroll, the spouse will lose all Plan benefits/coverages for three months. In order to become eligible for benefits again, the Employee must re-register the spouse as an eligible dependent by submitting the required forms/documentation under the rules of the Plan.

The following provisions will apply when a spouse enrolls in medical and drug coverages (primary) in his or her employer's group plan:

1. The spouse will receive secondary coverage for medical and drug benefits from this Plan.
2. This Plan will continue to provide vision and dental coverages.
3. Eligible Dependent Children will continue to be covered under this Plan.

If a spouse enrolls in his or her employer's Kaiser plan and utilizes medical services outside of Kaiser's network, this plan will only cover 70% of eligible charges of HMSA participating providers and 50% of eligible charges (after deductible) of non-participating providers.

Qualified Medical Child Support Orders

The Plan will recognize a Qualified Medical Child Support Order (QMCSO) and enroll a Dependent child under age 26 specified by the Order. A QMCSO is any judgment, decree, or order (including a National Medical and Support Notice or approval of a domestic relations settlement agreement) issued by a court or by an administrative agency that requires you to provide health coverage to the child.

You may enroll a child if a qualified QMCSO requires you to provide health coverage to that child. To be considered qualified, a medical child support order must include all of the following:

- Your name and current mailing address
- Name and last known address of each child covered by the Order
- Type of coverage to be provided to each child
- Period of time the coverage is to be provided
- Name of each Plan to which the order applies

The Fund Office will determine if the court order is qualified. A Medical Child Support Order will not be qualified if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

The Plan's procedures for handling QMCSOs are available at the Fund Office and will be provided free of charge upon written request.

Extended Eligibility for Disabled Children

You may continue coverage for an unmarried enrolled child beyond age 26 if the child is incapable of self-sustaining employment because of a mental or physical disability and is primarily dependent upon you for support. To qualify for the extended eligibility, all of the following conditions must be met:

- The child must be eligible and enrolled as a Dependent under this Plan and already disabled when he or she reaches age 26. You must complete the Disability Certification Form and provide evidence of the child's Total Disability to the Fund Office within 31 days after the date the child becomes age 26 and within 31 days after any time the Plan requests it.

Verification of Dependent Eligibility

Eligible Dependents must be registered on Personal History Cards provided by the Fund Office, and you must furnish such other information regarding family status and spouse employment information as the Trustees may require from time to time to verify Dependent status. Specific documentation to substantiate Dependent status will be required by the Plan, as part of the process to enroll for coverage, and may include (see the list below) a birth certificate, marriage certificate, proof of the dependent's age, the dependent's social security number, and other documents deemed necessary by the Plan.

NOTE: Failure to provide timely proof of Dependent status means that the Dependent is not yet considered eligible for benefits and claims submitted to the Plan for the Dependent will not be able to be considered for payment until such proof is provided. If a Health Care Provider requests confirmation of eligibility and proof of Dependent status has not yet been provided and the time limit for providing that proof has not yet elapsed, the provider will be notified that the dependent is not yet determined to be eligible, that the Plan is awaiting proof of Dependent status which must be received by a certain date, and that no claims will be paid until the proof of Dependent status has been received and verified by the Plan such that the Dependent can be confirmed as eligible for coverage.

Specific documentation that may be requested to substantiate Dependent status may include:

- **Marriage:** the certified marriage certificate, proof of enrollment in employer provided coverage (if applicable).
- **Birth:** the certified birth certificate showing biological child of employee. For a child born overseas, a "Consular Report of Birth Abroad of a Citizen of the United States of America (CRBA)" document is to be presented.
- **Stepchild:** the certified birth certificate, divorce decree or spouse death certificate (if applicable) and marriage certificate.
- **Adoption or placement for adoption**: court order paper signed by the judge showing that employee has adopted or intends to adopt the child, and certified birth certificate.
- **Foster Child:** court order documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgment, decree or court order from a court of competent jurisdiction, plus the child's birth certificate.
- **Disabled Dependent Child:** Current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically disabled (as that term disabled is defined in this document) and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining

employment as a result of that disability; and dependent chiefly relies on you and/or your Spouse for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child including proof that the child is claimed as a dependent for federal income tax purposes.

- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document signed by a judge or a National Medical Support Notice.

ELIGIBILITY RULES FOR ACTIVE NON-LABOR MANAGEMENT AGREEMENT EMPLOYEES

A full-time Non-Labor Management Agreement Employee of a Contributing Employer is eligible for benefits following the Contributing Employer's written agreement to enroll all of its full-time non-collectively bargained Employees, subject to all of the following:

- Full-time Non-Labor Management Employees become eligible for Abbreviated Benefit coverage effective the first day of the second calendar month after working for a Contributing Employer for at least two (2) consecutive months.
- Full-time Non-Labor Management Employees are eligible for Full Benefit Coverage for themselves and their Eligible Dependents on the first day of the second calendar month after working for a Contributing Employer for at least three (3) months.
- Contributions are paid on the basis of 140 hours per month, regardless of the hours worked by any such Employee in a month.

A full-time employee is defined as every Non-Bargaining Unit Employee working at least 20 hours per week. Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. Receipt of this document does not guarantee eligibility for Plan benefits. No individual shall have accrued or vested rights to benefits under this Plan.

ELIGIBILITY RULES FOR RETIREES

Establishment of Initial Eligibility

You are eligible for Retiree Employee benefits if you are:

- Receiving a pension (other than a Limited Term Disability Benefit) from the PAMCAH- UA Local 675 Pension Fund, and were eligible as an Active Employee at least 36 out of the 60 months preceding the effective date of your pension; or
- A non-Labor Management Agreement employee or self-employed person or partner that does not participate in the PAMCAH-UA Local 675 Pension Fund, who was eligible as an Active Employee at least 84 out of the 120 months preceding the effective date of retirement and have submitted evidence satisfactory to the Board of Trustees that you are retired and no longer working at any occupation for wages or profit within the plumbing industry.

In addition, you must be a member in good standing if you are a Union member. If you are a Union member receiving a pension, Union Dues are required to be deducted from your monthly pension check

Credit for Service Under the Jurisdiction of Local 669

If you have previously performed fire sprinkler work under collective bargaining agreements with Local Union 669 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry (Local 669), this service may be added to your Credited Service under this plan. As a result, you may receive a Retiree Subsidy percentage from the PAMCAH- UA Local 675 Pension Fund.

Effective Date of Eligibility

Subject to applicable enrollment requirements, eligibility for Retired Employees and their eligible Dependents becomes effective on the first day of the month for which a pension is first payable to a Retired Employee.

Benefits Provided to Retirees

If your coverage as an Active Employee is terminated due to your retirement, you and your Dependents may be eligible for the Fund's coverage for Retired Employees, subject to applicable enrollment requirements. You may also continue certain Active Employee coverage for yourself and your eligible Dependents under COBRA Continuation Coverage.

Eligible Retired Employees and their Dependents are eligible for medical benefits, prescription drug benefits, dental benefits and vision benefits. Please refer to the Medical and Dental Plan chapters for a description of the benefits provided under each Plan.

If you are a Retired Employee eligible for Medicare (and/or your spouse), you must enroll in both Part A and Part B of Medicare when you are first eligible due to age or disability. Failure to do so will result in large out-of-pocket expenses that will not be reimbursed by this Plan. Once enrolled in Medicare Part A and Part B, the Plan will provide you with medical coverage that supplements Medicare.

NOTE: The cost of coverage for Retirees and their Dependents is financed by a combination of Retiree contributions, and contributions made by Employers in accordance with the current Labor Management Agreement and other agreement. Thus, benefits are provided only while funds are collected and available for the purpose of Retiree coverage. Benefits are not vested or guaranteed.

Retiree coverage is subject to the right of the Board of Trustees to amend or terminate in whole or in part at any time in its sole discretion. The Board of Trustees reviews the Retiree coverage each year and determines whether to continue the Retiree benefits for the following year; whether to modify the benefits to be provided, and whether to increase the amounts to be paid by Retirees towards the cost of coverage. These rates are available from the Fund Office.

ENROLLMENT

Personal History Card

It is important that the Fund Office has a properly completed Personal History Card for you in its files, which is necessary before claims can be processed. Additional Personal History Cards are available at the Fund Office.

After you have submitted a properly completed Personal History Card, it is important that you notify the Fund Office in the event that:

- You change your home address,
- You wish to change your beneficiary, or
- There is a change in your family status by reason of marriage, birth or legal adoption of a child, death, or divorce. Proof of the change of status will be required, and you shall furnish such information regarding family status and spouse employment information as the Trustees may require from time to time (such as, for example and not limited to, a notice of legal separation, divorce decree, or death certificate). Please see Verification of Dependent Eligibility on page 10 for some additional examples of the types of documentation that may be required.

SPECIAL ENROLLMENT

A federal law known as HIPAA provides for enrollment after initial eligibility as follows:

Newly Acquired Spouse and/or Dependent Child(ren)

If you, as the Employee or Retiree, acquire a Spouse by marriage or if you acquire any Dependent Child(ren) by birth, adoption or placement for adoption, you may request enrollment for yourself, the newly acquired Spouse, Domestic Partner and/or any Dependent Child(ren) no later than 30 days after the date of marriage, birth, adoption or placement for adoption. You must provide the Trust Fund Office the documentation needed to demonstrate eligibility (such as a birth certificate or marriage license) as soon as practicable once it becomes available. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

Loss of Other Coverage

If you declined coverage when you initially became eligible because you had health care coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, certain types of individual health insurance, Medicare, or other public program) **and** you **lose coverage** under that other group health plan or health insurance policy; you may request enrollment for yourself and/or your Dependents within **30 days** after the termination of the coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:

- loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of Employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was "exhausted;" or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan;
- the other plan ceasing to offer coverage to a group of similarly situated individuals;
- the loss of dependent status under the other plan's terms; or

- the termination of a benefit package option under the other plan, unless substitute coverage offered.

COBRA Continuation Coverage is "exhausted" if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

* due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
* when the employer or other responsible entity terminates the health care Plan and there is no other COBRA Continuation Coverage available to the individual;
* when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
* because the 18-month, 29-month or 36-month period of COBRA Continuation Coverage has expired.

Medicaid/State Children's Health Insurance Program (CHIP)

You and your Dependents may also enroll in this Plan if you (or your eligible Dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your Dependents) lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends; or
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days after you (or your Dependents) are determined to be eligible for such premium assistance.

Start of Coverage Following Special Enrollment:

- Coverage of an individual enrolling because of loss of other coverage or because of marriage: If the individual requests Special Enrollment **within 30 days** of the date of the event that created the Special Enrollment opportunity, (except for a newborn and newly adopted child or on account of Medicaid or a State Children's Health Insurance Program (CHIP), (discussed below) generally coverage will become effective on the first day of the month following the date the Plan receives the request for Special Enrollment.
- If the individual requests enrollment within 60 days of the date of the Special Enrollment opportunity related to Medicaid or a State Children's Health Insurance Program (CHIP), generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.
- Coverage of a newborn or newly adopted newborn Dependent Child for whom enrollment is requested within 31 days after birth will become effective as of the date of the child's birth.
- Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption for whom enrollment is requested more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

Individuals enrolled during Special Enrollment have the same opportunity to select Plan benefit options (when such options exist) at the same costs and the same enrollment requirements as are available to similarly-situated Employees at initial enrollment.

Chapter 3: When Eligibility Ends

In this chapter you'll find:

- Termination of Employee eligibility
- Extended coverage by self-payment
- COBRA continuation coverage

TERMINATION OF ELIGIBILITY

Termination of Active Employee Eligibility

a. Your coverage will terminate on the last day of the calendar month following the end of a qualifying period in which you do not meet any of the following hourly requirements:

- The Qualifying Period during which you fail to have 360 work hours credited to you, or
- Two consecutive Qualifying Periods during which you failed to have 720 work hours credited to you, or
- Three consecutive Qualifying Periods during which you failed to have 1,080 work hours credited to you, or
- Four consecutive Qualifying Periods during which you failed to have 1,440 work hours credited to you, or
- The Qualifying Period during which your Employer failed to make required contributions for coverage.

"Qualifying Period" means any of the following three-month periods:

- March 1 of any year through May 31 of the same year
- June 1 of any year through August 31 of the same year
- September 1 of any year through November 30 of the same year
- December 1 of any year through the end of February of the following year

b. Eligibility will terminate on the date that you engage in Non-Covered Employment (including self-employment) for an employer who is not a Contributing Employer. You may again establish initial eligibility when you return to work for a Contributing Employer.

c. The date of Your death.

d. The date the Plan is terminated.

Reinstatement of Active Employee's Eligibility

Eligibility for benefits will be reinstated when you again meet the requirements for eligibility as described under *Establishment of Initial Eligibility* in Chapter 2, subject to applicable enrollment requirements. However, if your eligibility is terminated due to the failure of your Employer to make the required timely contributions for hours worked by its Eligible Employees, and that Employer subsequently makes the required contributions, your eligibility will be reinstated at its previous level, subject to applicable enrollment requirements, effective the date your coverage was previously terminated due to the Employer's failure to make timely contributions, provided the contribution is

received for a month not more than 6 months following the date of the termination of coverage. If the Employer's Contribution is made for a month 7 or more months subsequent to the Employee's termination of eligibility, the Employee must will be reinstated at his or her previous level, effective the first day of the second month following the month in which the Employer's contribution was received (that is, it will be reinstated prospectively).

Termination of Your Dependents' Eligibility

A Dependent's eligibility will terminate on the earliest to occur of the following dates:

- The date the Dependent ceases to be an eligible Dependent as defined by the Fund (e.g., if the Dependent Child ceases to be an eligible Dependent due to reaching the limiting age of 26, the Child will be covered through the end of the month in which the Child turns 26)
- The date eligibility terminates for the Active Employee or Retired Employee
- The date the Plan terminates
- In the event of the death of an Active Employee, their Dependents' eligibility will terminate on the last day of the calendar month following the last Qualifying period in which the deceased Employee's earned hours does not meet the work hour requirement in a Qualifying Period required to maintain eligibility.
- In the event of the death of the Retired Employee who has received less than 120 months of Retiree coverage (measured from the initial effective date of Retiree coverage), their Dependents' eligibility will terminate at the end of the 120-month period. Please note if at any point the Retired Employee loses eligibility for retiree coverage before having coverage reinstated (such as for example due to becoming regularly employed for 20 or more hours per week, see below section for more information), the 120-month measuring period runs concurrently with any period of ineligibility.
- For Dependents of Retirees only, the last day of the month in which the required contribution for coverage is not paid in full and on time.
- The date the Spouse enters the Armed Forces on full-time active duty eligibility will terminate for your Spouse. Any otherwise eligible Dependent Children will remain eligible.
- The date of the Dependent's death.
- The date Dependent coverage is discontinued by the Plan.

Termination of Retiree Eligibility

Your eligibility as a Retired Employee will terminate under the first of the following circumstances to occur:

- When your right to a pension from the PAMCAH-UA Local 675 Pension Fund is terminated, or when you are no longer considered to be retired
- 180 months following your pension effective date under the PAMCAH-UA Local 675 Pension Fund
- The end of the subsequent month in which a Retired Union Participant terminates Union membership and/or does not maintain Good Standing
- The last day of the month in which the required contribution for coverage is not paid in full and on time.
- The date you become regularly employed for 20 or more hours per week

- The date of your death.
- The date the Plan is discontinued.

Reinstatement of Retiree Eligibility

If a Retiree's eligibility for benefits was terminated due to employment of 20 or more hours per week, you will again become eligible for Retiree coverage 6 months after your employment ceases. If you failed to inform the Fund Office when you first became employed, you will not be eligible for Retiree coverage until the number of months following the termination of such employment equals the number of months you were employed ***plus*** an additional 6 months. For coverage to take effect, the Plan must receive your timely and proper enrollment.

Special Late Enrollment for Retirees

You must make payment for your first month of Retiree coverage and each subsequent month of Retiree coverage prior to the first day of each month of coverage. If you fail to make the required payment, you will not be allowed to enroll in the retiree benefits of this Plan at any later date. The only exception is if you provide the Fund Office, prior to the end of the first month for which you receive a pension, with evidence that you do not wish to enroll for retiree benefits because you and your qualified Dependents have alternative health care coverage under another health insurance policy or program including another employer sponsored group plan, COBRA Continuation Coverage, individual insurance, Medicare, or Medicaid. If you provide such evidence, you and your eligible Dependents who did not enroll for coverage at the time of your retirement may enroll in the retiree benefits of this Plan if you do so within 31 days after the termination of that alternative coverage.

Please note that Special Late Enrollment for the retiree benefits of this Plan will not extend the maximum period of time during which you and your Dependents are entitled to coverage under the retiree benefits. This opportunity ceases 180 months from the effective date of your Retiree coverage.

RE-ENTRY PLAN - EXTENDED COVERAGE BY SELF PAYMENT (FOR RETIREES AGE 65 AND OLDER)

If you are a Retiree age 65 and over and no longer covered by the Plan, you and/or your spouse (if also age 65, regardless of whether the Retiree also enrolls) may re-enter the Plan by making the required self-payments. To re-enter the Plan, you and/or your spouse must:

- Enroll in Medicare Part A and Part B, and
- Enroll in all Plan lines of coverage (medical, prescription drug, dental and vision benefits) and pay the required monthly payments to the Fund in the amount determined by the Board of Trustees.
- Prior Union Members must maintain Union membership and be in Good Standing.

No lapses in coverage are allowed. A lapse in coverage occurs in any of the following events:

- When a Participant waives Participation in the Retiree Plan (15 Year Plan). The Participant and/or Spouse must be enrolled in the Retiree Plan for a minimum of 12 months to be eligible for enrollment in the Re-entry Plan.

- Termination of Re-Entry Coverage (voluntary or involuntary) for any reason. Termination may occur due to delinquent payment, termination of union membership, or losing Good Standing status with the Union.

Retroactive Cancellation of Coverage

In accordance with the requirements in the Affordable Care Act and to the extent permitted by the Affordable Care Act, the Fund will not retroactively cancel coverage **except** when employer contributions or self-payments are not timely paid in full or, upon 30 days advance written notice, in cases of fraud or intentional misrepresentation of a material fact (including, but not limited, providing incorrect information to the Plan regarding the eligibility of a Dependent in connection with enrollment, such as incorrect information about your relationship to a Dependent on an enrollment form). If your coverage is terminated for either of these reasons, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.

COBRA CONTINUATION OF HEALTH CARE COVERAGE

Have Your Family Members Read This Section

If you do not elect COBRA continuation coverage, your spouse and each eligible Dependent child will have a separate right to elect it independently. Therefore, it is important that you, your spouse, and your eligible Dependent children all read this section of this booklet.

If your or your Dependents' coverage under the PAMCAH-UA Local 675 Health and Welfare Fund ends due to a "qualifying event," the federal Consolidated Omnibus Budget Reconciliation Act (commonly known as "COBRA") allows you to temporarily continue your health care coverage by electing COBRA continuation coverage and paying for it yourself.

Qualifying events are shown in the chart below. You may only continue health care coverage that was in effect at the time of the qualifying event (i.e., the day before your coverage terminated). COBRA continuation coverage does not include life insurance, accidental death and dismemberment benefits, or temporary disability benefits.

COBRA Continuation Coverage		
COBRA Qualifying Event	**Who May Continue Benefits**	**Maximum Period of Continuation Coverage**
You lose eligibility due to • a reduction in your work hours • termination of your employment for reasons other than gross misconduct, or • retirement	You, your spouse, and/or your Dependent children	18 months*
You die	Your spouse and/or your Dependent children	36 months
You and your spouse divorce	Your spouse and/or your Dependent children	36 months
Your child ceases to meet the Plan's definition of an eligible Dependent (for example, because of a change in age)	The affected Dependent child	36 months

* **Disability extension:** Coverage for all enrolled family members may be continued an additional 11 months (for a total of 29 months) if you or a covered Dependent becomes Totally Disabled before or during the first 60 days of COBRA continuation coverage. See "Extended COBRA Period for Disability" later in this section.

Effect of prior Medicare enrollment: If the low hours, termination of employment, or retirement occurs less than 18 months after the date you become entitled to Medicare (Part A, Part B, or both), the maximum period of continuation coverage for your Dependents covered under the Plan will be 36 months after the date of your Medicare entitlement.

Please note: When You retired, You (the Retiree) were offered a choice between electing a temporary continuation of group health coverage ("COBRA Continuation Coverage") or electing Retiree health coverage. As You elected the Fund's Retiree health coverage, You will have no further COBRA continuation rights when Retiree coverage ends. However, your covered Dependent(s) who experience a second COBRA Qualifying Event, as described in this section, will have another opportunity to elect COBRA.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace (the Marketplace helps people without health coverage find and enroll in a health plan, see your state Health Insurance Marketplace or www.healthcare.gov).

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Qualified Beneficiaries

Under the law, only "qualified beneficiaries" are entitled to COBRA continuation coverage. A qualified beneficiary is any individual who was covered under the Plan on the day before the COBRA qualifying event by virtue of being an Employee on that day, the spouse of an Employee, or the Dependent child of an Employee.

A child who becomes a Dependent child by birth, adoption, or placement for adoption with you during a period of COBRA continuation coverage and is enrolled within 30 days is also a qualified beneficiary and will have the same COBRA rights as a spouse or children who were covered by the Plan before the qualifying event that triggered the COBRA continuation coverage.

A spouse who becomes your spouse during a period of COBRA continuation coverage may be added to your coverage during the period you remain eligible for COBRA continuation coverage. (See "Special COBRA Enrollment Rights" later in this section.) However, the new spouse would not be a qualified beneficiary (in other words, the spouse would not have any independent enrollment rights or be eligible for additional months of coverage if one of the "second qualifying events" described below occurred).

Extended COBRA Period for Disability

If you lose eligibility because of low hours or termination or retirement and you or one of your covered Dependents is determined by the Social Security Administration to have been Totally Disabled at the time of the qualifying event or within 60 days of the qualifying event, coverage may be extended for you and all enrolled Dependents beyond the original 18 months up to 29 months.

See "COBRA Notification Responsibilities" below for information on procedures and timeframes for notifying the Fund Office of Social Security Administration determinations.

A higher premium will be charged for the additional 11 months of coverage.

If a Second COBRA Qualifying Event Occurs

If your Dependents are in an 18-month COBRA continuation coverage period because of your low hours or your termination of employment or retirement (or a 29-month period, in the case of disability) and one of the following qualifying events occurs, the maximum COBRA continuation period for your Dependents will be extended to 36 months (provided you and/or your Dependents notify the Fund Office of the second qualifying event within the timeframe discussed in "Notification Responsibilities" below):

- You get divorced,
- You die,
- Your child ceases to meet the Plan's definition of an eligible Dependent (in this case, only the child may extend coverage).

For example: Tom stops working (the first COBRA qualifying event), and enrolls himself and his family in COBRA continuation coverage for 18 months. Three months after his COBRA continuation coverage begins, Tom's child turns 26 and no longer qualifies as a Dependent child under the Plan's definition. Tom's child can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA continuation coverage.

Employees are not entitled to COBRA continuation coverage for more than a total of 18 months (unless you are entitled to an additional 11 months' continuation coverage because of a disability). Even if you experience a reduction in your work hours followed by retirement or termination of your employment, the retirement or termination is *not* treated as a second qualifying event and you may not extend your coverage.

Special Enrollment Rights

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Special enrollment for the balance of Your COBRA period is also allowed for Dependents who lose other coverage. For this to occur,

- Your Dependent must have been eligible for COBRA coverage on the date of the qualifying event but declined when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage,
- Your Dependent must exhaust the other coverage, lose eligibility for it, or lose employer contributions to it, and
- You must enroll that Dependent within 30 days after the termination of the other coverage or contributions.

Adding a spouse or Dependent child may cause an increase in the amount you must pay for COBRA continuation coverage.

Notification Responsibilities

You and/or your Dependents are responsible for providing the Fund Office with timely notice of the following qualifying events:

- Your (the Employee's or Retiree's) divorce from your spouse, or
- A child's ceasing to be eligible for coverage under the Plan as a "Dependent child."

In addition, you and/or your Dependents are responsible for notifying the Fund Office, within the timeframe noted below, of the following:

- A determination by the Social Security Administration that a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months is disabled, or

- A determination by the Social Security Administration that such a qualified beneficiary is no longer disabled, or
- The occurrence of a second qualifying event, as described under "If a Second COBRA Qualifying Event Occurs" above.

You must make sure that the Fund Office is notified of any of the occurrences listed above. Failure to provide this notice within the form and timeframes described below may prevent you and/or your Dependents from obtaining or extending COBRA coverage.

Your employer is responsible for notifying the Fund Office of your death, termination of employment, or retirement. Determinations of low hours will be the responsibility of the Fund Office. However, you are encouraged to inform the Fund Office of any qualifying event to assure prompt handling of your COBRA rights

The Fund Office will notify you and/or your Dependents of your rights to choose COBRA continuation coverage within 14 days of receiving notification of a qualifying event (based on the address information on file with Fund Office).

A notice sent to your spouse will be deemed to have also been sent to any eligible Dependent children residing with your spouse at the time (based on the address information on file with the Fund Office).

How to Provide Notice to the Fund Office

Notice of any of the five Notification Responsibilities listed above must be provided in writing. Send a letter to the Fund Office containing the following information:

- Your (the Employee's) name and Social Security number,
- Name of the Fund ("PAMCAH-UA Local 675 Health and Welfare Fund")
- The event you are providing notice for,
- The date of the event, and
- The individual(s) affected by the qualifying event and their relationship to you.

If the qualifying event is a divorce from your spouse, you will be required to provide verification of the termination of your marriage.

Where to Send the Notice

Notice must be sent by U.S. mail to the following address:

COBRA Administrator
PAMCAH-UA Local 675 Health and Welfare Fund
1109 Bethel Street, Room 403
Honolulu, HI 96813

Please keep a copy, for your records, of any notices you send to the Fund Office.

Deadline for Sending the Notice

Assuming you have been furnished with a copy of this booklet or a general (initial) COBRA notice by the Plan informing you of the responsibility to provide these notices and these notice procedures, timeframes for providing notice are as follows:

- If you are providing notice of a divorce, a Dependent child's losing eligibility for coverage, or a second qualifying event, you must send the notice no later than **60 days after** the date of the relevant qualifying event.
- If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than **60 days after the latest** of (1) the date of the disability determination by the Social Security Administration, (2) the date of the qualifying event, or (3) the date on which the qualified beneficiary would lose coverage under the Plan due to the qualifying event.
- If you are providing notice of a Social Security Administration determination that you or your Dependent **is no longer** disabled, notice must be sent no later than **30 days after** the date of the determination by the Social Security Administration that you or your Dependent is no longer disabled.

Who Can Provide Notice

Notice may be provided by the qualified beneficiary with respect to the qualifying event (You or your Dependents, as applicable) or any representative acting on behalf of the qualified beneficiary.

Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if you (the Employee), your spouse, and your child are all covered by the Plan and your child ceases to be a Dependent under the plan, a single notice sent by you or your spouse would satisfy this requirement.

If you or your Dependents send a notice to the Fund Office as described above and the Fund Office determines that you are not entitled to COBRA continuation coverage, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA continuation coverage. This will be provided within 14 days after the Fund Office receives your notice.

Electing Coverage

You and/or your covered Dependents have **60 days** to make your election from the later of:

- The date you would have lost coverage because of the qualifying event, or
- The date you received the COBRA notice from the Fund Office.

Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA continuation coverage. For example, both you (the Employee) and your spouse may elect COBRA continuation coverage, or only one of you may elect COBRA continuation coverage.

A parent or legal guardian may elect COBRA continuation coverage for a minor child. If you or your spouse elects COBRA continuation coverage, you will be deemed to be electing it for your eligible Dependent children as well, unless you specify otherwise in the election. If you and your spouse do not elect COBRA continuation coverage, your Dependent children will be able to elect it or reject it independently of your rejection.

If you and/or your Dependents do not elect COBRA within the 60-day period allowed, you will forfeit all rights to COBRA continuation coverage and your health care coverage will end.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal law, including the right to a special enrollment period to enroll in another group health plan (for example, a plan sponsored by your spouse' employer) following the termination of COBRA continuation coverage.

- You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). Special enrollment under this provision is allowed within 30 days (or 60 days as applicable) after your group health coverage ends because of the qualifying events listed above or at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

Coverage Options

You may elect to continue:

- Core coverage (medical and outpatient prescription drug coverage only), or
- Core coverage plus dental and vision benefits.

You may not elect any coverage you did not have immediately before the qualifying event.

Your initial continuation coverage may be modified if at a later date, coverage changes for other participants.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that You or Your Dependents are not entitled to the requested COBRA coverage, You will be sent, by the Fund Office, an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

If you elect COBRA Continuation Coverage, you will have to pay the full cost of the coverage. The Fund is permitted to charge the full cost of coverage for similarly situated active Employees and families (including both the Fund's and your share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Sending in Payment

Premiums for COBRA continuation coverage are payable monthly, in amounts established by the Board of Trustees.

Initial COBRA Payment

You have a maximum of 45 days from the date you mail your COBRA election form to the Fund Office in which to submit your first payment. This first payment must include the cost of coverage retroactive to the first day your coverage would have otherwise terminated.

All subsequent monthly premium payments are due on the 15th day of the month prior to the month for which continuation coverage is elected. A 30-day grace period for premium payment will be allowed before coverage is terminated.

For Monthly Payments, What If the Full COBRA Premium Payment Is Not Made When Due?

If the Fund Office receives a COBRA premium payment that is not for the full amount due, the Fund Office will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

If there is not a significant shortfall, the Fund Office will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall.

- If the shortfall is paid in the 30-day time period then COBRA continuation coverage will continue for the month in which the shortfall occurred.
- If the shortfall is not paid in the 30-day time period then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made (which may result in a mid-month termination of COBRA coverage).

Additional COBRA Election Period and Tax Credit In Cases of Eligibility for Benefits Under TAA

The Trade Act of 2002 created a tax credit (called the Health Coverage Tax Credit or HCTC) for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance including COBRA. While the HCTC expired on January 1, 2014, it was reinstated to be effective for coverage periods through 2019. For more information, visit, www.irs.gov/HCTC.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate on the earliest of the following dates:

- The last day of the maximum period of coverage (18, 29, or 36 months, as applicable)
- The date you or your Dependent fails to make the monthly payment in full and on time (you will be allowed a 30-day grace period from the premium due date)
- The date the person receiving COBRA becomes covered under another group health plan (which does not limit or exclude any pre-existing condition the person might have)
- The date the person receiving COBRA becomes covered under Part A or Part B of Medicare
- The date your employer terminates its participation in the Plan (If your employer replaces the Plan, you may be entitled to coverage under the replacement plan)
- The date the Social Security Administration determines that an individual on extended disability coverage is no longer disabled (This applies only to the 19th through 29th month of an extended COBRA period for a disability)

- The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).
- The date the Fund no longer provides group health coverage to any of its employees.

If COBRA continuation coverage is terminated before the end of the maximum period of coverage, the Fund Office will send you a written notice as soon as practicable following its determination that COBRA continuation coverage will terminate. The notice will set out the reason COBRA continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

Once COBRA terminates early, it cannot be reinstated.

Questions or Changes

If you have any questions regarding COBRA continuation coverage, please contact the COBRA Administrator at:

PAMCAH-UA Local 675 Health and Welfare Fund
1109 Bethel Street, Honolulu, HI 96813
Phone: (808) 536-4408

If you change your marital status or add new Dependents, please notify the Fund Office immediately. To protect your family's rights, you should also keep the Fund Office informed of any changes in the addresses of family members.

For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit their website at www.dol.gov/ebsa. The addresses and phone numbers of Regional and District EBSA offices are available through this website.

If Federal legislation alters the provisions of COBRA in existence at the time this Summary Plan Description/Plan Document is printed, you will be advised of any such modification as required.

Chapter 4: Medical Plan Benefits

In this chapter you'll find:

- A quick-reference summary of benefits
- Medical networks
- How to file Medical claims
- Annual Deductible
- Annual out-of-pocket limit
- Required Precertifications
- What the Plan covers
- Additional Covered Services and supplies
- Exclusions from coverage

The benefits discussed in this chapter are administered by Hawaii Medical Service Association (HMSA).Your comprehensive medical benefits provide coverage for diagnosis and treatment of non-occupational Illnesses and injuries, as well as certain preventive care. Included are visits to the doctor, hospitalization, surgery, chiropractic care, and treatment for mental health conditions or substance use disorder, among other medical services. More detailed information, including conditions for payment of different benefits, follows the Summary of Benefits chart.

Only services provided by Physicians, Health Care Practitioners, and Health Care Providers that are certified or licensed by the proper government authority, and render services within the lawful scope of their respective license will be covered.

All Employees and Retirees meeting the requirements of eligibility, including New Hires, are eligible for the benefits outlined in this chapter.

MEDICAL NETWORKS

The medical Plan has a Preferred Provider Organization (PPO), which is a network of Hospitals, Physicians, laboratories and other providers who are located within the state of Hawaii and who have contractually agreed to provide health care services and supplies for favorable negotiated discount fees applicable only to Plan Participants. If you receive Medically Necessary services or supplies from an in-network Contract Provider, you will usually pay lower Coinsurance, than if you received those Medically Necessary services or supplies from a Health Care Provider who is out-of-network or a Non-Contract Provider, and for many services the Deductible is waived when received from a Contract Provider. In addition, Contract Providers have agreed to accept the Plan's payment plus any applicable Coinsurance that you are responsible for paying as payment in full.

Because providers are added to and deleted from networks during the year, you should ask your Physicians or call HMSA to find out if your Physician or hospital is a Contract Provider. You will receive a list of participating Physicians and other health care providers from HMSA when you become eligible for benefits. Updated lists are available free of charge, upon request from HMSA.

In-Network (Contract Providers)

If you receive medical services or supplies from a Contract Provider, you will be responsible for paying less money out-of-your pocket. Contract Providers who are under a contract with the PPO have agreed to accept the discounted amount the Plan pays for Covered Services, plus any additional Copayments, Deductibles or Coinsurance you are responsible for paying, as payment in full, except with respect to claims involving a third party payer, including auto insurance, workers' compensation or other individual insurance. In those cases, the contracts of Providers with the PPO do not require them to adhere to the discounted amount the Plan pays for Covered Services, and they may charge in excess of what this Plan considers an Eligible Charge.

If you go to a Contract Hospital, you should not assume that all providers in the Hospital are also Contract Providers. To receive the maximum possible benefits, you should request that all your provider services (such as services by an anesthesiologist or assistant surgeon) be performed by Contract Providers whenever you enter a Hospital.

***Note*:** The fact that a provider is a Contract Provider does not necessarily mean that all services you receive from that provider will be covered benefits under the Plan.

Out-of-Network (Non-Contract Providers)

Out-of-Network or Non-Contract Providers are not contracted with the PPO Network. These non-contract providers may bill you a non-discounted amount for any balance that may be due in addition to the Eligible Charge payable by the Plan, also called Balance Billing.

If you receive covered medical services by a provider outside Hawaii who is not contracted with the PPO network, Plan benefits are based on the Eligible Charge for the same or comparable services rendered by Non-Contract providers in Hawaii.

Out-of-State

The Fund offers the **BlueCard Program** to reprice services when you receive health care outside of Hawaii. Benefit payments for Covered Services received out of state are based on contracts negotiated between out-of-state Blue Cross and/or Blue Shield Plans and BlueCard participating and BlueCard PPO providers.

If you get services from a Mainland BlueCard PPO provider, you enjoy discounted pricing advantages similar to those available when you receive health care from providers in Hawaii. For help finding BlueCard PPO providers outside Hawaii, call (800) 810-2583.

Medical Necessity

The Plan covers only Medically Necessary services and will not cover any unnecessary services nor will the unnecessary portion of any charge be paid. The Fact that a Physician may prescribe, order, recommend, or approve a service does not in itself constitute medical necessity or make a charge an Eligible Charge. You may ask your Physician to contact the Fund Office for a determination regarding the medical necessity of a service before it is performed.

HOW TO FILE MEDICAL CLAIMS

When you receive Covered Services in Hawaii:

- Present your Plan membership card to the provider,

- Be sure both the provider and the Fund Office have your correct mailing address, and
- Ask the provider to file the claim for you with HMSA.

Most providers will file claims for you. However, you are responsible for making sure that the claim is sent to the claims paying office of HMSA. The Plan can pay benefits only after your claim has been received. If you have already paid a provider for services covered by this Plan, you can file a claim with HMSA. You will then be reimbursed in accordance with the terms of the Plan.

***Note*:** Any claim sent or brought to HMSA or the Fund Office more than one year after the date of service will not be eligible for payment.

Where Payments are Sent

When you go to a Contract Provider, HMSA will send the benefit payment directly to the provider. When you go to a Non-Contract provider, HMSA will send the benefit payment to you and then you must pay the provider.

The Plan reserves the right to send benefit payments to you, to a provider, or if you have other coverage besides this plan, to the other carrier. You cannot assign Plan benefit payments to a provider or any other person (except as specifically provided below in accordance with Medicaid, or any other state plan for medical assistance approved under Title XIX of the Social Security Act). In the event of your death, the Plan can send benefit payments to your spouse, your survivors, your provider, or the person in charge of your estate.

Benefit payments will be made in accordance with any assignment of the payment of benefits made by you, or on your behalf, as required by Medicaid or any other state plan for medical assistance approved under Title XIX of the Social Security Act. Similarly, payments for benefits will be made in accordance with any state law which provides for acquisition by the state of the rights to payment. Note: You may not assign any right you have under the Plan or under other applicable law, including, but not limited to, any right to request for plan documents under ERISA Section 104(b)(4) or the right to bring a breach of fiduciary duty claim.

Report of Benefit Payments

HMSA will mail you an Explanation of Benefits (EOB) document after your claim has been processed showing the services performed, the actual charge, any adjustments to the charge, the Plan's Eligible Charge, and the amount paid by HMSA, on behalf of the Plan.

You may wish to keep your Explanation of Benefits and receipts for tax purposes. To be sure you receive payments and reports, please contact the Fund Office whenever you have a new mailing address.

Unclaimed or Uncashed Benefit Checks

A service charge will be assessed on a benefit check that has not been cashed, deposited, or otherwise negotiated by you prior to the check's expiration date. A schedule of the current service charge is available upon request.

***Note*:** The Claims Administrator (HMSA) has the discretionary authority to determine any questions of the amount and type of benefits payable, and the interpretation of the provisions of this booklet. The Board of Trustees has reserved the discretionary authority to determine eligibility or benefits and interpret the provisions of this booklet with respect to second level appeals of denied medical claims only – see Chapter 11, Claims and Appeals Procedures.

COST-SHARING

Cost-sharing refers to how you and the Plan split the cost for covered medical plan benefits. There are three types of cost-sharing under this Medical Plan: Deductibles, Copayments/Copays and Coinsurance. These are explained below in more detail and on the Schedule of Medical Benefits. Cost-sharing does not refer to premiums/contributions for coverage, balance billing amounts or non-covered/excluded medical expenses.

DEDUCTIBLES

The Deductible is the amount of Eligible Charges that you pay each Calendar Year before the Plan begins to pay benefits. The Deductible amount is $100 per Covered Individual each Calendar Year.

The Deductible applies separately to each Covered Individual, but no more than $300 will be applied to Deductibles for all members of your family in a Calendar Year, no matter how many Dependents are in your family. No more than $100 will be applied to any one person's Deductible for the Calendar Year.

Chiropractic services are excluded in determining the deductible.

COINSURANCE

Once you and your family members have met your Deductible each year, you and the Fund each pay a portion of most Eligible Charges. For example, when you use Contract Providers, the Fund pays 90% for most Eligible Charges and you pay 10%. The percentage you pay is called your "Coinsurance."

COPAYMENT

A copayment (or copay, as it is sometimes called) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur certain Eligible Medical Expenses. The Plan's copayments are indicated on the Schedule of Vision Plan Benefits.

ANNUAL MEDICAL OUT-OF-POCKET LIMIT

There is an annual cap, or limit, on the amount of cost-sharing (Coinsurance plus Deductible) you pay for each person, and an overall limit for a family. This cap is called the out-of-pocket limit.

The combined Medical Out-of-Pocket Limit for both Contract and Non-Contract providers is:

- $2,500 for each person, not to exceed
- $7,500 for your family.

Once your coinsurance payments (including the Deductible) for a particular individual's (yourself or a Dependent) Eligible Charges for the year reach $2,500, the Fund will pay 100% of Eligible Charges for that person for the rest of the Calendar Year (with the exceptions noted below).

Family Limit. Once your payments (including the Deductible) for your entire family's Eligible Charges for the year total $7,500, the Fund will pay 100% of Eligible Charges for you and each member of your family for the rest of the Calendar Year (with the exceptions noted below).

Expenses Not Counted Toward the Medical Out-of-Pocket Limit

The following do not count toward the out-of-pocket limit:

- Your expenses for outpatient prescription drugs, vision care services, dental care services, and chiropractic services. For more information regarding your separate Annual Prescription Drug Out-of-Pocket Limit, please see page 57.
- All expenses for medical services or supplies that are not covered by the Plan
- All charges in excess of the Eligible Charge determined by the Plan
- All charges in excess of any other limitation of the Plan
- Any additional other amounts you have to pay because you failed to comply with the Precertification Program

REQUIRED PRECERTIFICATION

Precertification is a special approval process to make sure that certain medical treatments, procedures, or devices meet payment determination criteria before the services are rendered. A precertification must be obtained from Hawaii Medical Service Association for certain types of medical services including but not limited to admission to a hospital, inpatient admission to a skilled nursing facility (waived for Contract Providers within the State of Hawaii) and certain surgical services including transplants. Inpatient elective hospital admission or residential treatment relating to mental illness or substance use disorder requires precertification (waived for Contract Providers). The Plan will pay reduced benefits in cases where precertification of otherwise Covered Services is required, but is not obtained.

You do not have to obtain precertification before seeking treatment of an Emergency Medical Condition in a Hospital emergency room.

From time to time, it is necessary to update the list of services and supplies that required precertification. Changes may occur at any time. Therefore, if you would like to know if a treatment, procedure or device is covered, contact HMSA at (808) 948-6464 (Oahu) or (800) 344-6122 (neighbor islands).

If you are under the care of a Contract Provider, he or she will get prior approval for you and accept any penalties for failure to get prior approval. If you are receiving care from a BlueCard PPO provider or a Non-Contract Provider, you are responsible for getting prior approval. If you do not receive prior approval, benefits may be denied.

If you do not agree with a benefit determination made under the Precertification process of this plan, you may ask for an appeal review by HMSA's Medical Directors.

Precertification for Certain Surgical Procedures

HMSA has identified certain surgical procedures in which a precertification from HMSA is required. The list of procedures changes periodically. To ensure your surgical procedure is covered, call HMSA to check if surgery requires approval before you receive the surgery.

If your Physician recommends one of the surgeries on the list and the surgery is not an emergency and can be scheduled in advance, your Physician must contact HMSA for precertification before your surgery. HMSA will work with your Physicians so you can make an informed decision about

your surgery and place of treatment (i.e., your Physicians' office, an outpatient surgical center, or hospital).

If you or your Dependent must receive one of the surgeries for emergency care, your Physician should contact HMSA within 48 hours after your surgery or on the next working day, whichever is later. Of course, never delay emergency treatment to obtain HMSA's approval for benefits.

HMSA will notify you and or your Physician of the results of the precertification. HMSA may approve or deny payment of benefits for the surgery, or may condition the payment of such benefits on you receiving a second opinion on the necessity of surgery.

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

Precertification for Inpatient Mental Health and Substance Use Disorder Treatment

Before an elective inpatient hospital admission for mental illness or substance use disorder services, you or your psychiatrist or psychologist must notify HMSA and obtain precertification (waived for Contract Providers). If you do not receive a required review, you may have additional expenses. For precertification, call (808) 948-6464 (Oahu) or (800) 344-6122 (neighbor islands).

HMSA will review the method and place of treatment and will approve benefits based on the Medical Necessity and appropriateness of the proposed mental health or substance use disorder treatment.

Precertification is required for Residential Treatment from Non-Contract Providers.

For outpatient mental health and substance use disorder services, you are not required to obtain precertification. However, you should still call HMSA to be directed to a network provider.

Precertification for Other Services

Precertification is also required for Home Health Care of longer than 30 days. If you remain in the facility or require treatment for more than 30 days, the attending provider must submit a report to HMSA showing the need for additional home health care at the end of each 30-day period.

Growth hormone therapy and genetic testing also require precertification.

Inpatient Review (Concurrent Review)

HMSA will periodically review your hospital medical records for the appropriateness of the inpatient care provided to you and the appropriateness of continuing hospitalization. This review will occur within 48 hours after admission and at set intervals, until you are discharged from the hospital. HMSA will also review discharge plans for the appropriateness of after-hospital care.

This review of the appropriateness of inpatient care and after-hospital care is for benefit payment purposes. You and your Physician will be notified if HMSA has a question regarding the appropriateness of continuing hospitalization or after-hospital care. If HMSA determines that the continuation of any service or care is not Medically Necessary or appropriate, you and your Physicians may still decide to continue with the service or care, but plan benefits will not be payable for that continued service or care.

Alternative Benefit Services

HMSA may assist you by providing benefits for alternative services that are medically appropriate but may not otherwise be covered by this plan. Benefits for any alternative services for your illness or injury will be paid in lieu of benefits for regularly Covered Services and will not exceed the total benefits otherwise payable for regularly Covered Services.

These alternative services will be paid at the Plan's discretion as long as you and your Physician agree that the recommended alternative services are medically appropriate for your illness or injury. Payment for alternative services for you in one instance does not obligate the Plan to provide the same or similar benefits for you or another member in any other instance. Payment of these alternative benefits is made as an exception and in no way changes or voids the Plan benefits, terms and conditions.

WHAT THE PLAN COVERS

Covered Services and supplies include those described below. Exclusions and limits that apply to specific services and supplies are described with those services and supplies; others are described in the "Exclusions from Coverage" that follow the Covered Services and supplies.

All benefits described in this section are payable after you have satisfied the annual Deductible, unless the benefit indicates the Deductible does not apply.

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called an "eligible medical expense." Eligible medical expenses are generally described in the Schedule of Medical Benefits. Eligible medical expenses are determined by the Plan Administrator or its designee, and are limited to those that are:

1. "Medically Necessary," but only to the extent that the charges are "Eligible Charges" (as those terms are defined in the Definitions chapter of this document). The fact that a physician prescribes or orders the service does not, in itself, make it medically necessary or a covered expense; and
2. not services or supplies that are excluded from coverage (as provided in the Exclusions chapter of this document); and
3. not services or supplies in excess of Maximum Plan Benefit as shown in the Summary of Medical Plan Benefits; and
4. ordered by a Physician or Health Care Practitioner for the diagnosis or treatment of an injury or illness (except where wellness/preventive services are payable by the Plan as noted in the this chapter or where prophylactic surgery/treatment is determined to be Medically Necessary by the Plan Administrator or its designee); and
5. expenses incurred while you are covered under this Plan. An expense is incurred on the date you receive the service or supply for which the charge is made.

Generally, the Plan will not reimburse you for all Eligible Medical Expenses. Usually, you will have some cost-sharing, meaning you will need to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. However, once you have reached the Out-of-Pocket limit no further cost-sharing will apply for the plan year. The Plan also requires precertification for certain services as explained beginning on page 31.

Special Provisions Regarding Women's Health Care

Federal law guarantees certain rights to women:

- Under the ***Newborns' and Mothers' Health Protection Act of 1996***, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, the Physician), after consultation with the mother, discharges the mother or newborn earlier.

  Plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

  In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification requirements in such a case, contact the Fund Office.

- Under the ***Women's Health and Cancer Rights Act of 1998***, all plans that cover mastectomies are also required to cover related reconstructive surgery. Available reconstructive surgery includes both reconstruction of the breast on which the mastectomy was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of all stages of mastectomy, including lymphedemas. These services are elective and coverage will be provided in a manner determined by the patient in consultation with the attending Physician. They are subject to the Plan's usual cost-sharing provisions.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions Section later in this Chapter and the Definitions Chapter of this document for important information**. All benefits are subject to the deductible except where noted. ***IMPORTANT: For services obtained at a Non-Contract Provider, you pay the Annual Deductibles and you also pay any difference between the actual and Allowed Charge, as defined in the Definitions Chapter of this document, unless otherwise stated.**

Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Allergy Services • The Plan pays for allergy testing and antigen & allergy shots.		90% of Allowed Charge, after Deductible	70% of Allowed Charge, after Deductible
Ambulance (Ground, Air) • Services must be received from a properly licensed or certified automobile ground or air ambulance service. • Air ambulance services are limited to intra-island or inter-island transportation within the state of Hawaii. After you satisfy the annual Deductible, benefits for ground and air ambulance charges will be paid as follows. For services provided by a Non-contract provider, you also pay any difference between the actual and Eligible Charges. • Transportation must be from the place where an injury occurred or first required care to the nearest facility equipped to furnish emergency treatment.	• The injury or illness must require emergency medical treatment, surgical treatment or hospitalization.	**Ground Ambulance**: 100% of Allowed Charge, after Deductible **Air Ambulance**: 90% of Allowed Charge, after Deductible	**Ground Ambulance**: 70% of Allowed Charge, after Deductible **Air Ambulance**: 70% of Allowed Charge, after Deductible
Ambulatory Surgical Center	• See the Outpatient (Ambulatory) Surgery Facility row in this Schedule.		
Annual Preventive Health Evaluation • Coverage is provided for one preventive physical exam per year, including height, weight, blood pressure and body mass index (BMI) measurements.	• For additional preventive services covered under this plan, please refer to the Preventive Care Benefits row.	100% of Allowed Charge, no deductible	70% of Allowed Charge, after Deductible
Audiology Exam	• See Hearing Aid Services row.		
Behavioral Health Services	• See the Mental Health and Substance Abuse Treatment row of this Schedule.		

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions Section later in this Chapter and the Definitions Chapter of this document for important information**. All benefits are subject to the deductible except where noted. ***IMPORTANT: For services obtained at a Non-Contract Provider, you pay the Annual Deductibles and you also pay any difference between the actual and Allowed Charge, as defined in the Definitions Chapter of this document, unless otherwise stated.**

Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Birthing Center/Facility	• See the Maternity Services row of this Schedule.		
Blood Transfusions • The Plan pays for blood transfusions, blood and blood products including blood costs, blood bank services and blood processing.	• Expenses related to autologous blood donation (patient's own blood) are not covered.	90% of Allowed Charge, after Deductible	70% of Allowed Charge, after Deductible
Chemotherapy and Radiation Therapy (Outpatient) • Benefits for high-dose chemotherapy, high-dose radiation therapy, or related services or supplies are covered when provided in conjunction with stem-cell transplants. Chemotherapy infusion and injections, including chemical agents and their administration to treat malignancy and radiation therapy are covered subject to the same limits as for high-doses.	• For chemotherapy (infusion, or injection), after you satisfy the annual Deductible, services will be paid as follows. • For Radiation Therapy, the annual Deductible only applies to Non-Contract providers. • Inpatient Radiation therapy is covered under the inpatient hospital services benefit. • Effective April 1, 2020, Oral chemotherapy drugs are covered only under the Outpatient Prescription Drug Benefit, please see page 57 for more information.	**Chemotherapy:** 90% of Allowed Charge, after Deductible **Radiation Therapy:** 90% of Allowed Charge, Deductible does not apply	**Chemotherapy:** 70% of Allowed Charge, after Deductible **Radiation Therapy:** 70% of Allowed Charge, after Deductible
Chiropractic Treatment • Chiropractic treatment, services or supplies provided by a licensed chiropractor	• Benefit payments for chiropractic treatment **are limited to a maximum of 12 office visits per Calendar Year.** Chiropractic services must be Medically Necessary for the diagnosis and treatment of an Injury or Illness of the back or spine and performed by a chiropractor. A chiropractor is a person who is licensed as a chiropractor by the appropriate government authority and renders services within the lawful scope of such license. • Note that your cost-sharing for chiropractic services does not count toward the Annual Deductible or the Annual Out-of-Pocket Maximum.	The Plan pays to $20 per visit, Deductible does not apply. For x-rays of the spine only, the Plan pays 50% of the Allowed Charge up to a maximum payment of $75 per Calendar Year, Deductible does not apply.	

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Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Clotting Factor Dispensations (hemophilia medication)	• For the highest benefits, these medications must be filled at a Hemophilia Alliance Pharmacy. For assistance in locating a Contract Provider, contact the HMSA. • You are responsible for any balance billing charges for these medications filled at a non-Hemophilia Alliance Pharmacy (including if filled at any OptumRx pharmacy).	Generic or mail-order: 100% of Allowed Charge, Deductible does not apply Brand (non-mail order): 90% of Allowed Charge, Deductible does not apply	Generic or mail-order: 100% of Allowed Charge, Deductible does not apply Brand (non-mail order): 90% of Allowed Charge, Deductible does not apply

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Corrective Appliances and Durable Medical Equipment Corrective Appliances is the general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). Durable Medical Equipment (DME) refers to equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable, is for the exclusive use of the patient, and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. Only Medically Necessary corrective appliances and durable medical equipment is covered. ***Precertification from HMSA is recommended for all medical equipment.*** **Covered** • Rental or purchase of medical equipment and supplies that are ordered by a Physician, are manufactured specifically for medical use, are of no further use when the medical need ends, are usable only by the patient, and are approved as Medically Necessary for the treatment of a condition, as determined by the Plan • Hearing aids (one device per ear every five years). Benefit payments for digital hearing aids are limited to no more than the amount the plan would pay for an analog hearing aid. • Cardiac pacemakers • Crutches or walkers • Artificial limbs, eyes, hips and other similar non-experimental prosthetic devices • Foot orthotics are covered only for specific diabetic conditions as defined by Medicare guidelines • Casts, splints, binder, braces, and crutches • Oxygen and rental of equipment for its administration • Rental or purchase of a wheelchair and hospital-type bed	**Not Covered** • Rental or purchase of equipment or supplies that are primarily for the comfort or hygiene or beautification of the patient, for environmental control (e.g., air purifiers, air conditioners, humidifiers), for exercise, or for prevention purposes • Rental charges that exceed the purchase price of the equipment • Any appliances and durable medical equipment not ordered by the attending Physician	90% of Allowed Charge, after Deductible	70% of Allowed Charge, after Deductible
Drugs (Outpatient Medicines)	• See the Outpatient Prescription Drug Benefits Chapter.		

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Durable Medical Equipment (DME)	• See the Corrective Appliances and Durable Medical Equipment row of this Schedule.		
Emergency Room • Hospital emergency room (ER) facility for a medical Emergency. • An emergency is the sudden onset of an acute condition requiring immediate treatment. The Physician's claim or hospital emergency report must describe the need for immediate treatment. Some examples of an emergency are heart attack, poisoning, loss of consciousness and convulsions. • Emergency Room Physician services are covered under the Physician Services or Surgical Services rows.	• **Note:** No payment will be made for use of emergency room facilities for any treatment which is not an emergency. No payment will be made for take-home drugs or supplies such as crutches or braces. • The Covid-19 Test and Covid-19 Related Services coverage described is effective only for services received on or after March 18, 2020 through the end of the Emergency Period in which the federal government has announced a National Emergency.	Covid-19 Test Related visit: 100% of Allowed Charge, Deductible does not apply All other: 90% of Allowed Charge, Deductible does not apply	Covid-19 Test Related visit: 100% of Allowed Charge, Deductible does not apply All other: 90% of Allowed Charge, Deductible does not apply
Family Planning, Reproductive, Contraceptive Services	• For maternity coverage see the Maternity Services row in this schedule. • See also the Outpatient Prescription Drugs Chapter. • See also Additional Covered Services and Supplies Section		

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Genetic Testing • Medically necessary genetic testing payable under this Plan is for: a) state-mandated newborn screening tests for genetic disorders; b) fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee; c) tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; d) genetic testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as prenatal genetic screening for cystic fibrosis; e) genetic testing (e.g. BRCA, stool DNA testing like Cologuard) and genetic counseling required as a Preventive service in accordance with the Affordable Care Act (ACA) regulations (see the Wellness row in this Schedule). f) the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants if all the following conditions are met: • the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and • the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and • the results of the test will directly impact clinical decision-making; outcome or treatment being delivered to the covered individual. **Precertification is required for genetic testing.**	• No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of individuals who are not covered under this Plan. Genetic testing costs may be covered for a non-covered individual only if such testing would directly impact the treatment of a covered plan participant. • **Precertification is required for genetic testing.** Plan participants should use the Plan's precertification procedure to contact HMSA to assist in determining if a proposed genetic test will be covered or excluded. • Genetic Counseling is not covered, except as specifically provided as a Preventive Care Benefit. Please see the Preventive Care Benefit row for more information. • Gene therapy is not covered.	90% of Allowed Charge, after Deductible	70% of Allowed Charge, after Deductible

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Hearing Aid Services • The Plan pays for evaluation for use of a Hearing Aid (audiology exam) and Hearing Aids.	• Hearing Aid limited to one per ear every five years.	90% of Allowed Charge, after Deductible	70% of Allowed Charge, after Deductible
Home Health Care Services **Covered** • Up to 30 days. If you need home health care services for more than 30 days, a Physician must certify that there is further need for the services and provide a continuing plan of treatment at the end of each 30-day period of care. • Up to 150 visits per Calendar Year for part-time skilled home healthcare services	• Services must be received from a qualified home health agency, which meets Medicare requirements and is approved by HMSA. Precertification is required for home health care lasting longer than 30 days. Your Physician must certify that you need skilled medical services because you are homebound. Being homebound means that you are unable to leave home, unless you use supportive devices or have assistance from another person, because of an Illness or Injury. Homebound standards defined by the Federal Medicare program apply. Services cannot be more costly than alternate services that would be effective to diagnose and treat your condition and without home health care, you would need inpatient hospital or skilled nursing facility care. **Not Covered** • Home care furnished primarily to assist in meeting personal, family and domestic needs such as general household services, meal preparation, shopping, bathing or dressing or other custodial care which does not require the training of a nurse or other health professional	100% of Allowed Charge, Deductible does not apply	70% of Allowed Charge, after Deductible
Hospice • Benefits are payable for inpatient and outpatient home Hospice care for terminally ill patients who are assessed by a Physician in writing to have a life expectancy of 6 months or less. "Hospice" means an agency or organization that provides a program of medical, psychological, social and spiritual care and may provide room and board. Benefits are based on an all-inclusive daily rate. If you elect hospice benefits, you will not be eligible for any other benefits for the treatment of the terminal illness except for Physician services. You may continue to receive benefits for all other illness or injuries.	HMSA offers an integrated case management services which is a program to help you 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 HMSA's criteria, your coverage provides you with alternate benefits to help meet health care needs that result from extreme Illness or Injury. You, your Physician, and the hospital can work with HMSA's 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, respiratory dependence, spinal cord injury, and long-term intravenous therapy.	100% of Allowed Charge, Deductible does not apply	Not covered

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Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Hospital Services (Inpatient) Up to 365 days per Calendar Year for hospital inpatient services • Room and Care, based on semiprivate room rate • Intermediate Care Unit • Isolation Care Unit • Intensive Care or Coronary Care Unit • Ancillary Inpatient Services • Operating room, surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics and other necessary drugs, blood transfusion services • Laboratory and X-ray Services **Precertification is required for elective hospital admission.**	• Inpatient reviews may take place after admission and at set intervals thereafter, until you are discharged from the facility. HMSA will also review discharge plans for after-hospital care. • If a Non-Contract hospital uses a single, all-inclusive daily charge instead of itemized charges for laboratory, x-ray, radiotherapy, and all other allowable hospital inpatient services and supplies, the plan pays 70% of Eligible Charges. At a Non-Contract Provider you also pay a Coinsurance of 30% of Eligible Charges and the difference (if any) between actual and Eligible Charges. In no event will the plan pay more than if the hospital had charged separately for these services.	90% of Allowed Charge, Deductible does not apply	70% of Allowed Charge, after Deductible
Immunizations	Well-baby/Well-Child immunizations in connection with Well-Baby/Well-Child care are designed to be consistent with the Immunizations Practices Advisory Committee of the United States Department of Health and Human Services and the American Academy of Pediatrics. For benefits for immunizations covered as an ACA mandated preventive service, please see the Preventive Care Benefits row. All other immunizations, including but not limited to travel immunizations such as hepatitis A and hepatitis B, are covered in accordance with the guidelines set by the Advisory Committee on Immunization Practices.	Well-Baby/Well-Child Immunizations: 100% of Allowed Charge, Deductible does not apply Adult and Travel Immunizations: 90% of Allowed Charge, Deductible does not apply	Well-Baby/Well-Child Immunizations: 100% of Allowed Charge, after Deductible. You pay any difference between the actual and Allowed Charge. Adult and Travel Immunizations: 70% of Allowed Charge, after Deductible

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Laboratory and Radiology Services (Outpatient) • Covers laboratory services and diagnostic tests, x-ray films, and radiotherapy. All applicable plan Deductibles shall be waived for laboratory tests in connection with well-baby care visits. Laboratory tests for well-baby care are limited to the following tests through age 6: two tuberculin tests (tine or skin sensitivity), two blood tests (hemoglobin or hematocrit) and one urinalysis (through age five).	• Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • The Covid-19 Test coverage described is effective only for services received on or after March 18, 2020 through the end of the Emergency Period in which the federal government has announced a National Emergency.	Covid-19 Test: 100% of Allowed Charge, Deductible does not apply All other: 90% of Allowed Charge, Deductible does not apply	Covid-19 Test: 100%, Deductible does not apply All other: 70% of Allowed Charge, after Deductible
Maternity Services • The Eligible Charge for delivery includes prenatal and postnatal care. If payments for prenatal care are made separately prior to delivery, the Plan will consider those payments advance payments and will deduct them from the maximum allowance for delivery. **Covered:** • Physician services, including prenatal, false labor, delivery and postnatal services • Surgery or complication of pregnancy including ectopic pregnancy • Nurse-midwife services (in lieu of Physician services). If you use a Contract provider, the Plan pays 100% of the Eligible Charge, Deductible does not apply. If you use a Non-contract provider, the Plan pays 70% of the Eligible Charge after you pay the Annual Deductible. You also pay the difference between actual and Eligible Charges. • Hospital or Birthing Center Services (precertification by HMSA required for stays of longer than 48 hours following vaginal delivery, or longer than 96 hours following a cesarean section). • Limited newborn care provided in the hospital immediately after birth when the mother is a covered eligible Dependent, Employee or Retiree. • Termination of pregnancy	In accordance with federal law, the Plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following 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 if applicable). In any case, the Plan does not require precertification of hospitalizations for childbirth from HMSA unless special circumstances require a stay in excess of 48 hours (or 96 hours for cesarean section).	Office Visits: 100% of Allowed Charge, Deductible does not apply Childbirth/delivery: 90% of Allowed Charge, Deductible does not apply	70% of Allowed Charge, after Deductible

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Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Medical Foods • Medical foods but only to treat certain inborn errors of metabolism.	• These expenses do not count toward you annual out-of-pocket limit.	80% of Allowed Charge, Deductible does not apply	80% of Allowed Charge, Deductible does not apply
Mental Health and Substance Abuse Treatment The Plan covers mental health and substance use disorder treatment in the same manner as any other medical condition. Elective hospital admission and residential treatment facility admission require precertification. **Covered** • Inpatient mental health or substance abuse treatment (including detoxification). **Elective hospital admission requires precertification.** • Residential treatment. **Residential treatment admission requires recertification.** • Inpatient services provided by a physician, psychiatrist, psychologist, clinical social worker, marriage and family therapist, licensed mental health counselor, or advanced practice registered nurse. • Outpatient treatment of mental or nervous disorders provided by a psychiatrist, psychologist, licensed clinical social worker (LCSW), or marriage, family and child counselor (MFCC) (including intensive outpatient treatment, partial hospitalization services, and office visits) • Outpatient psychological testing Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.	**Not Covered** • Mental health services which are not for the treatment of a nervous or mental disorder classified as such in the current version of the Diagnostic and Statistical Manual of the American Psychiatric Association • Educational programs to which drinking or drugged drivers are referred by the judicial system and any and all services performed by mutual self-help groups • Services to which drinking or drugged drivers are referred by the judicial system, except if otherwise a covered benefit and determined to be medically necessary	**Inpatient:** 90% of Allowed Charge, Deductible does not apply **Outpatient:** Office Visits: 90% of Allowed Charge, deductible does not apply Other outpatient services: 100% of Allowed Charge, Deductible does not apply	**Inpatient:** 70% of Allowed Charge, after Deductible **Outpatient:** 70% of Allowed Charge, after Deductible

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Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Outpatient (Ambulatory) Surgery Facility/Center • **Precertification is required for certain surgical procedures.** To ensure your surgical procedure is covered, call HMSA to check if surgery requires approval before you receive the surgery. **Covers**: • Operating room, surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, blood transfusion services • Covered services include routine laboratory and x-ray services normally associated with the surgery	• For services obtained at a Non-Contract hospital, you pay the Annual Deductible and you also pay any difference between the actual and Eligible Charges, unless otherwise stated. • To be eligible for benefits, the facility must be approved by HMSA. An outpatient surgical center is a facility, which provides surgical services without an overnight stay. This facility may be in a hospital or it may be a separate, independent facility.	100% of Allowed Charge, Deductible does not apply	70% of Allowed Charge, after Deductible

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Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Physical, Occupational & Speech Therapy Physical, occupational and speech therapy services are only covered if ordered by a Physician, Physician's Assistance, or Advance Practice Nurse under an individual treatment plan. The diagnosis must be established by a Physician and the medical records document the need for a skilled physical, occupational or speech therapist. Inpatient Admission requires precertification by HMSA. **Covered** • Physical therapy services provided by a registered physical therapist (R.P.T.) • One-to-one speech therapy services provided by a speech language pathologist certified as clinically competent by the American Speech-Language Hearing Association (ASHA) • Speech therapy services include speech/language therapy, swallow/feeding therapy, aural rehabilitation therapy and augmentative/alternative communication therapy	For physical and occupational therapy, services must be provided by a qualified provider who is licensed appropriately and performs within the scope of his or her licensure and is recognized by HMSA. The therapy must be 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 or Injury, or period therapeutic intervention. The therapy must be short-term 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. For speech therapy services, the therapy must be necessary to treat function lost or impaired by disease, trauma, congenital anomaly or prior therapeutic intervention. The therapy must be used to achieve significant, functional improvement through objective goals and measurements. **Not Covered** • Habilitation services • For physical therapy, group exercise programs • Physical therapy evaluations are not covered when provided by an occupational therapist. • For speech therapy, services for children with developmental learning disabilities (developmental delay) • For speech therapy, services must not duplicate services provided by another therapy or available through schools and/or governmental programs	**Inpatient:** 100% of Allowed Charge, Deductible does not apply **Outpatient:** 90% of Allowed Charge, Deductible does not apply	**Inpatient:** 70% of Allowed Charge, after Deductible **Outpatient:** 70% of Allowed Charge, after Deductible

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Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Physician Visits (Outpatient and Inpatient) **Covered Physician Visits:** • **Physician Visits, Physician Assistant, & Nurse Practitioner.** Home, office, hospital emergency room, or office consultations visits. Office visit benefits will be paid for a second opinion on the necessity of surgery. • **Hospital Visit.** One per day to an inpatient. Additional consultation visits requested by the attending Physician and approved by the Plan are also covered. • **Skilled Nursing Facility Visit.** One per day to an inpatient, up to 120 visits per Calendar Year. • **Surgery.** Inpatient or outpatient. If you use Contract Providers, the plan pays 100% of Eligible Charges. If you use Non-contract Providers, the Plan pays 70% of Eligible Charges after you pay the Annual Deductible. You also pay any difference between actual and Eligible Charges. • **Anesthesiology Services.** Services of an anesthesiologist (Physician or certified registered nurse anesthetist) that are required by a Physician. Services include general anesthesia, regional anesthesia and monitored anesthesia when you meet HMSA's high-risk criteria. Hospital anesthesia services (i.e., nurse anesthetist services) will be paid in accordance with Hospital Inpatient Services.	• The Plan has payment restrictions and rules that apply to multiple surgical services, services of an assistant surgeon, and payment for preoperative and postoperative care for major and minor surgical services. Contact HMSA for additional information regarding these restrictions and rules. • **Note:** The benefits described in this row do not apply to outpatient well child doctor visits or outpatient doctor visits for mental health treatment. They also do not apply to visiting a doctor or other health care practitioner for a routine physical exam, physical therapy, occupational therapy, chiropractic treatment or X-ray and laboratory charges. See the specific benefit descriptions in this chapter for information on benefits for those types of visits or services. • **Not covered:** More than one home or office "visit" charge per day by any one Physician. The term "visit" means a personal interview between you and the Physician and does not include telephone calls or other situations where you are not personally examined by a Physician. • The Covid-19 Test and Covid-19 Related Services coverage described is effective only for services received on or after March 18, 2020 through the end of the Emergency Period in which the federal government has announced a National Emergency.	Covid-19 Test Related visit: 100% of Allowed Charge, Deductible does not apply All other: 90% of Allowed Charge, Deductible does not apply	Covid-19 Test Related visit: 100% of Allowed Charge, Deductible does not apply Emergency room: 90% of Allowed Charge, Deductible does not apply Other: 70% of Allowed Charge, after Deductible.
Prescription Drugs (Outpatient)	• See the Outpatient Prescription Drugs Chapter.		

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This chart explains the benefits payable by the Plan. **See also the Exclusions Section later in this Chapter and the Definitions Chapter of this document for important information**. All benefits are subject to the deductible except where noted. ***IMPORTANT: For services obtained at a Non-Contract Provider, you pay the Annual Deductibles and you also pay any difference between the actual and Allowed Charge, as defined in the Definitions Chapter of this document, unless otherwise stated.**

Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Preventive Care Benefits The preventive care services outlined in the Fund's **Member Friendly Preventive Care Guidelines** are payable at 100%, with no Deductible **when received from a Contract Provider**.	The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, & the Centers for Disease Control & Prevention (CDC). These websites (periodically updated) list the types of payable preventive services: https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.uspreventiveservicestaskforce.org/BrowseRec/Index and http://www.hrsa.gov/womensguidelines/. (Note: For any wellness/preventive service added after the start of a plan year, the Plan will have up to one year to administer the new wellness/preventive service.) If preventive services are received from a non-contract provider, they will not be eligible for 100% coverage under this Preventive Services benefit unless there is no provider in the Plan's network who can provide the particular service. These services will be covered at the non-contract provider cost-share instead. Preventive services are payable without regard to gender assigned at birth, or current gender status. **For Participants enrolled in the Abbreviated Benefits Plan only, preventive care drugs received from a Contract Provider will be covered as a preventive service under the Medical Benefit. Participants in the Full Benefit Plan must refer to the Retail Pharmacy Program chapter for their preventive care drug benefits.**	100% of Allowed Charge, Deductible does not apply	Female Contraceptives: 70% of Allowed Charge, Deductible does not apply All Other: 70% of Allowed Charge, after Deductible.
Prosthetic Devices	• See the Corrective Appliances and Durable Medical Equipment row in this Schedule.		
Rehabilitation Services	• See Physical, Occupational & Speech Therapy row in this Schedule.		
Radiology (X-Ray), Nuclear Medicine, Imaging Studies and Radiation Therapy Services (Outpatient)	• See Laboratory and Radiology Services row in this Schedule.		

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions Section later in this Chapter and the Definitions Chapter of this document for important information**. All benefits are subject to the deductible except where noted. ***IMPORTANT: For services obtained at a Non-Contract Provider, you pay the Annual Deductibles and you also pay any difference between the actual and Allowed Charge, as defined in the Definitions Chapter of this document, unless otherwise stated.**

Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Skilled Nursing Facility (SNF) For Contract providers, the Plan pays a single, all-inclusive amount per day for all Covered Services as shown below. For Contract providers whose laboratory and x-ray services are not included in a single, all-inclusive amount per day, the Plan shall pay laboratory and x-ray services in accordance with *Outpatient Surgical Center Services* row above. For Non-Contract Providers, the Plan pays as follows after you satisfy the Annual Deductibles. You also pay any difference between the actual and Eligible Charges, unless otherwise stated. Up to 120 days per Calendar Year of skilled nursing facility services. If you remain in the facility more than 30 days, the attending Physician must submit a report showing the need for skilled nursing care at the end of each 30-day period. • Room and care based on semiprivate room rate • Routine surgical supplies, drugs, dressings, oxygen, antibiotics and other necessary drugs, and blood transfusion services • Laboratory and X-ray services **Precertification is required for inpatient admission (precertification waived for Contract Providers within the State of Hawaii).**	• Custodial Care is not covered. • To be eligible for benefits, the facility must meet Medicare standards and be approved by HMSA. A Physician must admit you to the facility. You must need skilled nursing services and must be under the care of an attending Physician while in the facility. No payment will be made for services furnished primarily for comfort, convenience, rest cure, or domiciliary care.	100% of Allowed Charge, Deductible does not apply	70% of Allowed Charge, after Deductible
Substance Abuse/Substance Use Treatment	• See the Behavioral Health row of this Schedule.		

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions Section later in this Chapter and the Definitions Chapter of this document for important information**. All benefits are subject to the deductible except where noted. ***IMPORTANT: For services obtained at a Non-Contract Provider, you pay the Annual Deductibles and you also pay any difference between the actual and Allowed Charge, as defined in the Definitions Chapter of this document, unless otherwise stated.**

Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Transplants (Organ and Tissue) • The following transplants are eligible for benefits: kidney; cornea; small bowel and multivisceral; stem-cell transplants; bone marrow, excluding high dose chemotherapy with bone marrow transplants or peripheral stem cell infusion for epithelial ovarian cancer, multiple myeloma, primary intrinsic tumors of the brain; liver; pancreas; pancreas-kidney; heart; heart-lung; and lung. All other organ transplants, including artificial or animal organ transplants are not eligible for benefits under the plan. • Benefits related to covered organ or tissue transplants are paid according to the type of service involved (Hospital charges, surgeon's professional fees, office visits). See the applicable sections of this chapter for benefit payment information. No benefits will be paid in connection with transplants (except corneal and kidney) without prior approval from HMSA. Covered services: • Consultation • Psychological evaluations that a facility uses in evaluating a potential transplant candidate • Laboratory and diagnostic tests • Transportation of organs or tissues as part of the procurement process To qualify for benefits, the transplant must meet all of the following conditions: • **Be precertified by HMSA** • Both you and the specific organ transplant must meet the "Medical Necessity" criteria. • Be received from a facility that is located in the State of Hawaii and has a contract with HMSA to perform the transplant or is an approved Blue Distinction Center for Transplants. You may contact HMSA for a current list of providers.	• After you satisfy the annual Deductible, benefits for organ donor services will be paid as follows. For services provided by a Non-contract provider, you also pay any difference between the actual and Eligible Charges. • Services related to the donor are covered only if a member is the recipient. If the donor is covered under another medical plan, that plan will be primary and its benefits will be applied before benefits under this plan apply. Eligible Charges for screening of donors are limited to expenses of the actual donor. Screening expenses of other donor candidates who do not become the actual donor are not eligible for benefits. The following services are not covered: • Any transplant that has not been precertified by HMSA • Any transplant that is classified by the Health Care Financing Administration as "Experimental" or "investigative" in the circumstances presented, or as not proven to be safe and effective • 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 • Your transportation for organ or tissue transplant services • Organ or tissue transplants received out of country	**For organ donor services:** 90% of Allowed Charge, Deductible does not apply. **For approved organ and tissue transplant recipients:** 100% of Allowed Charge, Deductible does not apply.	**For organ donor services:** 70% of Allowed Charge, after Deductible. **For approved organ and tissue transplant recipients:** Not covered.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions Section later in this Chapter and the Definitions Chapter of this document for important information**. All benefits are subject to the deductible except where noted. ***IMPORTANT: For services obtained at a Non-Contract Provider, you pay the Annual Deductibles and you also pay any difference between the actual and Allowed Charge, as defined in the Definitions Chapter of this document, unless otherwise stated.**

Benefit Description	Explanations and Limitations of Benefits	Contract Provider	Non-Contract Provider
Well-Baby/Well-Child Care Six visits during the first 12 months of a child's life (one additional visit is covered when a newborn child is discharged within 48 hours of birth), two visits during the next 12 months, and one visit each during ages two, three, four and five. Well-Baby routine laboratory tests are covered in conjunction with office visits from birth through age 6. Lab tests are limited during the well-child care period to two Tuberculin tests, two blood tests (hemoglobin or hematocrit) and one urinalysis (through age 5). All applicable plan Deductibles shall be waived for Well-baby care.	Well-Baby/Well-Child immunizations are covered under the Immunizations row.	90% of Allowed Charge, Deductible does not apply	70% of Allowed Charge, Deductible does not apply

ADDITIONAL COVERED SERVICES AND SUPPLIES

The Plan will pay benefits shown below for the following services and supplies, subject to any benefit-specific maximums mentioned below and the annual Deductible.

- For Contract Providers: 90% of the Eligible Charge after you pay the annual Deductible; you also pay 10% of the Eligible Charge, unless otherwise stated.
- For Non-contract Providers: 70% of the Eligible Charge after you pay the annual Deductible; you also pay any difference between actual and Eligible Charge, unless otherwise stated.

Covered

- Consultation services, as needed, for surgical, obstetrical, pathological, radiological, or other medical conditions when the attending Physician requires the consultation (Deductible waived when received from a Contract Provider)
- Growth hormone therapy but only if you meet HMSA's precertification criteria and if growth hormone is for replacement therapy services to great 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 have been tried; short stature; neonatal hypoglycemia secondary to growth hormone deficiency; Prader-Willi Syndrome; or severe growth hormone deficiency in adults
- Home IV therapy services and supplies for outpatient injections, biological therapeutics, biopharmaceuticals, or intravenous nutrient solutions needed for primary diet
- Inhalation therapy
- Outpatient services and supplies for injection or intravenous administration of medication, biological therapeutics and biopharmaceuticals, or nutrient solutions needed for primary diet, and travel immunizations in accordance with guidelines set by the Advisory Committee on Immunization Practices (ACIP)
- Dialysis and supplies
- FDA approved Contraceptive devices and services for women, including female sterilization. The Plan will pay benefits of 90% of the Eligible Charge, no Deductible, if received from a Contract Provider, or 70% of the Eligible Charge, no Deductible, if received from a Non-Contract Provider.
- Tubal ligation. The Plan will pay benefits of 100% of the Eligible Charge, no Deductible, if received from a Contract Provider, or 70% of the Eligible Charge after Deductible if received from a Non-Contract Provider.
- Vasectomy. The Plan will pay benefits of 100% of the Eligible Charge, no Deductible, if received from a Contract Provider, or 70% of the Eligible Charge after Deductible if received from a Non-Contract Provider.
- Urgent Care visit
- Bariatric surgery (precertification required)
- One in vitro fertilization program per Participant or covered spouse per lifetime

- Laser therapy for plaque psoriasis
- Fecal Occult Blood Test (FOBT), Deductible does not apply when received from a Contract Provider.
- Newborn circumcision. The Plan will pay benefits of 100% of the Eligible Charge, no Deductible, if received from a Contract Provider, or 70% of the Eligible Charge after Deductible if received from a Non-Contract Provider.
- Prostate Specific Antigen (PSA) Test/screening, Deductible does not apply when received from a Contract Provider.

EXCLUSIONS FROM COVERAGE

Comprehensive medical benefits are not payable for the following:

1. Any expenses that:
   - Exceed Eligible Charges,
   - Are for services and supplies that are not deemed "**Medically Necessary**" (other than the preventive care services specifically covered by the Plan), or
   - Are incurred by you or a Dependent on a date you are not covered by the Plan (an expense is deemed to have been incurred on the date the person receives the service or supply for which the charge is made).
2. Any services or supplies listed as "**Not Covered**" in relation to specific benefits described earlier in this chapter
3. Services for which **no charge** or collection would be made if you or your Dependents had no health plan coverage
4. Services provided without charge by any federal, state, municipal, territorial or other government agency
5. Services due to an **act of war** (whether or not a state of war legally exists) or required during a period of active duty that exceeds 30 days in any armed force or which are incurred or aggravated while in the service of the armed forces
6. Services which are or may be covered by **Workers' Compensation** or any other employer's liability insurance
7. Services for an Injury or Illness caused by another person or **third party** from whom you have or may have a right to recover damages
8. **Refractive eye surgery** to correct visual problems
9. Rest cures
10. Treatment with non-ionizing radiation, except as otherwise identified as covered.
11. Cosmetic services (services that may improve physical appearance but do not restore or materially improve a bodily function)
12. Treatment of any complications as a result of previous cosmetic, Experimental, or investigative services, or other services not covered in this Plan.
13. Treatment of baldness, including hair transplants and topical medications; expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees, hairpieces, hair cranial prosthesis or hair analysis; and hair removal products/services.
14. Reversal of sterilization
15. Infertility services, including those pertaining to diagnosis, treatment, or fertilization by artificial means (except for one in vitro fertilization program per Participant or covered spouse)
16. Custodial care consisting 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. It also includes supervising services by a Physician or nurse for a person who is not under specific medical, surgical or psychiatric treatment to improve that

person's condition and to enable that person to live outside a facility providing this care, including adult day care, assisted living, senior care facilities, and/or memory care facilities.

17. Biofeedback and any other forms of self-care or self-help training and any related diagnostic testing, including cardiac rehabilitation or pulmonary rehabilitation programs
18. Weight loss or weight control programs (except as expressly provided as payable as a preventive service)
19. Routine physical examinations, except as specifically provided for
20. Services not described as covered in this booklet
21. Dental services which are generally done only by dentists and not by Physicians. These exclusions include: orthodontia; dental splints and other dental appliances; dental prostheses, osseointegration and all related services; removal of impacted teeth; and any other dental procedures involving the teeth, gums and structures supporting the teeth. In addition, any services in connection with the diagnosis or treatment of temporomandibular joint problems or malocclusion (misalignment of the teeth or jaws) are not eligible for benefits under this plan. These exclusions apply regardless of the symptoms or illnesses being treated.
22. A Physician's waiting or stand-by time
23. Human growth hormone therapy, except replacement therapy services to treat:
    - Hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy
    - Turners 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 have been tried
24. Any food products except for the treatment of inborn errors of metabolism in accordance with Hawaii State law. Precertification is required and 20% coinsurance do not apply toward the out-of-pocket limit.
25. Foot orthotics, except for specific diabetic conditions
26. Expenses for services or supplies for which a third party is required to pay are not covered. Expenses (past, present or future) for which another party is required to pay (e.g. no fault, personal injury protection, etc.) are not covered. See the Chapter on Third Party Liability in the for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
27. Bereavement counseling (except medically necessary services that are otherwise a covered benefit under the Mental Health benefit)
28. Marriage or family counseling
29. Genetic counseling (except as specifically provided as a preventive health benefit)
30. Any technique that uses genes to treat or prevent disease (gene therapy) including but not limited to Kymriah, Yescarta, Luxturna, and Zolgensma.
31. Outpatient prescription drugs (please refer to Chapter 5 for more information regarding your outpatient prescription drug benefits, if applicable)

32. Eyeglasses and contacts (please refer to Chapter 7 for more information regarding you vision care benefits, if applicable)
33. Acupuncture
34. Airline oxygen
35. Autologous blood transfusion
36. Carcinoembryonic antigen when used as a screening test
37. Ductal lavage
38. Electron Beam Computed Tomography (EBCT or Ultrafast CT) for coronary artery calcifications
39. Enzyme-potentiated Desensitization for asthma
40. Extracorporeal Shock Wave Therapy except when used for the treatment of kidney stones
41. Hypnotherapy
42. Intradiscal Electro Thermal Therapy (IDET)
43. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, hand rails, shower/tub grab bars, chair lifts, ceiling mounted lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.
44. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual.
45. Thoracic Electric Bioimpedance in an outpatient setting.
46. Vertebral Axial Decompression (VAX-D)
47. Private duty nursing

Chapter 5: Outpatient Prescription Drug Benefits

In this chapter you'll find:
- Generic and Brand name drugs
- A quick-reference schedule of benefits
- Retail pharmacy program
- Mail service program
- What the Plan covers
- Exclusions from coverage

The prescription drug program provides benefits for drugs you purchase at a retail pharmacy. It also includes a mail service program for drugs you take on a longer-term basis. When you need a medication for a short time (an antibiotic, for example) it's best to choose the retail pharmacy program. If you are taking medications on a long-term basis (such as to control diabetes, high blood pressure, arthritis, etc.), it is usually best to have it filled through the mail service program.

The Plan has contracted with OptumRx to provide you with prescription drugs at contract rates when you use a participating retail pharmacy or the OptumRx mail order service. OptumRx has the sole and exclusive authority to determine prescription drug claims and discretion to interpret the terms of the Plan governing prescription drug benefits. The Board of Trustees has reserved the discretionary authority to determine benefits and interpret the provisions of this booklet with respect to second level appeals of denied outpatient prescription drug claims only – see Chapter 11, Claims and Appeals Procedures.

When you are eligible, you will receive an OptumRx ID card.

If you use a non-participating provider, you must pay the full cost of the drug at the time of purchase. Ask the pharmacy or call OptumRx at the number provided in the Contacts Chart at the front of this document for a claim form. You will be reimbursed the amount the Plan would have paid for the same drug at a contracted pharmacy.

New Hires are not eligible for Prescription Drug benefits.

ANNUAL PRESCRIPTION DRUG OUT-OF-POCKET LIMIT

There is an annual cap, or limit, on the amount of cost-sharing you pay for each person, and an overall limit for a family. This cap is called the out-of-pocket limit.

The Prescription Drug Out-of-Pocket Limit for Contract pharmacies is:

- $5,400 for each person, not to exceed
- $8,300 for your family.

There is no limit on your expenses at a Non-Contract Pharmacy.

Once your cost-sharing payments for a particular individual's (yourself or a Dependent) Eligible Charges for the year reach $5,400, the Fund will pay 100% of Eligible Charges for prescriptions filled at a Contract Pharmacy for that person for the rest of the Calendar Year (with the exceptions noted below).

Family Limit. Once your payments for your entire family's Eligible Charges for the year total $8,300, the Fund will pay 100% of Eligible Charges for prescriptions filled at a Contract Pharmacy for you and each member of your family for the rest of the Calendar Year (with the exceptions noted below).

Expenses Not Counted Toward the Prescription Drug Out-of-Pocket Limit

The following do not count toward the Prescription Drug Out-of-Pocket Limit:

- Your expenses for medical services, vision care services, dental care services. For information regarding your separate Annual Medical Out-of-Pocket Limit, please see page 30.
- All expenses for prescription drugs filled at a Non-Contract Pharmacy
- All expenses for prescription drugs that are not covered by the Plan
- All charges in excess of the Eligible Charge determined by the Plan
- All charges in excess of any other limitation of the Plan
- Any additional other amounts you have to pay because you failed to comply with the Precertification Program

GENERIC AND BRAND NAME DRUGS

Many prescriptions are available in both brand name and generic versions. Generic drugs have the same active ingredients, strength and quality as the brand name equivalent. However, generic medications are less costly than brand name medications. **Generics should be the first line of prescribing.** If there is no generic available, there may be more than one brand name medication to treat a condition. To save money on your prescriptions, ask your doctor or pharmacist if a generic equivalent is available for the prescriptions you need.

There is no cost-share when you use generic medications.

SCHEDULE OF BENEFITS FOR OUTPATIENT PRESCRIPTION DRUGS

Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them.

The following chart is intended to provide a convenient quick-reference guide to your outpatient prescription drug benefits. More detailed information follows the chart.

Your Cost Sharing for Each Prescription or Refill			
	In-network retail (up to a 30 day supply)	**In-network retail (up to a 90 day supply)**	**Mail Order (up to a 90 day supply)**
ACA Mandated Preventive Care Drugs (For members enrolled in the Full Benefit Plan)	$0	$0	$0
Generic drugs	$0	$0	$0
Brand drugs	10%	10%	$0
Specialty drugs	10%	Not available	Not available
Diabetic supplies: Insulin, non-insulin injectable medications (blood glucose meters, lancets, test strip)	$0	$0	$0

RETAIL PHARMACY PROGRAM

The retail pharmacy program is intended for medications you need immediately for acute, short-term use (such as antibiotics).

Participating Retail Pharmacy

The Plan has contracted with OptumRx to provide you with prescription drugs at contract rates. Present your OptumRx ID card to the provider who dispenses your drugs. If you need to fill a prescription when you are without your ID card, ask your pharmacist to call OptumRx. Be sure the provider and the Fund Office have your correct mailing address.

If you go to a participating pharmacy, the provider will collect your cost-share, if there is one, at the time the drug is dispensed and file a claim for you. If you go to a non-participating pharmacy, you must pay the full cost of the drug and complete and submit an approved claim for reimbursement of the covered amount, less the applicable Coinsurance for brand name drugs. This should be submitted to OptumRx at the contact information included in the Contacts Chart at the front of this document.

If there is any problem with your eligibility, you will need to pay the full cost of the prescription and submit a claim to OptumRx for reimbursement.

Finding a Participating Pharmacy

To find a participating pharmacy nationwide, visit www.OptumRx.com or you can also contact OptumRx at (844) 265-1718.

You can also access your personal benefit information and view your prescription plan eligibility and prescription plan documentation for you and your Dependents by visiting www.OptumRx.com.

Benefits for Drugs Purchased from a Retail Pharmacy

If you use a participating pharmacy, you pay 10% coinsurance of Eligible Charges for each brand name drug prescription. There is no charge for generic drugs obtained at a participating pharmacy. Unless your Physician 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.

Supply Limit

Prescriptions filled at a retail pharmacy cannot exceed a 90-day supply. Some drugs may be subject to other lower quantity limits. Your Coinsurance is the same, whether your supply is for 1 day or 90 days, with the exception of a 90-day supply of Brand Name drugs filled at a Safeway pharmacy, which will be filled at no charge.

Non-Participating Pharmacy

If you go to a non-participating pharmacy, you must pay the full cost of the drug and complete and submit an approved claim for reimbursement of the covered amount, less the applicable Coinsurance for brand name drugs. This should be submitted to OptumRx at the contact information included in the Contacts Chart at the front of this document.

MAIL SERVICE PROGRAM

The OptumRx mail service pharmacies provide a convenient and cost-effective way for you to order medicine that you take on an ongoing basis (such as for diabetes, high cholesterol, arthritis, high blood pressure, etc.) and have the medicine delivered to your home.

Benefits for Drugs Purchased from the Mail Service

The mail order service provides convenient home-delivery at no additional charge. You may receive up to a 90-day supply of each prescription or refill, although some drugs may be subject to other lower quantity limits. Refills are available if indicated on your original prescription and are allowed up to one year from the date the original prescription was written. There is no Copayment for Brand Name Drugs if you use the OptuimRx mail service pharmacy.

How to Use the Mail Service

Prescriptions for 90-day maintenance medications will be handled through the OptumRx Home Delivery Pharmacy Program. To use the mail service program, have your Physician send your prescription electronically or phone in your prescription to OptumRx. Or you can go online or call OptumRx at the address or phone number listed in the Contacts Chart at the front of this document. Your 90-day mail order prescriptions can then be mailed to you.

WHAT THE PLAN COVERS

The Plan pays benefits for drugs and supplies when they are prescribed for the treatment of a non-occupational Illness or Injury. A prescription drug is any drug which by federal law can only be

dispensed upon a Physician's 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. Coverage for certain drugs (e.g., rheumatoid arthritis or opioid addiction drugs) may require specific precertification from OptumRx. The following types of drugs are covered:

1. Drugs that legally require a written prescription of a Physician or dentist
2. Insulin and diabetic supplies, when they are obtained by prescription, dispensed by a licensed pharmacy or Physician and when their use is Medically Necessary

Coverage for the following prescribed medications is limited:

1. **Vitamins and minerals:** Coverage of vitamins and minerals that are prescription drugs is limited to the following:
    - The treatment of an Illness that in the absence of such vitamins and minerals could result in a serious threat to your life, for example, folic acid used for the treatment of cancer
    - Sodium fluoride, if dispensed as a single drug (for example, without any additional drugs such as vitamins) for prevention of tooth decay
    - Prenatal vitamins prescribed for a pregnant woman
    - Pediatric multi-vitamins containing fluoride
2. **Compound preparations:** Compound preparations are covered provided they contain at least one prescription drug that is not a vitamin or mineral
3. **Contraceptive pills and devices:** Birth control pills and other contraceptive devices are covered in accordance with Hawaii State law (at least one brand from the monophasic, multiphasic, and the progestin-only categories), as well as FDA approved contraceptive methods for females including long-acting contraceptives, contraceptive injections, short-acting hormonal methods, barrier methods, and emergency contraception (brand drugs will be payable at no charge only if generic is medically inappropriate).
4. Preventive care drugs to comply with Affordable Care Act (ACA) regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control & Prevention (CDC) are covered with a written prescription at no charge when received from a Participating Pharmacy.
5. Oral fertility drugs if used in conjunction with one treatment cycle of invitro fertilization, per lifetime. Precertification by OptumRx is required or no coverage.

EXCLUSIONS FROM COVERAGE

No prescription drug benefits are provided for the following:

1. Immunization agents other than Hepatitis A (please see the Schedule of Medical Plan Benefits for information on coverage under the Medical Benefit)
2. Agents used in skin tests to determine allergic sensitivity, allergy injections
3. Injectable drugs intended for use in a Physician's office or drugs dispensed to a person confined as a registered bed patient
4. Biological sera, blood or blood plasma
5. Blood monitoring kits

6. Fertility drugs (other than as specifically noted as covered above)
7. Drugs that may be purchased without a prescription (other than certain preventive care drugs specifically noted as covered above)
8. Therapeutic devices, crutches, braces, support garments and appliances
9. Drugs intended for cosmetic indications
10. Erectile dysfunction drugs (except Muse)
11. Vaccinations/toxoids
12. Diagnostic agents
13. Repackaged Products
14. Surgical Supplies / Medical Devices (other than as specifically noted as covered above)
15. Multi-Vitamins / Multi-Vitamins with Iron
16. Non-Oral Systemic Contraceptives (IUD or Implantable devices, for example)
17. Weight loss drugs
18. Nutritional Supplements, Electrolyte Replacement products, and Dietary Management
19. H
20. Clotting factor dispensations, i.e., hemophilia medication (please see the Schedule of Medical Plan Benefits for information on coverage under the Medical Benefit)

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR INDIVIDUALS WITH MEDICARE

THE FOLLOWING PROVISION IS NOT APPLICABLE TO NEW HIRES AS YOU DO NOT HAVE PRESCRIPTION DRUG BENEFITS:

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug Plan (PDP) benefits. **It has been determined that the prescription drug coverage outlined in this chapter (a benefit of the self-funded medical plan available to Non-New Hire Active Employees and Retirees) is "creditable."** "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare Part D Prescription Drug Plan (PDP) coverage will pay. **PLEASE NOTE:** As New-Hires are not eligible for outpatient prescription drug benefits, this provision does not apply to you. This means that the New-Hire Plan does not provide outpatient prescription drug coverage that is considered "creditable" with Medicare Part D.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Part D Prescription Drug Plan (PDP) in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Part D Prescription Drug Plan (PDP) during Medicare's annual enrollment period (generally October 15 through December 7th of each year).

You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If you enroll in a Medicare Part D Prescription Drug Plan (PDP) you will need to pay the Medicare Part D premium out of your own pocket.

Note that you may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical plan.

Medicare-eligible individuals can enroll in a Medicare Part D Prescription Drug Plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (generally October 15th through December 7th); or
- for beneficiaries leaving employer/union group health coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare Part D Prescription Drug Plan.

If you do not have creditable prescription drug coverage and you do not enroll in a Medicare Part D Prescription Drug Plan when first offered that enrollment opportunity, you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.

For more information about creditable coverage or Medicare Part D coverage see the Fund's Medicare Part D Notice of Creditable Coverage (a copy is available from the Fund Office. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

Chapter 6: Dental and Orthodontic Benefits

In this chapter you'll find:

- A quick-reference schedule of benefits
- How the Dental Plan works
- Covered dental and orthodontic services
- Exclusions from coverage
- Payments and Reports
- Coordination of Benefits
- Termination of Coverage

Dental plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the Affordable Care Act. A separate election is required for Dental Plan benefits.

The Fund has contracted with Hawaii Dental Service (HDS), a member of the Delta Dental Plans Association, to process dental claims and to use the HDS network and Delta Dental Premier network of dental providers. HDS has the sole and exclusive authority to determine claims and interpret the terms of the Plan governing dental benefits. Dental benefits provide coverage for services ranging from checkups and cleanings to dentures when the services are provided by a licensed Dentist and when they are necessary and customary under the generally accepted standards of dental practice.

New Hires are not eligible for Dental and Orthodontic benefits. Retirees and their Dependents are not eligible for Othodontic benefits.

You are covered for expenses you incur for most, but not all, dental services and supplies provided by a Dental Care Provider as defined in the Definitions chapter of this document that are determined by the Plan Administrator or its designee to be **"Medically Necessary,"** but only to the extent that:

- the Plan Administrator or its designee determines that the services are the most cost-effective ones that meet acceptable standards of professional dental practice and would produce a satisfactory result; **and**
- services are not **experimental or investigational; and**
- **services or supplies are not excluded** from coverage (as provided in the Dental Exclusions section of this chapter); and
- **services or supplies are not in excess** of a Maximum Plan Benefit as shown in this chapter; and
- the charges for dental services are an **"Allowed Amount."** See the Definitions chapter under "Allowed Amount."

The Medical Plan deductible and Medical Plan Out-of-Pocket Limit does not apply to Dental Plan benefits.

SCHEDULE OF DENTAL BENEFITS

The following chart is intended to provide a quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the chart.

	Contract Provider	Non-Contract Provider
Dental Benefits for Active Employees and Their Dependents		
Diagnostic and Preventive Benefits	Plan pays 100% of Allowed Amount	Plan pays 100% of Allowed Amount. You are responsible for any balance billing.
Oral Surgery, Restorative Dentistry, Endodontics, Periodontics and Prosthodontics	Plan pays 90% of Allowed Amount	Plan pays 90% of Allowed Amount. You are responsible for any balance billing.
Calendar Year Maximum	No Maximum	No Maximum
Dental Benefits for Retired Employees and Their Dependents		
Diagnostic and Preventive Benefits	Plan pays 100%	Plan pays 100% of Allowed Amount. You are responsible for any balance billing.
Oral Surgery, Restorative Dentistry, Endodontics, Periodontics and Prosthodontics	Plan pays 90%	Plan pays 90% of Allowed Amount. You are responsible for any balance billing.
Plan Year Maximum	$1,500 per person	$1,500 per person
Orthodontic Benefits (for Active Employees and their Dependent children)		
To correct malalignment of teeth	Plan pays 90% of Allowed Amount	Plan pays 90% of Allowed Amount. You are responsible for any balance billing.
Lifetime Maximum for Orthodontic benefits	$2,500 per person	$2,500 per person

All dental claims must be filed within 12 months of the date of service for HDS claims payment.

HOW THE DENTAL PLAN WORKS

For Services in Hawaii, Guam and Saipan – Choose a HDS Contract Dentist

Before you begin any dental treatment, please contact the Fund office to check if:

1. You or your Dependents are eligible; and
2. 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 Fund immediately of any of the following changes to your:
   - Name
   - Address
   - Dependents

Inform your dentist that you are covered under the PAMCAH-UA Local 675 Health and Welfare Fund and present your HDS Membership Information Card to your dentist.

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

For Services on the Mainland

1. Choose a Delta Dental Contract Dentist. Your dental program provides for the payment of dental services rendered outside the State of Hawaii. For a list of Delta Dental contract dentists, visit the HDS website at www.hawaiidentalservice.com and click on "Members/Find a Participating Dentist." Click on the link "US Mainland & Puerto Rico." Select "Delta Dental Premier" as your plan type. Or you may call the HDS Customer Service Department.

   - When visiting a dentist on the Mainland, let the dentist know that you have an HDS plan and present your HDS member identification card.
   - If the dentist is a Delta Dental contract 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 member identification card.
   - HDS's payment will be based upon the Delta Dental dentist's agreed upon fee for his/her state.
   - Your Patient Share will be the applicable coinsurance.

2. If you choose to have services performed by a dentist who is not an HDS or Delta Dental contract dentist, you are responsible for the difference between the amount that the non-contract dentist actually charges and the amount paid by HDS in accordance with your plan (also known as balance billing).

   Because non-contract 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-contract dentist renders the services.

   - On your first visit, advise the non-contract dentist that you have an HDS dental plan and present your HDS member identification card.
   - In most cases you will need to pay in full at the time of service.
   - The non-contract 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-contract dentist fee schedule and a reimbursement check will be sent to you along with your Explanation of Benefit (EOB) report.

Whether you visit a contract or non-contract dentist, please be sure to discuss the total charges and 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.

How to Contact Hawaii Dental Service (HDS)

For any questions or to find a HDS Contract provider:

From Oahu call:	(808) 529-9248
From all other locations call Toll Free:	(844) 379-4325

You can also log on to the HDS website at www.hawaiidentalservice.com and select the Delta Dental Premier Network to find a Contract dentist near you.

COVERED DENTAL AND ORTHODONTIC SERVICES

Diagnostic Services

The Plan pays 100% of the Allowed Amount (the amount of allowable dental charge to which the HDS Copayment Percentage is applied to calculate the HDS Share and Patient Share) for the following:

- Examinations - twice per Calendar Year
- Bitewing X-rays - twice per Calendar Year through age 14, once per Calendar Year thereafter
- Full mouth X-rays - once every five years

Preventive Services

The Plan pays 100% (90% for Periodontal) of the Allowed Amount for the following:

- Cleanings - twice per Calendar Year
    - Expectant mothers - Cleaning or Periodontal Maintenance three times per Calendar Year
    - Diabetic patients - Cleaning or Periodontal Maintenance four times per Calendar Year
- Fluoride - twice per Calendar Year (through age 19)
- Fluoride - high risk - once per Calendar Year
- Space maintainers - through age 17
- Sealants (through age 18) - One treatment application, once per lifetime only to permanent molar with no prior occlusal restorations, regardless of the number of surfaces sealed

Restorative Services

The Plan pays 90% of the Allowed Amount for the following:

- Amalgam (silver-colored) fillings
- Composite (white-colored) fillings - limited to the anterior (front) teeth
- Gold restorations and crowns - once every seven years when teeth cannot be restored with amalgam or composite fillings

NOTE: Composite (white) restorations and Porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent. You are responsible for the cost difference up to the amount charged by the dentist.

Endodontics

The Plan pays 90% of the Allowed Amount for the following:

- Pulpal therapy
- Root canal treatment, retreatment, apexification, apicoectomy

Periodontics

The Plan pays 90% of the Allowed Amount for the following:

- 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

The Plan pays 90% of the Allowed Amount for the following:

- Fixed bridges - once every seven years for age 16 and over
- Dentures - complete and partial, once every seven years for age 16 and over
- Implants (covered as alternative benefit). Active Employees and their Dependents are subject to a $2,500 per person calendar year maximum for endosteal implants. Please remember that Retirees and their Dependents are subject to an overall calendar year maximum of $1,500 per person.

Oral Surgery

The Plan pays 90% of the Allowed Amount for the following:

- Extractions
- Other surgical dental procedures, including per-operative and post-operative care.

Adjunctive General Services

- Adjunctive Services (The Plan pays 90% of the Allowed Amount)
- Palliative Treatment (The Plan pays 100% of the Allowed Amount)

Covered Orthodontic Services

Only For Active Employees and their Dependent Children

Orthodontic benefits are provided for Active Employees and their Dependent children when orthodontic appliances are used to correct malalignment of teeth. The program will pay 90% of a contract orthodontist's fees, but not to exceed the maximum of $2,500 per individual per lifetime.

Payment for orthodontic treatment will be made in Eight (8) quarterly payments of $312.50.

Orthodontic services are not covered if services were started prior to the date member and/or dependent became eligible under this Fund's plan. If a member and/or dependent's eligibility end

prior to the completion of the orthodontic treatment, payments will not continue. If your Fund elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.

EXCLUSIONS FROM COVERAGE

1. Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document.
2. 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.
3. Congenital malformations, medically related problems, cosmetic surgery or dentistry for cosmetic reasons
4. Procedures, appliances or restorations other than those for replacement of structure loss from cavities that are necessary to alter, restore or maintain occlusion.
5. Dental services which are covered under the medical benefits for this Fund's medical plan
6. Costs of replacement or repair of an orthodontic appliance furnished under this program
7. Separate fees for orthodontic consultation or planning.
8. Charges for broken appointments
9. Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to a patient by a dentist
10. All transportation costs such as airline, taxi cab, rental care and public transportation are not covered
11. Treatment of disturbances of the temporomandibular joint (TMJ).
12. Orthodontic services (except as specifically provided in your Summary of Benefits)
13. Implants (except as specifically provided in your Summary of Benefits)
14. All prescription medication
15. Other exclusions listed in HDS's Procedure Code Guidelines

PAYMENTS AND REPORTS

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

EOBs are available electronically and are accessible through your HDS website account. If you choose to receive EOBs through the mail, you will not receive an EOB for services with no patient share or when only tax is due.

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

Calculating Your Benefit Payments

Determining the amount you should pay your HDS participating dentist is based on a simple formula (see box). HDS will pay the "% plan covers" amount.

You are responsible for the balance owed to your dentist which includes the Approved Amount (the maximum amount that the member is responsible for), any applicable deductible amounts, and taxes, less the HDS payment.

Participating dentists are paid based upon their Allowed Amount. (The amount to which the benefit percentage is applied to calculate the HDS payment.)

Dentist's Allowed Amount
X % plan covers

HDS Payment

Dentist's Approved Amount
<minus HDS Payment>

Patient Share

It is important to note that when determining payment, HDS may consider your prior dental work performed under another plan and your current plan's limitations.

QUESTIONS ON YOUR CLAIMS

If you have any questions or concerns about your dental claims, please call HDS Customer Service department at 529-9248 on Oahu or toll-free at 1-844-379-4325.

If you are not satisfied with the plan benefit determination, a request for reconsideration may be sent to the Manager of Customer Service within one year of the date of service. Please see the Claims Procedures and Internal Appeals Procedures chapters for more information.

COORDINATION OF BENEFITS

If you or your dependents are also covered by another dental plan:

- 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 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.

TERMINATION OF COVERAGE

Your eligibility for coverage under this dental program will terminate on the last day of the month in which your eligibility under the PAMCAH-UA Local 675 Health and Welfare Fund terminates.

Any dental work remaining on your treatment program, which had not been started by the time your eligibility terminated, will not be covered by this dental plan.

Please note that you may be entitled to continue your dental coverage along with other health benefits under the Fund's COBRA provision.

Chapter 7:
Vision Care Benefits

In this chapter you'll find:

- A quick-reference schedule of benefits
- How the Vision Plan works
- What the Plan covers
- Limitations and exclusions
- How to file a vision claim

Vision Care benefits are treated as a standalone (or excepted) benefit under HIPAA and the Affordable Care Act. A separate election is required for Vision Care benefits.

The Fund has contracted with Vision Service Plan (VSP) to process vision claims and to use the VSP Network of vision care providers as well as Affiliate Providers, to provide covered vision expenses at contract prices. VSP has the sole and exclusive authority to determine claims and interpret the terms of the Plan governing vision benefits.

Affiliate Providers are providers of Covered Services and materials who are not contracted as VSP member doctors but who have agreed to bill VSP directly for Plan benefits provided pursuant to the schedule outlined below. However, some Affiliate Providers may be unable to provide all Plan benefits included in the schedule of vision benefits.

Your Plan benefits will go farther when you use VSP Member Doctors. Complete information about the benefits is available in the brochures provided by VSP. If you have questions or would like to discuss requested services, you can contact VSP Customer Care at (800) 877-7195.

New Hires are not eligible for Vision Care Benefits.

SCHEDULE OF VISION BENEFITS

The chart below is intended to provide a quick-reference guide to your vision benefits. More detailed information, including conditions for payment of certain benefits, follows the chart.

Vision Benefits	VSP Member Doctor	Non-VSP Provider
Vision Examination – Limited to once every 12 months	Plan pays 100% after $5 Copayment	Plan reimburses up to $50 per exam
Retinal screening as part of vision examination available once every 12 months	Plan pays 100% after a $4 Copayment	Not covered
Lenses – Limited to once every 12 months Benefits for lenses are per complete set, not per lens.	Plan pays 100% for standard prescription lenses (plastic or glass)	Plan reimburses up to: Single Vision: $ 50 Lined Bifocal: $ 75 Lined Trifocal: $100 Lenticular: $125 Lens options: Tinted / Photochromic: $5
Non-Covered Lens Option	Average discount of 35%-40% on retail charges	N/A
Frames – Limited to once every 12 months	Up to $175 retail frame allowance plus 20% discount on frame overages Up to $70 retail frame allowance at Costco Optical	Plan reimburses up to $70
Medically Necessary Contact Lenses – Limited to once every 12 months (in lieu of glasses)	Plan pays 100% of VSP approved fee	Plan reimburses up to $210 subject to VSP approval
Elective Contact Lenses – Limited to once every 12 months (in lieu of glasses)	Plan pays 100% for contact lens fitting & evaluation after a $60 Copayment (exam covered in full after $5 Copayment). Plan pays 100% up to $175 allowance for contact lenses. 15% discount on usual & customary professional fees for contact lens evaluation and fitting.	Plan reimburses up to $130 for lenses, fitting and evaluation

HOW THE VISION PLAN WORKS

Steps for using a VSP Member Doctor or Affiliate Provider are as follows:

1. Call any VSP Member Doctor or Affiliate Provider to make an appointment. Identify yourself as a VSP member and provide your VSP member identification number (usually your social security number) and the name of the group Plan ("PAMCAH-UA Local 675 Health and Welfare Fund").
2. After you have scheduled an appointment, the VSP Member Doctor or Affiliate Provider will contact VSP to verify your eligibility and Plan coverage. The doctor will also obtain authorization from VSP for services and materials.
3. When you go for your visit, pay the VSP Member Doctor or Affiliate Provider your applicable Copayment and charges for any costs not covered. VSP will pay the doctor directly for the balance of the charges.

If you need assistance locating a VSP Plan doctor, call VSP at (800) 877-7195 or log on to the VSP website at www.vsp.com and use the "Find a doctor" feature.

When you use a VSP Member Doctor or Affiliate Provider, you are responsible for payment of the Copayment, and any amounts that exceed Plan maximums. You do not need to file a claim for reimbursement.

If you use a Non-VSP provider, you must pay for all services and supplies at the time you receive them and then submit a claim for reimbursement. You will be reimbursed the applicable amount shown in the Schedule of Benefits after deduction of your Copayment. There is no assurance that the schedule will be sufficient to pay for the examination or materials. Services received from a Non-VSP provider are in lieu of obtaining services from a VSP Member Doctor or Affiliate Provider and count toward Plan benefit frequencies. See "How to File a Vision Claim" at the end of this chapter for information on submitting claims for non-VSP provider services.

The Copayment

The Copayment applies when you use a VSP Member Doctor or Affiliate Provider. The Copayment is per individual.

The Copayment is due only once each year, for the first service you receive each year. If you pay the Copayment for your exam, for example, you will have satisfied your Copayment responsibility for the year for exam and glasses. However, please note the retinal screening has a separate additional copayment of $4, and the contact lens fitting and evaluation has a separate additional copayment of $60.

WHAT THE PLAN COVERS

Eligible Charges include:

1. Vision exam, including visual analysis of visual functions and prescription of corrective eyewear when indicated, once every 12 months
2. Retinal screening is covered as an enhancement to the eye examination, covered in full after a $4 copayment, once every 12 months
3. Lenses, once every 12 months
4. Frames, once every 12 months. VSP offers a wide selection of frames within the Plan's allowance. If more expensive frames are chosen, you will be responsible for the additional amount over the Plan's maximum allowance.
5. Contact Lenses, once in any 12-month period, in lieu of all other lens and frame benefits available. Once you get contact lenses under the Plan, you will not be eligible for other lenses or frames again for 12 months.
   - Medically Necessary Contact Lenses. Contact lenses are medically necessary if they are needed to restore or maintain visual acuity and a less expensive professionally acceptable alternative is not available. Coverage for medically necessary contact lenses is subject to approval from VSP regardless of whether they are obtained from a VSP Member Doctor or a Non-VSP provider.
   - Elective Contact Lenses. If you choose contact lenses for other than the medically necessary circumstances described above, they are considered Elective contact lenses.

The vision exam benefit is a way that diabetics can get their annual retinal eye exam.

Low Vision Benefit

A Low Vision Benefit is available if you have severe visual problems that are not correctable with regular lenses. If you qualify for this benefit, you may receive supplemental testing, which includes

evaluation, diagnosis and prescription of vision aids where indicated, and low vision aids, subject to the maximums outlined in the following chart.

Low Vision Benefits	VSP Member Doctor	Non-VSP Provider
Supplemental testing	Covered in full	Plan reimburses up to $125
Supplemental Aids	Plan pays 75% of cost	Plan reimburses 75% of approved amount
Maximum Benefit	$1,000 per person, every two (2) years	

ProTec Safety Eyecare Program

A Safety Eyecare program is available to Employees who require safety eyewear due to the nature of their work environment. Benefits are available from all VSP Member Doctors. Select VSP ProTec Safety doctors will have the ProTec Eyewear kits in their office for you to physical try on. There are no benefits from Non-VSP Providers or Affiliate Providers.

ProTec Safety Eyecare Benefits	VSP Member Doctor
Examination	Covered in full through the VSP based plan, once every 12 months after a $5 Copayment. An intermediate or comprehensive exam may be covered under the ProTec Safety Eyecare Plan only when you are not eligible for an exam under the base VSP eye care plan.
Lenses Single Vision Lined Bifocal Lined Trifocal Covered lenses tested and certified as meeting current American National Standards Institute (ANSI) standards for impact protection according to the level specified by the Fund	Coverage for Safety eyeglass lenses, once every 12 months include necessary corrective lenses covered in full (plastic or glass) VSP doctors also extend cost controls on lens options
Frames All frames provided under this plan will be tested and certified as meeting ANSI specifications.	Coverage includes a frame from VSP's ProTec Safety Eyewear Kit. .

Diabetic Eyecare Program

A Diabetic Eyecare Program is available to Covered Individuals who have been diagnosed with Type 1 or Type 2 diabetes who also have specific ophthalmological conditions. The Diabetic Eyecare Program does not cover medical treatment for Covered Individuals with diabetic or other medical conditions. It is coverage in addition to the medical plan for limited vision-related medical services.

A current list of the covered procedures will be made available to covered individuals upon request. The frequency at which these services may be provided is dependent upon the specific service and diagnosis associated with such service.

LIMITATIONS AND EXCLUSIONS

In addition to any general Plan exclusions and limitations, Vision Benefits are not paid for the following expenses.

1. The Plan will pay the basic cost of allowed lenses, and you must pay any additional cost when you select any of the following extra items:

   - Optional Cosmetic processes
   - Anti-reflective coating
   - Color coating, mirror coating or scratch coating
   - Blended lenses
   - Laminated lenses
   - Cosmetic lenses
   - Oversize lenses
   - Polycarbonate lenses
   - Progressive multifocal lenses
   - UV (ultraviolet) protected lenses
   - A frame that costs more than the Plan allowance
   - Certain limitations on low vision care

   Please note that the Plan is designed to cover visual needs rather than Cosmetic materials.

2. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a +0.50 diopter power); or two pair of glasses in lieu of bifocals
3. Replacement of lenses and frames that are lost or broken, except at the normal intervals when services are otherwise available
4. Medical or surgical treatment of the eyes, including any refractive vision surgery
5. Corrective vision treatment of an Experimental nature
6. Costs for services and/or materials above Plan benefit allowances shown on the Schedule of Benefits
7. Services or materials not shown as covered on the Schedule of Benefits
8. For the ProTec Safety Eyecare Program, the following are not covered:

   - Subnormal vision aids
   - Orthoptics or vision training and any associated supplementary testing not specifically related to Safety EyeCare
   - Two pairs of glasses in lieu of bifocals
   - Plano lenses
   - Contact lenses
   - Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available
   - Medical or surgical treatment of eyes

- Corrective vision treatment of an Experimental nature

9. For the Diabetic Eyecare Program, the following are not covered:
   - Insulin or any medications or supplies of any type
   - An eye examination required by an employer as a condition of employment
   - Services and/or materials not specifically included in the Rider as Plan Benefits
   - Frames, lenses, contact lenses or any other ophthalmic materials
   - Orthoptics or vision training and any associated supplemental testing
   - Surgery of any type, and any pre- or post-operative services
   - Treatment for any pathological conditions

HOW TO FILE A VISION CLAIM

When you use a VSP Member Doctor or Affiliate Provider, you do not need to file a claim for reimbursement. If you use a Non-VSP provider, call VSP to have an Out-of-Network Reimbursement Form mailed or faxed to you. You can also fill out the form online at www.vsp.com and print it.

If you have any questions about submitting your claim, contact VSP at 800-877-7195.

Note: You must submit your claim **within 1 year** from the date you received the vision service. Benefits will not be payable if you submit your vision claim more than 1 year after the date the expense was incurred.

Appeals of Denied Vision Care Benefits

If your claim is denied, in whole or in part, you will receive written notification from VSP including the reasons for denial. If you do not agree with the denial you may then submit a written request to VSP for reconsideration within 180 days from the date you received the denial. Any request for reconsideration should include documents or records in support of your appeal. VSP will provide a written response to the appeal within 30 days after it is received. Any request to VSP should be sent to the following address:

Vision Service Plan
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670

Once you have exhausted VSP's appeals process, you may file a voluntary appeal with the Plan's Board of Trustees.

If You Have Other Vision Coverage

Make sure you notify your vision provider if you have other vision coverage. If you don't tell the provider about other coverage, VSP will be unable to coordinate benefits, and this could result in a delay in the processing of your claim. For more information on Coordination of Benefits, please see the Coordination of Benefits Chapter of this document.

Chapter 8: Employee & Dependent Life Insurance

In this chapter you'll find
- Active Employee life insurance
- Death benefit during Total Disability
- Conversion Privilege
- Dependent life insurance

The Fund has contracted with Pacific Guardian Life Insurance Company (PGL) to provide Active Employee and Dependent life insurance benefits. PGL is solely financially responsible for paying life insurance benefit and has the sole and exclusive discretion to determine benefits and interpret the terms of the group policy and certificate of coverage governing this benefit.

This section outlines the fully insured Life Insurance coverage; however, where this chapter deviates from the certificate of coverage produced by PGL, the insurance company documents will prevail. Contact the insurance company at the number provided in the Contacts Chart in the front of this document for a copy of insurance certificate and complete life insurance benefit information.

New Hires and Retired Employees are not eligible for Life Insurance Benefits.

EMPLOYEE LIFE INSURANCE

When an insured Active Employee dies, PGL will pay a benefit in the amount of $50,000 term group life insurance. This benefit will be paid in a lump sum as provided by the master Policy, to the named beneficiary. In no event will payment with respect to any one insured Active Employee be made under more than one of the following sections of the Master Policy:

- Employee Life Insurance – Death Benefit
- Employee Life Insurance – Death Benefit Continued During Total Disability
- Employee Life Insurance – Conversion Privilege

A death benefit will be paid if an Active Employee dies within 31 days after Employee Life Insurance would otherwise have terminated.

Your Beneficiary

Subject to the Assignment provision, an insured Active Employee has the right to name or change his beneficiary. The beneficiary must be a natural person taking in his own right as an individual and not in a fiduciary capacity. At no time may a Contributing Employer or the Fund be a beneficiary.

A beneficiary designation must be made in writing and in a form that is acceptable to PGL. A beneficiary designation will take effect on the date it is signed when it is received by PGL. Any payment made prior to receipt of any beneficiary designation shall fully discharge PGL's obligation for such payment.

When the beneficiary designation does not direct otherwise, the following shall apply:

1. Two or more named beneficiaries will share equally in the proceeds. If one named beneficiary dies before the insured Active Employee, the share such predeceased beneficiary would have received will be paid equally to the remaining beneficiaries.
2. If there is no named beneficiary or no surviving named beneficiary, the proceeds will be paid to:
    - The insured Active Employee's surviving spouse, if any; or
    - If there is no surviving spouse, to the insured Active Employee's surviving children, in equal shares; or
    - If there is no surviving spouse or child, to the insured Active Employee's surviving parents, in equal shares; or
    - If there is no spouse, child or parent, to the insured Active Employee's surviving brothers and sisters, in equal shares; or
    - If none of the above survives to the insured Active Employee's estate.

Any payment made pursuant to this beneficiary provision shall completely discharge PGL from further liability for the amounts paid.

You may request a change of beneficiary at any time by submitting a new beneficiary form to the Fund Office. If you have named an irrevocable beneficiary, the insurance company must first have the written consent of that beneficiary.

A change in beneficiary will take effect as of the date it is signed by you but will not affect any payment the insurance company makes or action it takes before receiving your notice.

Assignment

No Assignment by an Active Employee or beneficiary of any present or future right, interest or benefit shall be recognized by PGL unless:

- The Assignment is made in writing in a form that is prescribed by PGL; and
- The Assignment is an absolute Assignment which transfers all of the rights and interest under the Master Policy, except those of an irrevocably named beneficiary. *Collateral Assignment, by whatever name called, will not be permitted.*

No Assignment will be binding unless and until made with the written consent of the Board of Trustees, and the signed original or duplicate is accepted at PGL's home office. PGL is not responsible for the validity or result of the assignment. Note: No assignment of any right under ERISA or under other applicable law may be made, including the right to request plan documents under ERISA Section 104(b)(4) or to bring a breach of fiduciary duty claim.

Active Employee Certificates

PGL will issue a certificate to the Fund Office for delivery to each insured Active Employee. This certificate will state the essential features of coverage under the Master Policy. The certificate will not alter, amend or modify a liability, right or privilege of PGL as stated in the Master Policy.

DEATH BENEFIT CONTINUED DURING TOTAL DISABILITY

Qualifying for Continued Insurance during Total Disability

This provision applies only to Employee Life Insurance, and does not apply to any other benefit.

Employee Life Insurance for any Active Employee will continue in effect, even without continued payment of premium for such Active Employee, for a maximum period of one year from the date PGL receives satisfactory proof of Total Disability only if:

- The Active Employee ceases to be a member of an eligible class; and
- The Total Disability started while the Active Employee was insured and under age sixty (60); and
- Total Disability has been continuous for not less than nine (9) consecutive months; and
- PGL has certified and approved the Active Employee as being Totally Disabled.

Employee Life Insurance benefits will be continued without premium payment on a year-to-year basis if:

- The Active Employee remains Totally Disabled; and
- Proof acceptable to PGL of such disability is furnished, and such Total Disability is acknowledged and approved by PGL.

Amount of Insurance Continued during Total Disability

The amount of insurance which will be continued under this provision is:

- The amount of insurance in force for such Active Employee on the last day such Active Employee ceased to be a member of an eligible class;
- Subject to the age reduction schedule and termination provisions of the Master Policy that was in effect on the last day of active employment; and
- Further reduced by the amount of any payments of a portion of the basic Life Insurance made prior to the death of the Active Employee.

Notice and Proof of Total Disability

Initial written notice and proof of Total Disability must be received by PGL's home office after the ninth (9^{th}) month but prior to the end of the twelfth (12^{th}) month after the start of continuous Total Disability.

Thereafter, subsequent written proof of Total Disability must be furnished when and as required by PGL. Such proof will not be required to be furnished more often than once each Calendar Year.

Failure to give any notice or proof of Total Disability within the time required will not invalidate the claim if the notice and proof were given as soon as was reasonably possible (reasonableness is to be determined solely by PGL), and in any event, not later than twelve (12) months from the time that:

- The initial written notice and proof of Total Disability was first required as provided above; or
- Subsequent written proof was required.

Death Benefit while Totally Disabled

A death benefit will be paid when an insured Active Employee dies during the continuation of life insurance due to Totally Disability. A death benefit will also be paid if an insured Active Employee dies in the first 12 months before giving written notice and proof of Total Disability if, and only if, such Total Disability:

- Began while the Active Employee was both insured and under age sixty (60); and
- Has been continuous until death.

PGL must receive within 90 days from the date of death:

- Satisfactory written proof that the insured Active Employee met both of the requirements above, and
- Written proof of death.

When Insurance Being Continued Terminates

Termination of the Master Policy will *not* terminate this continued insurance. This continued insurance shall cease on the earliest of the following dates:

- The date the disabled Active Employee ceases to be Totally Disabled; or
- The date the disabled person attains age sixty-five (65); or
- The date the disabled Active Employee fails to give written proof of continued Total Disability within the time required in *Notice and Proof of Total Disability* above; or
- The date the disabled Active Employee dies; or
- The date the disabled Active Employee relocates outside the United States.

Effect of Conversion on Total Disability Continuance

Coverage of a policy issued under the Conversion Privilege for Employee Life Insurance will be in place of this continued insurance. For the Total Disability continued insurance to apply, the conversion policy must be surrendered without claim. In that case, the premium for that policy will be refunded. The beneficiary named in the conversion policy, if different from the last one named under the Master Policy prior to conversion, will be treated as a beneficiary change under the Master Policy.

CONVERSION PRIVILEGE

If your eligibility for Employee Life Insurance terminates, you may convert to an individual life insurance policy. A conversion policy will take effect at the end of the 31 days after termination of Employee Life Insurance, provided that the following has been submitted to PGL within that 31-day period:

- Written application for a conversion policy; and
- The first premium payment.

Upon Termination of Eligibility

An Active Employee may convert all or part of the amount of insurance that ends due to termination of eligibility for coverage. The converted policy cannot exceed the amount of insurance you had on the date of such termination.

Upon Termination of Master Policy

If the Master Policy is terminated, no conversion is allowed unless the Active Employee has been insured under the Master Policy for at least 5 years prior to the termination. The converted policy cannot exceed the smaller of:

- $10,000; or
- All or part of the amount of insurance that ends due to termination of eligibility for coverage. This amount is reduced by any new life insurance amount for which the Active Employee becomes eligible under any other group policy issued within 31 days of termination under the Master Policy.

Type of conversion Policy Available

A conversion policy will:

- Be an individual life insurance policy of any type (except term life insurance or a policy providing benefits in event of total and permanent disability or additional benefits in event of accidental death) then being issued by the Company for the applicable age and for the amount applied for;
- Not include accidental death, disability or other supplementary benefits;
- Be issued without Evidence of Insurability; and
- Not be for an amount less than $1,000.

The premiums for the conversion policy will be determined in accordance with the usual rate for the type and amount of the conversion policy, the person's class of risk, and the person's age at their nearest birthday as of the effective date of the conversion policy.

Effect of a Previously Acquired Conversion Policy

An Active Employee who has converted any part of Employee Life Insurance under this Master Policy, and who again becomes an insured Active Employee at a later date in accordance with the terms of this Master Policy, shall have the amount of Employee Life Insurance reduced on a dollar-for-dollar basis by the amount of the converted benefit in force. This reduction will not apply if:

- The Active Employee meets the Evidence of Insurability requirements for the Employee Life Insurance in force under the Master Policy; or
- The Active Employee surrenders the conversion policy without claim.

DEPENDENT LIFE INSURANCE FOR SPOUSES OF ACTIVE EMPLOYEES

A death benefit will be paid as shown below upon the furnishing of written proof of death acceptable to PGL. The benefit shall be paid to the Active Employee, if living at the time of payment; otherwise, the benefit will be paid to the Active Employee's estate.

"Dependent" means the Active Employee's spouse, if not legally separated or divorced from the Active Employee. A person who is also eligible as an Active Employee for Employee Life Insurance will not be insured for this benefit.

Death Benefit for Spouses of Active Employees

When the spouse of an insured Active Employee dies, PGL will pay a death benefit in the amount of $10,000 term group life insurance.

Death Benefit during the Conversion Period

A death benefit will be paid if a spouse of an Active Employee dies within 31 days after Dependent Life Insurance would otherwise have terminated.

Termination of Dependent Life Insurance

Dependent Life Insurance for any Dependent spouse will terminate at the earliest of any of the following dates:

- Upon termination of all Dependent Life Insurance under the Master Policy;
- The date the Active Employee's life insurance coverage under the Master Policy terminates;
- The date the Dependent spouse ceases to be a Dependent as defined in the Master Policy.

Conversion Privilege

If a spouse's eligibility for Dependent Life Insurance terminates, or upon the death of the Active Employee, a spouse may convert to an individual life insurance policy under the same terms and conditions as described under *Death Benefit for Active Employee*.

Chapter 9: Employee Accidental Death and Dismemberment (AD&D) Benefit

In this chapter you'll find:

- A guide to AD&D benefits and the Table of Losses
- Exclusions from coverage

Like Employee and Dependent life insurance, Employee AD&D benefits are provided through an insurance contract with Pacific Guardian Life Insurance Company. PGL is solely financially responsible for paying AD&D benefit and has the sole and exclusive discretion to determine benefits and interpret the terms of the group policy and certificate of coverage governing this benefit.

This section outlines the fully insured Accidental Death & Dismemberment coverage; however, where this chapter deviates from the certificate of coverage produced by PGL, the insurance company documents will prevail. Contact the insurance company at the number provided in the Contacts Chart in the front of this document for a copy of insurance certificate and complete AD&D benefit information.

New Hires and Retired Employees are not eligible for Accidental Death and Dismemberment Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

Accidental Death and Dismemberment benefits will be paid as shown in the Table of Losses below, if an Active Employee sustains a Covered Loss. Benefits for loss of life are paid as provided for in the beneficiary provision. Benefits for dismemberment will be paid to the insured Active Employee.

A Covered Loss means a loss as provided for in the Table of Losses, which conforms to all of the following requirements:

- The Covered Loss must result directly and solely from an injury and from no other cause. The injury must be caused by an accident, which occurs during the period in which the Active Employee is insured under this Master Policy.
- The Covered Loss must occur within the 90-day period following the date of the accident.
- The Covered Loss must not be listed under *Exclusions*.
- Loss of hands and feet shall mean severance at or above the wrist or ankle join, and loss of sight shall mean total and irrecoverable loss of sight.

Table of Losses

Description of Loss	The Benefit Amount Is
Loss of Life	$50,000
Loss of both hands, both feet or sight of both eyes:	$50,000
Loss of one hand and one foot	$50,000
Loss of one hand or one foot and sight of one eye	$50,000
Loss of one hand or one foot	$25,000
Loss of sight in one eye	$25,000

EXCLUSIONS FROM COVERAGE

A loss which results directly or indirectly from any one or more of the following reasons is not a Covered Loss, even though caused by an accidental bodily injury:

1. Sickness, disease or infirmity of the mind or body, including but not limited to mental or emotional distress
2. Ptomaines or bacterial infection, except pus-forming infections resulting from an Injury not excluded by these Exclusions
3. Medical or surgical treatment, except when it is both for:
   - Treatment of an injury that meets the tests of a Covered Loss; and
   - Treatment performed within (90) days after the injury occurred.
4. Any declared or undeclared insurrection, international armed conflict or conflict involving any armed forces, or act of war
5. Unlawful participation in a riot or other such public disturbance
6. An assault or felony or attempt to commit an assault or felony
7. Intentionally self-inflicted injury, whether or not the Covered Loss was intended
8. Suicide or attempted suicide whether, in either case, sane or insane
9. Riding in or ascending to or descending from any kind of aircraft:
   - As a passenger on any kind of aircraft operated by or for any armed forces; or
   - As a pilot or crewmember in any kind of aircraft. A crew member is anyone who has duties at any time on any flight involving either the flight or the aircraft; or
   - As a participant in aviation training; or
   - As a participant in a sporting event or hobby.
10. Voluntarily or involuntarily taking any drug or poison or inhaling gas that is not prescribed by a Physician
11. Intentionally taking any drug that is not prescribed by a Physician
12. Being under the influence of alcohol as defined by the law of the state where the loss occurs

13. Participation in hazardous activities such as skydiving, motor racing, hang-gliding, skydiving, scuba, skin or deep sea diving, dirt bike racing, mountain climbing, using off-road vehicles, or bungee jumping
14. Driving or riding in any speed contest or race of the testing of any land or water motor vehicle on any race track, speedway or testing area, including joyriding and/or street racing
15. An accident occurring while serving on full-time active duty of more than thirty (30) days in any Armed Forces

Chapter 10: Weekly Sickness and Accident Benefit for Active Employees

In this chapter you'll find:

- The Weekly Benefit Payable
- Exclusions
- Temporary Disability Benefits for Active Employees

Like Employee and Dependent life insurance and Employee AD&D benefits, Weekly Sickness and Accident Benefits are provided through an insurance contract with Pacific Guardian Life Insurance Company. PGL is solely financially responsible for paying Weekly Sickness and Accident Benefits and has the sole and exclusive discretion to determine benefits and interpret the terms of the group policy and certificate of coverage governing this benefit. Temporary Disability Benefits are self-funded through the Trust Fund.

This section outlines the fully insured Weekly Sickness and Accident coverage; however, where this chapter deviates from the certificate of coverage produced by PGL, the insurance company documents will prevail. Contact the insurance company at the number provided in the Contacts Chart in the front of this document for a copy of insurance certificate and complete Weekly Sickness and Accident benefit information.

New Hires and Retired Employees are not eligible for Weekly Sickness and Accident benefits.

WEEKLY BENEFIT PAYABLE

Benefits are payable when an Active Employee becomes continuously Totally Disabled and is prevented from performing any and every duty of his occupation, requiring the regular attendance of a Physician. Total Disability, for purposes of this chapter, is defined as the total inability of an employee to perform the duties of his/her employment caused by sickness, pregnancy, termination of pregnancy, or accident other than a work injury.

Benefits begin with the eighth (8^{th}) consecutive day of Total Disability due to Injury or Sickness, and are payable for a maximum of 52 weeks for any one period of disability. If you are disabled on the effective date of your eligibility, you will not become insured until you are actively at work or available for work.

The weekly benefit is based on the lesser of 70% of basic weekly earnings or the maximum weekly amount determined by the State of Hawaii.

In no event shall benefits be payable for longer than fifty-two (52) weeks for any single period of disability.

Successive periods of disability, due to the same or related causes, will be considered one period of disability unless they are separated by at least two consecutive weeks of active work or availability for work. Successive periods of disability due to entirely unrelated causes will be considered as separate periods of disability.

Weekly Sickness and Accident benefits will cease effective when an Active Employee is awarded Social Security Disability, or applies for and begins receiving a Regular, Service, Early Retirement, or Disability Pension from the Pension Fund.

EXCLUSIONS

No Weekly Sickness and Accident benefits shall be paid for any loss resulting from:

- Any period of disability during which you are not under the care of a Physician; or
- Insurrection or war, declared or undeclared, or any act incident thereto, or participation in a riot; or
- A disability which begins before you become eligible.

TEMPORARY DISABILITY BENEFIT FOR ACTIVE EMPLOYEES

Active Employees for whom contributions are made to the Fund but who have not yet met the Fund's eligibility rules will be covered for the State Temporary Disability Insurance of 58% of average weekly wage, up to the current weekly maximum prescribed by law. Benefits begin with the eighth day of disability and are payable for a maximum of 26 weeks in a benefit year for all disabilities.

In order to be eligible for this benefit, the following requirements must be met:

- The Active Employee must have worked within two weeks of the first date of Total Disability; and
- The Active Employee must have been employed at least 14 weeks during each of which they were paid 20 hours or more and earned wages of a least $400, during the fifty-two (52) weeks immediately preceding the first day of disability.

If you have any questions about this benefit, contact the Fund Office at the number provided in the Contracts Chart at the front of this document for more information.

Chapter 11: Claims and Appeals Procedures

This chapter includes:
- Claims procedures
- Internal appeals procedures
- External Review

CLAIMS PROCEDURES

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures, which are described in this section. These procedures for filing claims for benefits from the PAMCAH-UA Local 675 Health and Welfare Fund (Plan) cover all self-funded hospital-medical, prescription drug, dental, and vision claims. Procedures will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim or a Post-Service Claim (defined below).

Appropriate Claims Administrator: The various organizations under contract to the Fund to perform claims adjudication services to administer health claims and/or claim appeals are known as Claims Administrators. "Claims Adjudication" refers to the determination of the Plan's payment or financial responsibility, after the plan participant's benefits are applied to a claim.

Claims are adjudicated by several different claims administrators depending on which type of benefit is being sought. The organizations that administer each type of health claim (the Appropriate Claims Administrator) are outlined in the chart below and have the discretion to determine benefits and interpret the terms of the Plan that governs the applicable benefit. (For contact information for each claims administrator, see the Contacts Chart in the front of this document.)

Appropriate Claims Administrator	Types of Claims Processed
Fund Office	• Eligibility Claims • Temporary Disability Benefits Claims
HMSA	• Medical post-services claims • Medical Urgent, Concurrent and Pre-service claims • Medical claim appeals • Hemophilia medication claims and appeals
OptumRx	• Pre-service drugs (drugs requiring pre-approval) as described in Chapter 5 • Post-service claims for out-of-network retail drugs as noted in Chapter 5 • Drug claim appeals • Drug claim external review
Hawaii Dental Service	• Dental claims and appeals
VSP	• Vision claims and appeals
Pacific Guardian Life Insurance Company (Insured)	• Life Insurance Claims and Appeals • Accidental Death and Dismemberment Claims and Appeals • Weekly Sickness and Accident Claims and Appeals

Appropriate Claims Administrator	Types of Claims Processed
The Board of Trustees	• Appeals of Eligibility claims • Appeals of Temporary Disability Benefits Claims • Voluntary Second-Level Appeals of claims

Eligibility Disputes

If your claim is denied because you are not shown as eligible on the records of the Fund office, your eligibility status will be resolved by the Fund office, working with the medical, prescription drug, dental, vision claims administrator or life insurance company as necessary, in accordance with the procedures and time lines prescribed below for Post-Service claims.

Medical Claims and Appeals

All medical claims (whether pre-service, urgent, concurrent, or post-service) should be filed directly with HMSA. The procedures for filing medical claims and appeals are described in the Guide to Benefits you receive from HMSA, in accordance with the procedures and timelines prescribed below. Medical benefit claim second-level appeals should be filed with the Fund Office for final determination by the Board of Trustees.

Prescription Drug Claims and Appeals

All prescription drug claims and appeals (whether pre-service, urgent, concurrent, or post-service) should be filed directly with OptumRx, in accordance with the procedures and timelines prescribed below. If applicable, requests for external review should also be filed directly with OptumRx. Prescription drug claim second-level appeals should be filed with the Fund Office for final determination by the Board of Trustees.

Dental and Vision Claims

All dental claims should be filed directly with Hawaii Dental Service. The procedures for filing dental claims and appeals are described in the Evidence of Coverage you receive from Hawaii Dental Service.

Vision service claims will be filed by your provider directly to Vision Service Plan (VSP) if you use a network provider. If you do not use a network provider, you are responsible for filing a claim with VSP to receive reimbursement. The procedures for filing out-of-network claims and vision claim appeals are described in the Evidence of Coverage you receive from VSP.

Life Insurance, Disability and AD&D

Life Insurance, Accidental Death & Dismemberment (AD&D), Dependent Life Insurance, Weekly Sickness and Accident claims should be filed with Pacific Guardian Life Insurance Company (PGL) with written proof of death or disability. The procedures for filing claims or appeals for life insurance, Accidental Death & Dismemberment (AD&D) or Weekly Sickness and Accident benefits are described in the Evidence of Coverage or Contract you receive from PGL. You should contact PGL directly if you have any questions about your claim.

Temporary Disability Benefits Claims and Appeals

All temporary disability benefit claims and appeals should be filed with the Fund Office. The procedures and timelines for filing temporary disability claims and appeals are described in the below under Disability Claims and Appeals.

Types of Claims

The term "Claim" means a request for a benefit made by an eligible individual (referred to as a "Claimant") in accordance with the Plan's reasonable procedures. There are four types of claims applicable to the benefits described in this booklet.

Pre-service Claim: A pre-service claim is a claim for a benefit for which the Plan requires prior approval (precertification) (in whole or in part) from the plan before medical care or outpatient prescription drug services are obtained in order to receive the maximum benefits provided by the Plan.

The list of procedures requiring precertification are provided in Chapter 4.

Generally, a determination on a pre-service claim will be made within 15 days of receipt of a properly filed claim. The plan may request one 15-day extension. All pre-service claims must include at a minimum:

- Your name;
- Your specific medical condition or symptom; and
- A specific treatment, service or product for which precertification is requested in order for the medical plan to respond.

Urgent Claim: Claims involving Urgent Care must be submitted to HMSA by fax at (808) 952-7546. They are **not** to be submitted via the US Postal Service.

> **Note:** Urgent Care Claims procedures do not apply to emergency care. If you experience a medical emergency, such as acute onset of chest pain, major trauma, or sudden shortness of breath, you should go to the nearest hospital emergency room. **The charges for these services will be submitted as Post-service claims.**

Any claim that a Health Care Provider with knowledge of your medical condition determines in his/her opinion:

- Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or
- Would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

shall be treated as an Urgent Care Claim.

The medical plan will respond to your doctor with a determination as soon as possible taking into account the medical circumstances, but not later than 72 hours after receipt of a properly filed claim by the medical plan. Urgent claims must include at a minimum:

- Your name
- Your specific medical condition or symptom; and
- A specific treatment, service or product for which approval is requested in order for the medical plan to respond.

Concurrent Care Claim: A concurrent care claim is a claim that is reconsidered by the medical plan after an initial approval was made and results in a reduction or termination of a benefit. The medical plan will notify you early enough to allow you to have an appeal decided before the benefit is reduced or terminated. If you are requesting an *extension* of approved Urgent Care treatment that is in progress, the medical plan will respond within 24 hours of receipt of your claim.

Post-service Claim: Claims for services that have already been provided will be considered to have been filed as soon as they are received by the medical plan (however, the plan will not consider claims submitted more than 12 months after the date of service). Contract Hospitals, pharmacies, and other providers will file your claim directly to the medical plan. All other claims should be filed with the medical plan. If treatment is due to accident, you may be required to sign a Third Party Liability Agreement to reimburse the Plan if you recover damages. You must provide information on other insurance coverage, if any. Ordinarily, the medical plan will process your Post-service claim within 30 days from receipt of the claim. You will be notified before the 30 days expire if the plan requires an extension of time (up to 15 days) to render a decision. A claim regarding a rescission of coverage will be treated as a post-service claim.

Disability Claim: A disability claim is a claim for benefits under the Plan to which the Plan conditions the availability of the benefit on proof of a claimant's disability. A claim regarding rescission of disability coverage will be treated as a disability claim.

Other Definitions

Independent Review Organization or IRO means a private accredited entity that conducts independent external review of Adverse Benefit Determinations in accordance with the Plan's external review provisions and current federal external review regulations. The Plan contracts with, and rotates cases between, at least three IROs.

Relevant Documents include documents pertaining to a claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations, or constitute the Plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan's rules were appropriately applied to a claim.

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions. The Plan is permitted to rescind coverage of an Eligible Individual if he/she performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

What is Not a Claim

The following are **not** considered claims and are thus not subject to the requirements and timelines described in this section:

- Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a claim. However, if a Claimant files a claim for specific benefits and the claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a claim.
- A request for precertification of a benefit that does not require precertification by the Plan as a condition for receiving maximum benefits is not considered a claim.
- A prescription you present to a pharmacy to be filled to the extent benefits are determined based on cost and coverage rules predetermined by the Plan is not considered a claim. (However, if a pharmacy, Physician or hospital declines to render services or refuses to fill a prescription unless you pay the entire cost, you should submit a post-service claim for the services or prescription.

Using an Authorized Representative

An Authorized Representative, such as a spouse or adult child, may submit a claim or appeal on your behalf if you have designated the individual to act on your behalf in writing on a form available at the Fund Office. The Fund Office may request additional information to verify that the person is authorized to act on your behalf.

For an urgent care claim, a health care professional with knowledge of your medical condition may act as an authorized representative without your having to designate in writing that the health care professional is your authorized representative.

How To File a Post-Service Claim for Benefits Under This Plan

A claim for post-service benefits is a request for Plan benefits (that is not a pre-service claim) made by you or your authorized representative, in accordance with the Plan's claims procedures, described in this chapter. See also the "Key Definitions" section of this chapter for a definition of a "claim" and the information on what is and is not considered a claim.

Plan benefits for post-service claims are considered for payment upon receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim or bill usually contains the necessary proof of claim but sometimes additional information or records may be required. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim. Generally, network Health Care Providers send their bill directly to the Plan.

Generally, Plan benefits for a network provider, Hospital or Health Care Facility will be paid directly to the provider or facility; however, the fact that the Plan may pay benefits directly to a provider does not give such provider "Beneficiary" status under ERISA. For eligible claims, the Plan pays its portion of the billed services and you, the covered person, are responsible to pay your portion of the claim to the provider. When deductibles, coinsurance or copayments apply, you are responsible for paying your share of these charges.

Often, when health care services are provided through the network Health Care Facility/Provider will usually submit the written proof of claim directly to the Network for repricing or to the Appropriate Claims Administrator. This means that when using network providers there are generally no forms or claims or paperwork to complete. If you pay for non-network health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to the Appropriate Claims Administrator that you or your covered dependent paid some or all of those charges. If non-network benefits are payable to you, they will be paid up to the amount allowed by the Plan for those expenses.

For claims incurred outside the U.S. (foreign claims), in most cases you will have to pay the provider at the time of service. Then at a later date you can submit the foreign claim and your proof of payment to this Plan for consideration of reimbursement in accordance with Plan rules outlined in this document. If the provider located outside the U.S. does not require payment at the time of service, when such claims are determined to be payable by this Plan, payment for covered services will be sent to the plan participant. Foreign claims will be processed like any other non-network claim. The claims administrator will have the claim translated into English and then will determine the daily rate of exchange between the U.S. dollar and the applicable foreign currency (based on the rate of exchange quoted on www.oanda.com on the date when the treatment or services were received). Then payment will be made to you so that you can forward payment to the appropriate provider outside the U.S.. Payment is not made by this Plan to a provider outside the U.S.

Claim Forms: Occasionally a health care provider will send a claim directly to you. In this case you should contact the Appropriate Claims Administrator (defined in this chapter) to find out if they require you to complete a claim form. If a claim form is required, it may be obtained from the Appropriate Claims Administrator whose contact information is listed on the Contacts Chart in this document.

(a) Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."

(b) The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Provider can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:

1) A description of the services or supplies provided.
2) Details of the charges for those services or supplies, including CPT/CDT codes.
3) Diagnosis including ICD or DSM codes.
4) Date(s) the services or supplies were provided.
5) Patient's name, social security or ID number, address and date of birth.
6) Insured's name, social security or ID number, address and date of birth, if different from the patient.
7) Provider's name, address, phone number, professional degree or license, and federal tax identification number.

(c) Please review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the Appropriate Claims Administrator.** This can reduce costs to you and the Plan.

(d) Complete a **separate claim form** for each person for whom Plan benefits are being requested.

(e) If another plan is the primary payer, send a copy of the other plan's **Explanation of Benefits (EOB)** along with the claim you submit to this Plan. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your deductible, if a plan maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, how to appeal a claim, etc.

(f) Mail the claim form and a copy of the provider's actual claim to the Appropriate Claims Administrator.

(g) If at the time you submit your claim, you furnish evidence acceptable to the Plan that you or your covered dependent paid some or all of those charges, Plan benefits for covered services may be able to be paid to you up to the amount allowed by the Plan for those services. In all instances, when deductibles, coinsurance or copayments apply, you are responsible for paying your share of the charges.

The Appropriate Claims Administrator will review your post-service claim no later than **30 calendar days** from the date the claim is received. You will be notified if you did not properly follow the post-service claims process.

(a) This 30-day period may be **extended one time for up to 15 additional calendar days** if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30-day period using a written Notice of Extension.

(b) The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve

those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.

(c) If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed from the date that the Notice was sent to you.

(d) The Appropriate Claims Administrator will then make a claim determination no later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.

(e) **Proof Needed In Order to Process Claims:** When processing claims submitted on behalf of a **Newborn Dependent Child** the Appropriate Claims Administrator must receive confirmation of the child's eligibility for coverage (*e.g*. copy of certified birth certificate for newborn).

1) When processing claims submitted on behalf of a **Dependent Child who is age 26 or older,** the Appropriate Claims Administrator must receive confirmation of the child's eligibility (e.g. disabled adult child verification).

2) If claims are submitted on behalf of a **Dependent child for whom the Plan has not yet received proof of dependent status**, the Appropriate Claims Administrator must receive the proof of eligibility, or confirmation from the Plan Administrator of the child's eligibility for coverage, before the claim can be considered for payment.

3) When processing claims submitted on behalf of a **new Spouse**, the Appropriate Claims Administrator must receive confirmation of the Spouse's eligibility (e.g. copy of marriage certificate).

4) When processing **claims related to an accident** the Appropriate Claims Administrator may need information about the details of the accident in order to consider the claim for payment.

Notice of Decision on a Post-Service Claim

If the post-service claim is approved, you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits.

If the post-service claim is denied in whole or in part, you will be provided with written notice of a denial of a claim. Notice will be sent by the medical, prescription drug, dental or vision plan and will provide:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- Contain a statement that you are entitled to receive, upon request, free access to and copies of documents, records and other information relevant to your claim;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. The required determination may be provided orally and followed with written notification.

If you disagree with a denial of a post-service claim, you or your authorized representative may ask for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review of a medical claim denial, and 180 calendar days following receipt of a denial to request an appeal review of any other type of benefit claim denial. The Plan will not accept appeals filed after this 180 calendar day period.

How to File a Disability Claim

A claim for disability benefits is a request for disability plan benefits made by you or your authorized representative (as defined in this chapter) in accordance with the Plan's disability claims procedures, described below in this chapter. See also the "Types of Claims" section of this chapter for a definition of a "disability claim" and the information on what is and is not considered a claim.

In the case of disability benefit claim determinations and claim appeals, the Plan will take steps to ensure that claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits. Medical and vocational experts will be selected based on their professional qualifications.

Please note: The below claims procedures apply to the self-funded benefits and eligibility for benefits of the Fund. Claims for any fully insured benefits must be filed according to the procedures provided in the Evidence of Coverage or Contract of Insurance you received from the Insurer.

1. Obtain a disability claim form from the Appropriate Claim Administrator. Complete the patient portion of the form. Then give the form to your physician to complete the health care provider section of the form. Return the completed disability claim form to the Fund Office. **Disability claims will be determined no later than 45 calendar days after receipt of the claim for disability benefits by the Appropriate Claims Administrator.**
2. **All disability claims must be submitted to the Plan within 90 days from the date of onset of the disability. No Plan benefits will be paid for any claim submitted after this period.**
3. You will be notified if you did not follow the disability claim process or if you need to submit additional medical information or records to prove a disability claim and provided 45 calendar days in which to obtain this additional information.
   (a) Proof of disability must be provided to the Plan no later than 90 calendar days after the end of the period for which disability benefits are payable. If you do not provide proof of disability within the time specified, you can still claim full benefits if you can show that proof was furnished as soon as reasonably possible.

(b) The Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending or payable.

4. The Appropriate Claims Administrator determines if employees are eligible to receive disability benefits under this Plan. The Plan will review your disability claim and notify you or your authorized representative in writing (or electronically, as applicable) no later than 45 calendar days from the date the Fund Office receives the claim.
   (a) This 45-day period may be **extended for up to 30 calendar days** provided the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period, that additional time is needed to process the claim, the special circumstances for this extension and the date by which it expects to render its determination.
   (b) If, prior to the end of this first 30-day extension, the Appropriate Claims Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.
   (c) A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. **If the Appropriate Claims Administrator needs additional information from you to make its decision**, you will have at least 45 calendar days to submit the additional information. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed from the date that the Notice was sent to you.)

5. Disability benefits begin when the claim for disability benefits has been determined to meet the definition of total disability under this Plan and it is determined that Plan disability exclusions do not apply to the claim.

6. **If the claim for disability benefits is approved**, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.

7. **If the claim for disability benefits is denied** in whole or in part, a notice of this initial denial (an Adverse Benefit Determination) will be provided to the employee in writing (or electronically, as applicable). This notice of initial denial will:
   (a) give the specific reason(s) for the denial of disability benefits (including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the plan);
   (b) reference the specific Plan provision(s) on which the determination is based;
   (c) contain a statement that you are entitled to receive upon request, free access to and copies of documents, records and other information relevant to your claim;
   (d) describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   (e) provide an explanation of the Plan's appeal procedure along with time limits;

(f) contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;

(g) describe any applicable contractual limitation periods on benefit disputes (such as the Plan's time limit on when a lawsuit may be filed following an appeal);

(h) if the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request; and

(i) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

(j) Contain a statement that is a Participant is not proficient in English and has questions about a claim denial, they should contact the Appropriate Claims Administrator (see the Contacts Chart) to find out if assistance is available.

8. **If you disagree with a denial of a disability claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

INTERNAL APPEALS PROCEDURES

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. This Plan maintains a 2 level appeals process. Appeals must be submitted in writing to the Appropriate Claims Administrator for the first level of appeal review and to the Board of Trustees for the second level appeal review, both of whom have their contact information listed on the Contacts Chart in this document. Life/AD&D/Weekly Sickness and Accident benefit claims must be appealed directly to the insurance company in accordance with the rules described in their brochures.

First Level Appeals involving an adverse determination of a hospital-medical Urgent Care Claim should be made by calling HMSA.

First Level Appeals for non-Urgent Care hospital-medical claims should be made by submitting a written request to HMSA.

First Level Appeals for non-Urgent Care prescription drug claims should be made by submitting a written request to OptumRx

First Level Appeals of Eligibility Claims or Disability Claims, and Second Level Appeals of any Claim, should be made by submitting a written request to the Fund Office for review by the Board of Trustees. Contact information is listed on the Contacts Chart in this document.

Your request for review of a denied claim must meet the following criteria:

- Be in writing;
- State the reason(s) for disputing the denial;
- Be accompanied by any pertinent material not already furnished; and
- Be submitted within 180 days after you receive notice of denial.

Failure to file an appeal that meets all of these criteria will constitute a waiver of your right to a review of the denial of your Claim.

Review Process

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon), it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of plan policy regarding the denied treatment or service.

You will be provided with the opportunity to submit written comments, documents, records and other information relating to the claim for benefits; and a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination.

You will be provided a review that does not afford deference to the initial determination, and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial determination that is the subject of the appeal, nor the subordinate of such individual.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person at the medical plan will review your claim than the one who originally denied the claim and who is not the subordinate of such individual. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied in whole or in part on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Investigational or Experimental), the appropriate named fiduciary will consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

Review Process for Disability Claim Appeals, Post-Service Claim Appeals

In addition to the process outlined above, the Plan will provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

Timing of Notice of Decision on Appeal

For First Level Appeals filed with an Appropriate Claims Administrator that is not the Board of Trustees, please refer to that Appropriate Claims Administrator's Evidence of Coverage or Contract documents for an explanation of that Appropriate Claims Administrator's Appeals procedures and timeframes for rendering a decision.

For First Level Appeals of Adverse Benefit Determinations regarding Eligibility or Disability, the Plan will make an appeal determination according to the following timeframes:

(a) **If an appeal is filed with the Plan more than 30 days before the next Board meeting**, the review will occur at the next Board meeting date.

(b) **If an appeal is filed with the Plan within 30 days of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.

(c) If special circumstances (such as the need to hold a hearing) require a further extension of time, the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.

Administrative procedures will not be deemed to be exhausted if the plan's violation was de minimis and did not cause, and is not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information with the claimant. However, this exception is not available if the violation is part of a pattern or practice of violations. The plan must provide a written explanation of the violation with 10 days or receipt of a request.

Notice of Decision on Appeal

The decision on any review of your claim will be given to you in writing. **If the claim review on appeal is denied** in whole or in part you will be provided with written notice of decision on appeal at each level of the appeal review. Notice will provide:

- Information sufficient to identify the claim involved;
- A statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a second level appeal or external review (when external review is available);
- The specific reason(s) for the determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request (automatically for a disability appeal) and free of charge;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;

- For first-level appeals: an explanation of the Plan's voluntary second level appeals process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- If the determination was based on medical necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.
- The statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- Disclosure of the availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).
- A discussion of the decision, including the basis for disagreeing with or not following:
  a) The view of a treating physician or vocational professional who evaluated the claimant;
  b) The views of medical or vocational experts obtained by the plan, and
  c) Any disability determination by the Social Security Administration.
- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;
- Any plan internal rules, guidelines, protocols, standards or other similar criteria that were used in denying the claim or a statement that such internal rules do not exist;
- A statement when the claim is denied that the claimant is entitled to receive relevant documents upon request; and to respond to new information by presenting written evidence and testimony.
- A statement that if a Participant is not proficient in English and has questions about a claim denial, they should contact the Fund Office to find out if assistance is available.

Additional Voluntary Appeals to the Board of Trustees

If still dissatisfied with the First Level Appeal determination you will have 180 calendar days under this Plan from receipt of the first Notice of Decision on Appeal to request a Second Level Appeal review by submitting a voluntary appeal in writing to the Board of Trustees of the Fund. The Board of Trustees will consider any additional information you provide with your appeal and will not give deference to the initial adverse determination. The decision on the Second Level Appeal involving will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received in the Fund office within 30 days of the next regularly scheduled meeting, your request for review may be considered at the

second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached by the Board of Trustees, you will be notified by the Fund office of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Outline of Timeframes for Initial Claim Decision and Claim Appeal Process

Overview of Claims and Appeals Timeframes					
	Urgent	**Concurrent**	**Pre-service**	**Post-service**	**Disability**
Plan must make an **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days	45 days
Extension permitted during initial benefit determination?	No[1]	No	Yes, one 15-day extension.	Yes, one 15-day extension.	Yes, up to 2 extensions each 30 days in duration.
First (initial) Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days	180 days
Plan must make an **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days for each appeal level	30 days for the first level and at the Board meeting for level 2.	Within the timeframe for Board meetings
Second Appeal Request must be submitted to the Plan within:	NA	NA	180 days	180 days	NA
Extension permitted during appeal review?	No	No	No	No	Yes

Post-service and Disability Appeal Timeframes for Multiemployer Plan with Committee or Boards of Trustees that meet at least Quarterly		
Appeal filed **within 30 days** of the next Board meeting:	Board review occurs no later than the second meeting following receipt of the appeal.	If special circumstances require an extension of time, Board review can occur at the third meeting following receipt of the appeal.
Appeal filed **more than 30 days** before next Board meeting:	Board review occurs at the next Board meeting date.	If special circumstances require an extension of time, Board review can occur at the second meeting following receipt of the appeal.
Board's decision on the appeal to be provided to claimant as soon as possible after the Board decision but no later than 5 days after the Board's decision date.		

EXTERNAL REVIEW

After the internal claims and appeals process has been exhausted, and after receipt of an adverse benefit determination on review, external review may be available for certain claims. The adverse benefit determination on review will provide the procedures for external review.

This voluntary External Review process is intended to comply with the Affordable Care Act (ACA) external review requirements. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

External Review is only applicable in certain cases. You may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied and it fits within the following parameters:

(a) The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment.

(b) The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this external review process does not pertain to claims for life/death benefits, AD&D, disability, the Dental benefits, or the Vision benefits. There are two types of External Claims: Standard (Non-Urgent) Claims and Expedited Urgent Care Claims.

External Review of Standard (Non-Urgent) Claims.

You may submit a request for external review within four months after the date of receipt of the notice of final adverse benefit determination (first level of appea). An external review request on a standard claim should be made to the following appropriate **Plan designee**:

1) HMSA, with respect to a denied Post-Service, Urgent, Pre-service or Concurrent review determination on a medical claim not involving prescription drug expenses retail or mail order prescription drug expenses;

2) OptumRx, with respect to a denied claim involving outpatient retail or mail order prescription drug expenses;

3) The Fund Office, with respect to an eligibility claim regarding a rescission of coverage;

If the claim is not eligible for external review, the appropriate Plan designee will notify you of this determination, including the reason the claim has been determined ineligible. If the request is incomplete, the appropriate Plan designee will notify you of the specific information needed to make the request complete, and you will have the opportunity to provide the needed information within the four month filing period or 48 hours of receiving the notification, whichever is later.

If the claim is determined to be eligible for external review, the appropriate Plan designee will provide the claim information to an Independent Review Organization (IRO). The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions

reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

The IRO will convey a final decision to the Plan and the claimant within 45 days for standard reviews and within 72 hours for expedited reviews. Expedited reviews are permitted when standard review timeframes would seriously jeopardize the life or health of the member. The IRO's decision will be binding, except to the extent that other remedies may be available by law (including judicial review).

The assigned IRO's decision notice will contain:

a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

b) The date that the IRO received the request to conduct the external review and the date of the IRO decision;

c) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

d) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

e) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

f) A statement that judicial review may be available to you; and

g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes

Overview of Timeframes for External Review Process

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Claimant requests an external review (*generally after internal claim appeals procedures have been exhausted*)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice)	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Appropriate Plan designee performs preliminary review	Within 5 business days following the appropriate Plan designee's receipt of an external review request	Immediately
Appropriate Plan designee's notice to claimant regarding the results of the preliminary review	Within 1 business day after the appropriate Plan designee's completion of the preliminary review	Immediately
When appropriate, claimant's timeframe for perfecting an incomplete external review request	Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete	Expeditiously
Appropriate Plan designee assigns case to IRO	In a timely manner	Expeditiously
Notice by IRO to claimant that case has been accepted for review along with the timeframe for submission of any additional information	In a timely manner	Expeditiously
Time period for the appropriate Plan designee to provide the IRO documents and information the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expeditiously
Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days)	Expeditiously
IRO forwards to the Plan any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expeditiously
If (on account of the new information) the Plan reverses it's denial and provides coverage, a Notice is provided to claimant and IRO	Within 1 business day of the Plan's decision	Expeditiously

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
External Review decision by IRO to claimant and Plan	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Plan.)
Upon Notice from the IRO that it has reversed the Plan's Adverse Benefit Determination	Plan must immediately provide coverage or payment for the claim	Plan must immediately provide coverage or payment for the claim

Limitation on When a Lawsuit may be Started

The denial of a claim to which the right to review has been waived, or the decision of the Board (or the medical plan acting for the Board) with respect to a petition for review, is final and binding upon all parties including the Claimant or the petitioner, subject only to any civil action you may bring under ERISA. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or right to arbitration.

You or any other Claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's claim appeal review procedures described in this document) for every issue deemed relevant by the Claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision, but not later than one year after the decision of the final internal level of appeal is issued.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Board of Trustees or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the Health Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. The

Plan, Plan Administrator, Claims Administrators nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

Chapter 12: Other Important Plan Information

This chapter includes:
- Coordination of benefits with other plans
- Worker's Compensation
- Third party liability
- General Plan Information
- Information required by ERISA

COORDINATION OF BENEFITS (COB) WITH OTHER PLANS

How Duplicate Coverage Occurs

This chapter describes the circumstances when you or your covered Dependents may be entitled to health care benefits under the self-funded portion of this Plan and may also be entitled to recover all or part of your health care expenses from some other source. In this chapter the term "you" references all covered Plan Participants. In many of those cases, either this Plan or the other source (the primary plan or program) pays benefits or provides services first, and the other (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered Dependent is also covered by:

- Another group health care plan (including but not limited to a plan which provides the Covered Individual with COBRA Continuation Coverage); or
- Medicare; or
- Other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, motor vehicle including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency; or
- Workers' compensation.

Duplicate recovery of health care expenses can also occur if there is any other coverage for your health care expenses including third party liability.

This chapter describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

In some instances, this Plan will not provide coverage if you can recover from another source. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party (see also the subrogation provisions in this chapter). Duplicate recovery of health care

expenses may also occur if a third party caused the injury or illness by negligent or intentionally wrongful action.

Coverage Under More than One Group Health Plan

When and How Coordination of Benefits (COB) Applies

1. For the purposes of this Coordination of Benefits chapter, the word "plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the Covered Individual or that provides health care services to the Covered Individual. A "group plan" provides its benefits or services to Employees, Retirees or members of a group who are eligible for and have elected coverage (including but not limited to a plan that provides the Covered Individual with COBRA Continuation Coverage).
2. Many families have family members covered by more than one medical or dental plan. If this is the case with your family, you must let this Plan and its insurers know about all medical and dental plan coverages when you submit a claim.
3. Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the health care expenses incurred. Sometimes, the combined benefits that are paid will be less than the total expenses.

Coordination of Benefits if Your Spouse Works

If a spouse is offered the opportunity to enroll in another group plan sponsored by the spouse's employer and elects not to enroll, the spouse will lose all Plan benefits/coverages for three months. In order to become eligible for benefits again, the Employee must re-register the spouse as an eligible dependent by submitting the required forms/documentation under the rules of the Plan.

The following provisions will apply when a spouse enrolls in medical and drug coverages (primary) in his or her employer's group plan:

1. The spouse will receive secondary coverage for medical and drug benefits from the Plan.
2. This Plan will continue to provide vision and dental coverages.
3. Eligible Dependent Children will continue to be covered under this Plan.

If a spouse enrolls in his or her employer's Kaiser plan and utilizes medical services outside of Kaiser's network, this plan will only cover 70% of eligible charges of HMSA participating providers and 50% of eligible charges (after deductible) of non-participating providers.

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

- Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. Any group plan that does not use these same rules always pays its benefits first.
- When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan

that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent or Dependent

1. The plan that covers a person other than a Dependent, for example, as an Employee, Retiree, member or subscriber is the primary plan that pays first; and the plan that covers the same person as a Dependent is the secondary plan that pays second.
2. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (that is, the plan covering the person as a retired Employee); then the order of benefits is reversed, so that the plan covering the person as a Dependent pays first; and the plan covering the person other than as a Dependent (that is, as a retired Employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

1. The plan that covers the parent whose Birthday falls earlier in the Calendar Year pays first; and the plan that covers the parent whose Birthday falls later in the Calendar Year pays second (known as the "Birthday Rule"), if:
   - The parents are married;
   - The parents are not separated (whether or not they ever have been married); or
   - A court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.
2. If both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.
3. The word "Birthday" refers only to the month and day in a Calendar Year; not the year in which the person was born.
4. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.
5. If the specific terms of a court decree state that both parents are responsible for the Dependent child's health care expenses or health care coverage, the plan that covers the parent whose Birthday falls earlier in the Calendar Year pays first, and the plan that covers the parent whose Birthday falls later in the Calendar Year pays second.
6. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:
   - The plan of the custodial parent pays first; and
   - The plan of the spouse of the custodial parent pays second; and

- The plan of the non-custodial parent pays third; and
- The plan of the spouse of the non-custodial parent pays last.

7. For a dependent child who has coverage under either or both parents' plans and also has his/her own coverage as a dependent under a spouse's plan, the order of benefits shall be determined, as described in the longer/shorter length of coverage rule, and if length of coverage is the same, then the birthday rule applies between the dependent child's parent's coverage and the dependent spouse's coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to the longer/shorter length of coverage first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent child or the employee-spouse covering the dependent child.

Rule 3: Active/Laid-Off or Retired Employee

1. The plan that covers a person either as an Active Employee (that is, an Employee who is neither laid-off nor retired), or as that Active Employee's Dependent, pays first; and the plan that covers the same person as a laid-off or Retired Employee, or as that laid-off or Retired Employee's Dependent, pays second.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. If a person is covered as a laid-off or Retired Employee under one plan and as a Dependent of an Active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

1. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an Employee, Retiree, member or subscriber (or as that person's Dependent) pays first, and the plan providing continuation coverage to that same person pays second.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. If a person is covered other than as a Dependent (that is, as an Employee, former Employee, Retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a Dependent of an active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

1. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.
2. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
3. The start of a new plan does not include a change:
   - In the amount or scope of a plan's benefits;
   - In the entity that pays, provides or administers the plan; or
   - From one type of plan to another (such as from a single employer plan to a multiple employer plan).

4. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: When No Rule Determines the Primary Plan

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered individual.

How Much this Plan Pays When it is Secondary

Secondary Liability of this Plan: When this Plan pays second, it will pay the same benefits that it would have paid had it paid first, less whatever payments were actually made by the plan (or plans) that paid first. In no case will this Plan pay more in benefits for each claim as it is submitted than it would have paid had it been the Plan that paid first. This has the effect of maintaining this Plan's Deductibles, Coinsurance and exclusions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the health care services.

Benefit Reserve: This Plan does not administer a benefit reserve (also called a benefit bank, credit balance, credit reserve or credit savings) calculation in the Coordination of Benefits.

"Allowable Expense" means a health care service or expense, including Deductibles, Coinsurance or Copayments, which is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room, unless the patient's stay in a private Hospital room is determined (by the Plan Administrator it is designee) to be Medically Necessary.
- If the coordinating plans determine benefits on the basis of an Allowed charge amount, any amount in excess of the highest Allowed Charge is not an allowable expense.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If one coordinating plan determines benefits on the basis of an Allowed charge amount and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans.
- When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Administration of COB

1. To administer COB, the Plan reserves the right to:
   - Exchange information with other plans involved in paying claims;
   - Require that you or your Health Care Provider furnish any necessary information;

- Reimburse any plan that made payments this Plan should have made; and
- Recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.

2. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.
3. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.
4. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the Plan's Allowed charge.
5. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.
6. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Coordination of Benefits with Medicare

IMPORTANT NOTE FOR MEDICARE-ELIGIBLE INDIVIDUALS – Retirees and Dependents of Retirees and Actives as Set Forth Below

Subject to applicable law, your coverage under the PAMCAH Health and Welfare Trust will continue when you become eligible for Medicare; however, Medicare will become the primary payer for your medical expenses and this Plan will pay benefits after Medicare pays its portion of the bill.

Subject to applicable law, benefits that are paid for by this Plan for Medicare-eligible individuals are reduced by the amounts payable under Medicare Parts A (Hospital), and B (Professional services). This reduction will apply even if the Medicare-eligible individual is NOT enrolled in Medicare Part A and B.

1. **Entitlement to Medicare Coverage:** Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (usually after a waiting period).
2. **Medicare Participants May Retain or Cancel Coverage Under This Plan:** If an eligible individual under this Plan becomes covered by Medicare, whether because of end-stage renal

disease (ESRD), disability or age, that individual may either retain or cancel coverage under this Plan. If the eligible individual under this Plan is covered by both this Plan and by Medicare, as long as the eligible Employee remains actively employed, that Employee's medical expense coverage will continue to provide the same benefits and contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If an eligible individual under this Plan is covered by Medicare and an Employee cancels coverage under this Plan, coverage of their spouse and/or Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the COBRA chapter for further information about COBRA Continuation Coverage. If any of the eligible Employee's Dependents are covered by Medicare and the Employee cancels that Dependent's coverage under this Plan, that Dependent will not be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the Employee. Neither this Plan nor the Employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

3. **Coverage Under Medicare and This Plan When Totally Disabled:** If an eligible Employee under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, the eligible Employee will no longer be considered to remain actively employed. As a result, once the Employee becomes entitled to Medicare because of that disability, Medicare pays first and this Plan pays second. Generally, if an eligible Dependent under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that Dependent and Medicare pays second. This Medicare secondary payer rule applies to employers with 100 or more employees.
4. **Coverage Under Medicare and This Plan for End-Stage Renal Disease:** If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

How Much this Plan Pays When it is Secondary to Medicare

1. **When Covered by this Plan and also by Medicare Parts A and B:** When an eligible individual under this Plan is also covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays the same benefits provided for active Employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the Health Care Provider.
2. **When Covered by this Plan and also by a Medicare Advantage Program (formerly called Medicare + Choice or Part C) without prescription drug benefits:** If an individual is covered by both this Plan and a Medicare Advantage program, and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this Plan will not coordinate with the Medicare Advantage plan, meaning that this plan will not pay any expenses that are not otherwise payable by the Medicare Advantage plan.

   Also, if an eligible individual does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, precertification/preauthorization, case management or utilization of In-Network provider requirements, this Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the individual receives.

3. **When Covered by this Plan and the Individual also Enters Into a Medicare Private Contract:** Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners (who have opted out of Medicare), under which the individual agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.
4. **When Covered by this Plan and also by a Medicare Part D Prescription Drug Plan:** If you have dual coverage under both this Plan and Medicare Part D, the following explains how this Plan and Medicare will coordinate that dual coverage:
    - For Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage is primary and this group health plan pays secondary. Note that dual coverage may affect your Out-of-Pocket maximum under your Medicare prescription drug plan.
    - For Medicare eligible Active Employees and individuals no longer actively employed but still receiving benefits based on hours accumulated when they were working and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary.

For more information on Medicare Part D refer to www.medicare.gov or contact the Fund Office.

Coordination with Other Government Programs

1. **Medicaid:** If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.
2. **TRICARE:** If a Dependent is covered by both this Plan and the TRICARE Program that provides health care services to Dependents of active armed services personnel, this Plan pays first and TRICARE pays second. For an Employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by this Plan.
3. **Veterans Affairs/Military Medical Facility Services:** If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are medically necessary and the charges are Allowed Charges.
4. **Motor Vehicle Coverage Required by Law:** If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second.
5. **Indian Health Services (IHS):** If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.
6. **Other Coverage Provided by State or Federal Law:** If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is

provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

WORKER'S COMPENSATION

The Plan will not pay benefits for an illness or injury that is work-related (a Workers' Compensation case) or if you forfeit your rights to Workers' Compensation benefits, or if the illness or injury was caused by another person or party from whom you have or may have a right to recover damages (a personal injury case). The Trustees understand that it takes some time to settle these cases and the Fund Office may pay the amount the Plan would have paid in benefits as an interest-free loan to help you meet some of your medical expenses. To request consideration for this loan, you must fill out, sign, and return to the Fund Office all the papers we needed to guarantee that you will repay it.

For a work-related illness or injury, you may receive this loan if your claim for Workers' Compensation has been denied and you have formally appealed the disputed claim. You must notify the Fund Office of your appeal with the State Department of Labor and Industrial Relations or the appropriate government agency.

For Workers' Compensation or personal injury cases, you agree to promptly repay this loan if and when you receive an award or settlement even if the award or settlement does not specifically include medical expenses. If you do not repay the loan from your settlement, the Plan shall have the right to take legal action to recover the amount the Plan paid for your injury or illness or to withhold the amount from your future benefit payments.

If the Plan paid benefits before learning that you have a right to recover damages or that your illness or injury is work-related, you agree to repay the Plan from any recovery or settlement you receive. These rules also apply to your Dependents on whose behalf you accept the loan.

If You're Injured in a Motor Vehicle Accident

If you or your Dependents are injured in a motor vehicle accident and the injury is covered by no-fault insurance, no-fault benefits will be paid or applied first. In addition, coordination-of-benefits rules will also be used where applicable.

Before this plan's benefits for any injury also covered by no-fault insurance, the Fund Office will list the medical expenses that no-fault covers according to the date on which the expenses were incurred. The Fund Office will add up the no-fault expenses for each day until the day when the no-fault benefit maximum is used up. They will then pay this plan's benefits for covered medical services provided from that day on.

If another person caused the motor vehicle accident and you may recover damages from that person, this Plan will not cover the injury resulting from that accident. However, the Plan may help you by paying the amount you would have received in benefits as an interest-free loan after no-fault insurance benefits have been exhausted as described above and until you receive a settlement. As a member of this Plan, PAMCAH-UA Local 675 Health and Welfare Fund, you agree to fully repay this loan from any recovery or settlement you receive, including recovery from any underinsured or uninsured motorist coverage.

THIRD-PARTY LIABILITY

Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party pays or is liable to pay due to any recovery, whether by settlement, judgment or otherwise. (See the exclusion regarding Expenses for Which a Third Party Is Responsible in the Exclusions chapter), but it will advance payment on account of Plan benefits (hereafter called an "Advance"), subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee and/or a representative, guardian, conservator, or trustee of the Covered Individual, and/or Dependent(s) if and when there is any recovery from any third party. The right of reimbursement will apply:

- Even if the recovery is not sufficient to make the ill or injured Covered Individual whole pursuant to Hawaii law or otherwise; and
- Without any reduction for legal or other expenses incurred by the Covered Individual in connection with the recovery against the third party or that third party's insurer; and without limitation by any equitable defenses that might be asserted by the Covered Individual, including but not limited to the "double recovery rule" or the "common-fund" rule; and
- Regardless of the existence of any Hawaii law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity; and
- Even if the recovery was reduced due to the negligence of the Covered Individual or any other common law defense; and
- To all monies recovered by the Covered Individual regardless of how the amounts are characterized---the Plan's subrogation and reimbursement rights extend to monies recovered for medical and loss of time benefits paid and to monies recovered for other than medical and loss of time benefits paid including, but not limited to, monies recovered for pain and suffering whether some or all of the monies are paid by the third party, the third party's insurer, or the Covered Individual's insurer. This means that the Fund specifically will not recognize any claim by the Covered Individual that monies recovered were insufficient to allow the Covered Individual to be "made whole;"
- For all benefits the Plan has paid to or on behalf of the Covered Individual as of the date the Covered Individual is entitled to recover monies and for all other benefits the Plan pays after the date of recovery to or on behalf of the Covered Individual; and
- The Plan has a first lien on any such recovery without regard to the identity of the property's source or holder at any particular time or whether at any particular time the property exists, is segregated, or the Participant has any rights to it.

Reimbursement and/or Subrogation Agreement

The covered Employee and/or any covered Dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the "Agreement") in a form provided by or on behalf of the Plan. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor Dependent child) or spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an

Agreement, that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights.

Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Dependent(s) each agree:

- To reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party's insurer for the entire amount Advanced; and
- That the Plan has the first right of reimbursement from any judgment or settlement; and
- To do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and
- To not assign the right of recovery to any third party without the prior written consent of the Plan; and
- To notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the Advance, before entering into any settlement Agreement with that third party or third party's insurer based on those acts, or before any distribution of payments made by the third party or the third party's insurer(s); and
- To provide the Plan Administrator with the name and address of legal counsel retained by Covered Individual, to provide said legal counsel with a copy of this Agreement, and to inform the Plan Administrator of all material developments with respect to all claims, actions, or proceedings against the third party; and
- To stipulate on request of the Plan Administrator to the entry of a temporary restraining order or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until such dispute is resolved and the Plan receives all amounts that must be reimbursed.
- To take possession of any property subject to the Plan's lien (including, but not limited to, an equitable lien by contract) in his or her own name, place it in a segregated account within his/her/their control (at least in the amount of lien), and not to alienate it or otherwise take any action so that it is not in his/her/their possession prior to the satisfaction of such lien
- To inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

Subrogation

1. By accepting an Advance, the covered Employee and/or covered Dependent(s) jointly agree that the Plan will be subrogated to the covered Employee and/or covered Dependent's right of recovery from a third party or that third party's insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have been responsible for the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or covered Dependent(s), but only to the extent of the amount of the Advance. The Plan is subrogated in any and all actions against third parties for the portion of all recoveries that the Plan is entitled.
2. Under its subrogation rights, the Plan may, at its discretion:

- Start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Dependent(s), but in doing so, the Plan will not represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or
- Intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent(s) against any third party or third party's insurer concerning the injury or illness that resulted in the Advance.

Application to Any Fund

1. The Plan's right to reimbursement and subrogation shall apply to any fund, account or other asset created:
   - Pursuant to the judgment of any court awarding damages against any third party in favor of the ill or injured Employee and/or Dependent(s) payable by any third party on account of an illness or injury alleged to have been caused by that third party; or
   - As a result of any settlement paid by any third party on account of any claim by or on behalf of the ill or injured Employee and/or Dependent(s).

Lien and Segregation of Recovery

By accepting the Advance the covered Employee and/or covered Dependent agrees to the following:

1. The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment or otherwise, by the covered Employee and/or covered Dependent. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.
2. The Plan holds in a constructive trust that portion of the recovery that is the extent of the Advance. The covered Employee, covered Dependent, and those acting on their behalf, shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the plan is satisfied. The location of the account and the account number must be provided to the Plan.
3. Should the covered Employee, covered Dependent or those acting on their behalf, fail to maintain this segregated account or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed.

Remedies Available to the Plan

In addition to the remedies discussed above, if the covered Employee or covered Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

1. Apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Dependent(s) to the amount not reimbursed; or

2. Obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the covered Employee and/or covered Dependent(s).

GENERAL PLAN INFORMATION

Assignment of Benefits

You may not sell, transfer, or otherwise dispose of benefits payable under the Plan or your right to receive Plan benefits, nor shall such benefits or rights be subject to the claims of creditors or other Claimants. You may, however, direct that benefits be paid directly to a Hospital or other health care provider instead of being paid to you. Note: No assignment of any right under ERISA or under other applicable law may be made, including the right to request plan documents under ERISA Section 104(b)(4) or to bring a breach of fiduciary duty claim.

If your benefits are overpaid or the Fund pays benefits for which you receive reimbursement elsewhere, the Fund may deduct the overpaid or reimbursed amounts from future benefits due you.

Right to Examinations

The Fund has the right and opportunity to require as many examinations as reasonably necessary during the claims process (including an autopsy, unless prohibited by law). Such examinations would be at the Fund's expense.

Right to Freedom from Liability for Payment

There is no liability on the Board or any other individual or entity to provide payments over and beyond the amounts in the Fund collected and available for such purpose. Any benefits provided by the Plan can be paid only to the extent that the Fund has available adequate resources for payment.

No Liability for Provider-Related Loss or Injury

The Fund has no control over any diagnosis, treatment, care, or other services delivered by a health care provider, whether the provider is a Contract Provider or a Non-contract Provider, and disclaims liability for any loss or Injury caused by any provider by reason of negligence, failure to provide treatment, or otherwise.

No Replacement for Workers' Compensation

The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage under Workers' Compensation insurance laws or similar legislation.

INFORMATION REQUIRED BY ERISA

Plan Facts

Name of Plan	PAMCAH-UA Local 675 Health and Welfare Fund
Type of Plan	Employee welfare benefit plan maintained for the purpose of providing medical, prescription drug, dental, vision care, life insurance and accidental death and dismemberment benefits to eligible Employees and their eligible Dependents.

Plan Sponsor	A joint labor-management Board of Trustees: PAMCAH-UA Local 675 Health and Welfare Fund 1109 Bethel Street, Room 403 Honolulu, HI 96813 Telephone: (808) 536-4408 Names and addresses of the Trustees as of the date this booklet was issued are shown later in this section. A complete list of the employers sponsoring the Plan may be obtained by Participants upon written request to the Plan Sponsor, and is available for examination by Plan Participants.
IRS Employer Identification Number (EIN)	99-6009435
Plan Number	501
Plan Year	The date of the end of the Plan year is July 31.
Funding Medium	Benefits are provided from the Fund's assets, which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and are held for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. All self-funded benefits are provided directly through the Fund. Premium payments for insured benefits are paid to insurers from the Trust while benefits are paid pursuant to the terms of the group policy governing such benefit by the applicable insurer.
Source of Contributions	All contributions to the Fund are made by individual employers in accordance with the Labor Management Agreement in force with UA Local Union 675 and other agreements with employer at fixed rates per hour. The Fund's assets and reserves are currently held in trust. The benefits provided by this Plan, while intended to remain in effect indefinitely, can be guaranteed only so long as the parties to the Labor Management Agreement continue to require contributions into the Fund sufficient to underwrite the cost of the benefits. Should contributions cease and the reserves be expended, the Trustees would no longer be obligated to furnish coverage. These are not guaranteed lifetime nor vested benefits.

Plan Administrator	The Board of Trustees PAMCAH-UA Local 675 Health and Welfare Fund 1109 Bethel Street, Room 403 Honolulu, HI 96813 Telephone: (808) 536-4408 Names and addresses of the Trustees as of the date this booklet was issued are shown later in this section. A complete list of the employers sponsoring the Plan may be obtained by Participants upon written request to the Plan Administrator, and is available for examination by Plan Participants.
Agent for Service of Legal Process	The Board of Trustees has been designated as agent for service of legal process. Service of legal process may be made upon the Board of Trustees or a Plan Trustee.
Discretionary Authority of the Board of Trustees	The Board of Trustees is responsible for the operation of the Fund and has full power to interpret the Plan and all Plan documents, agreements, rules and regulations and to decide all questions concerning the Plan. The Board of Trustees has delegated the authority and discretion to determine claims and interpret the applicable terms to the Claims Administrators as set forth in this booklet and to the applicable insurers for insured benefits.

Administration of the Plan

PAMCAH-UA Local 675 Health and Welfare Fund self-funds the Plan's Eligible Medical Expenses, Prescription Drugs, Dental and Vision benefits. Claims for these benefits are administered by independent Claims Administrators. The Funding for the benefits is derived from contributions made by covered Employees. The Plan self-insures (not insured) these benefits.

Independent insurance companies administer the fully insured benefits of this Plan (including Life Insurance, Accidental Death and Dismemberment benefits, Dependent Life Insurance and Weekly Sickness and Accident benefits) and provide payment of claims associated with these benefits. Such insurers are solely financially responsible for the payment of insured benefits.

Board of Trustees

The names and addresses of the Trustees as of the date of this booklet are listed below:

Labor Trustees

Valentino B. Ceria, Co-Chairman
Plumbers and Fitters, UA Local 675
1109 Bethel Street, Lower Level
Honolulu, HI 96813

Employer Trustees

Kent A. Matsuzaki, Co-Chairman
Economy Plumbing & Sheet Metal, Inc.
1029 Ulupono Street
Honolulu, HI 96819

Labor Trustees

Matthew Brady
Plumbers and Fitters, UA Local 675
1109 Bethel Street, Lower Level
Honolulu, HI 96813

Benjamin Panis
Plumbers and Fitters, UA Local 675
1109 Bethel Street, Lower Level
Honolulu, HI 96813

Employer Trustees

Mark K. Suzuki
Commercial Plumbing, Inc.
1820 Colburn Street
Honolulu, HI 96819

Samuel T. Fujikawa
Continental Mechanical of the Pacific
2149 Puuhale Place
Honolulu, HI 96819

Gregg S. Serikaku (Alternate Trustee)
Plumbing & Mechanical Contractors
Association of Hawaii
1088 Bishop Street, Suite 408
Honolulu, HI 96813

Your Rights Under ERISA

As a Participant in the PAMCAH-UA Local 675 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights:

Receive Information About Your Plan and Benefits

You have the right to:

- 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. These documents include 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. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan 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

You also have the right to:

- Continue health care coverage for yourself, your spouse, or your Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided

a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:

- You lose coverage under the plan;
- You become entitled to elect COBRA continuation coverage; or
- Your COBRA continuation coverage ceases.

You may also request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion 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 employee benefit plans. 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 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 it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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 after you have exhausted the Plan's internal claim appeal and external review process. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory.

Alternatively, you may obtain assistance by calling EBSA toll-free at (866) 444-EBSA (3272) or writing to the following address:

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 obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at (866) 444-3272 or contacting the EBSA field office nearest you.

You may also find answers to your plan questions and a list of EBSA field offices at the website of EBSA at www.dol.gov/ebsa.

Fund Consultants

In accordance with prudent management standards, the following professional consultants are retained by the Fund to assist the Board of Trustees and the Fund administrator in the operation of the Fund:

- A Benefit Plan Consultant, who assists the Board of Trustees in technical matters relating to the operations of the Fund, such as the design of benefit programs and eligibility provisions, analysis of emerging loss experience and projections of anticipated benefit costs, preparation of specifications for competitive bids when necessary, etc.
- A Certified Public Accountant, who is responsible for auditing the records of the Fund.
- Legal Counsel, who assist and counsel the Board of Trustees on all legal matters, including interpretations of the many laws and regulations under which the Fund operates.

Authority

Only the Board of Trustees is authorized to interpret the plan of benefits described in this booklet. No employer or local union or any representative of an employer or union is authorized to interpret this Plan on behalf of the Board.

Although the Trustees, Union representatives, and other persons familiar with the Plan may be able to answer certain questions for you, the Plan cannot be bound to any inaccurate information they may give. At the direction of the Board of Trustees, the Fund Office is authorized to give you answers to your questions, but only if you have furnished in writing full and accurate information concerning your situation. If you wish to be certain of your right to any particular benefit, contact the Fund Office and obtain written confirmation of the right with which you are concerned.

Any dispute as to eligibility, type, amount, or duration of benefits or any right or claim to payments from the Fund shall be resolved by the Board or its duly authorized designee in accordance with the Plan Rules and Regulations and the Trust Agreement. Any decisions will be binding on all parties, subject only to such judicial review as may be in harmony with Federal labor law.

Plan Documents

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the Fund Office during regular business hours. Upon written request, copies of these documents will be provided.

The Trustees may make a reasonable charge for the copies. The Fund Office will state the charge for specific documents on request, so you may know the cost before ordering.

Collective Bargaining Agreements

The Plan is maintained pursuant to a Labor Management Agreement. Copies of the Labor Management Agreement as well as the following documents, may be examined at the Fund Office during regular business hours, Monday through Friday, except holidays:

- Trust Agreement
- Labor Management Agreement
- Annual Report Form 5500 filed with the Internal Revenue Service and Department of Labor

You may also obtain copies of the documents by writing for them and paying reasonable costs of duplication. You should find out what the charges will be before requesting copies. If you prefer, you can arrange to examine the report, 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 Administrator at the Fund Office.

A summary of the annual report which gives details of financial information about the Fund's operation is furnished annually to all Participants free of charge. Upon written request, the Fund Office will provide information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the Labor Management Agreement, and the employer's address.

Plan Amendment or Termination

The Board of Trustees reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to Participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

- Amendments to the Plan may be made in writing by the Board of Trustees (or other designated officers) and become effective on the written approval of the Board of Trustees, or on such other date as may be specified in the document amending the Plan.
- The Plan or any coverage under it may be terminated by the Board of Trustees, and new coverages may be added by the Board of Trustees. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan will terminate.

Allocation and Disposition of Assets Upon Termination

In order for the Fund to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by these Plan Rules
- To alter or postpone the method of payment of any benefit
- To amend or rescind any provision of these Plan Rules

In addition, the Trust may be terminated by the Board of Trustees, subject to the terms of the trust agreement. In the event the Plan terminates, the Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan and Trust have been paid; provided that any such distribution will be made only for the benefit of former

Participants and for the purposes set forth in the Plan and the trust agreement. Upon termination of the Plan, the Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Plan and trust.

Statement of the Fund's Rights

- The Fund makes no representation that employment with it represents lifetime security or a guarantee of continued employment. Further, your eligibility or rights to benefits under this Plan should not be interpreted as a guarantee of employment. An individual's employment may be terminated because of:
  - Unsatisfactory job performance;
  - Unsatisfactory attendance;
  - Violation of Fund's rules and policies; or
  - Because an individual's services become excess to the Fund's staffing needs.
- An individual's employment may also be terminated whenever the employer, in its sole judgment, deems that to be in its best interest.
- The Board of Trustees, as Plan Sponsor, intends that the terms of this Plan described in this document, including those relating to coverage and benefits, are legally enforceable, and that each plan is maintained for the exclusive benefit of Participants, as defined by law.
- Any written or oral statement other than a written statement signed by the Chairman of the Board of Trustees that is contrary to the provisions of this subchapter is invalid, and no prospective, active or former Employee or Retiree should rely on any such statement.

Right of Plan to Require a Physical Examination

The Plan reserves the right to have the person, who is totally disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a Physician, to be examined by a Physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this Plan. The cost of such an examination will be paid by the Plan.

Information You and Your Dependents Must Furnish to the Plan (Very Important Information)

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered Dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan. **If you fail to do so, you or your covered Dependents may lose the right to obtain COBRA Continuation Coverage or to continue coverage of a Dependent Child who has a physical or mental disability.**

Submit such information in writing to the Fund Office at the address shown in the Contacts Chart in the front of this document. The information needed and timeframes for submitting such information are outlined below. See also the COBRA chapter for special timeframes applicable to those benefits:

Type of Information Needed	*Date Information is to be Submitted to the Plan*
Change of name or address or the existence of other health care coverage for any Covered Individual.	As soon as possible but not later than 60 days after the change or addition of other coverage.
Marriage, divorce, legal separation, addition of a new Dependent, death of any Covered Individual.	Within 30 days
Covered Dependent (spouse or child) becomes disabled or is no longer disabled.	Within 30 days of the date the person becomes disabled or is no longer disabled.
Covered child ceases to be a Dependent as defined by this Plan (*e.g.* over the limiting age of the Plan,)	Within 60 days of the date the child is no longer considered a Dependent.
Employee receives a determination of disability from the Social Security Administration (SSA) or is no longer disabled according to SSA. Medicare enrollment or disenrollment.	See the COBRA chapter for timeframe.

HIPAA: Use and Disclosure of Protected Health Information

Effective April 14, 2003, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the **PAMCAH-UA Local 675 Health and Welfare Fund** (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

- **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA), life insurance, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you and is also available from the Administrative Office. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.** Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

1. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

    - **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

    - **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

        - Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and Copayments as determined for an individual's claim), and establishing employee contributions for coverage

        - Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), Coordination of Benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing

        - Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review

    - **Health Care Operations** includes, but is not limited to:

        - Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies and quality assessment, patient safety activities;

        - Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions

        - Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 C.F.R. 160.103 for underwriting purposes as set forth in 45 C.F.R. 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities

        - Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs

        - Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers

- Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents

2. **When an Authorization Form is Needed:** Generally the Plan will require that you sign a valid authorization form (available from the Administrative Office) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure of PHI without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.
3. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

   - Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,
   - Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
   - Not use or disclose the information for employment-related actions and decisions,
   - Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).
   - Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
   - Make PHI available to the individual in accordance with the access requirements of HIPAA,
   - Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
   - Make available the information required to provide an accounting of PHI disclosures,
   - Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA,
   - If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible, and
   - Notify you if a breach of your unsecured Protected Health Information (PHI) occurs.

4. **In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained** in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

   - Staff of the Administrative Office involved in administration of the self-funded group health plan benefits

   - Business Associates under contract to the Plan including but not limited to the medical Claims Administrator, preferred provider organization network, utilization management company, COBRA administrator, vision plan network, vision plan claims administrator, dental plan network, dental plan claims administrator.

5. The persons described in section 4 above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer.

6. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

   - Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

   - Ensure that the adequate separation discussed in 4 above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

   - Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

   - Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Chapter 13: Definitions

This chapter includes:

- Definitions of specific terms and words used in this document.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Abbreviated Benefit Coverage: The Member-only coverage provided for New Hires consisting of Medical benefits only; Employees eligible for Abbreviated Benefit Coverage are NOT eligible for outpatient prescription drug, dental, or vision benefits, and their dependents are not eligible for coverage.

Accidental Injury: Injury to a body part as the result of a sudden and unforeseen event caused by an external or extrinsic source, that is not work-related, and that occurred while the Plan Participant was covered under the Plan.

Allowed Charge/Allowed Amount/Allowable Charge: The amount this Plan allows as payment for eligible Medically Necessary medical, dental and vision services or supplies. The Allowed Charge amount is determined by the Plan Administrator or its designee to be the lowest of:

1. With respect to a Contract provider, the negotiated fee/rate set forth in the agreement between the participating Health Care or Dental Care Provider/facility and the network or the Plan; or
2. With respect to a non-contract provider, Allowed Charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by non-network providers. The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this chapter; or
3. For a Contract health care provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-Network claim; or
4. The negotiated discounted amount that a non-contract provider agreed to, reducing the provider's original billed charges to a lower, discounted amount; or
5. The Health Care or Dental Care Provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible

and Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies.

Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual Out-of-Pocket Limit. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan.

Balance Billing: A bill from a health care provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with Balance Billing are not covered by this Plan, even if the Plan's Out-of-Pocket maximum limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Remember, amounts exceeding the Allowed Charge do not count toward the Plan's Out-of-Pocket maximum and may result in Balance Billing to you. Out-of-Network Health Care Providers commonly engage in Balance Billing a Plan Participant for any balance that may be due in addition to the amount payable by the Plan. Typically, In-Network providers do not balance bill except in situations of third party liability claims. Generally, you can avoid Balance Billing by using In-Network providers.

Behavioral Health Disorder: Behavioral Health is an umbrella term that refers to mental health and/or substance abuse/substance use disorder. A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical Plan Exclusions chapter of this document. See also the definition of Substance Abuse.

Board: The Board of Trustees of PAMCAH-UA Local 675 Health and Welfare Fund.

Calendar Year: The 12-month period beginning January 1 and ending December 31. For the Medical program, all annual Deductibles, Out-of-Pocket Maximums and Annual Maximum Plan benefits are determined during the Calendar Year.

Claimant: The Employee or eligible Dependent.

COBRA: Means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and refers to temporary continuation of health care coverage. See the COBRA chapter of this document for more information.

Coinsurance: That portion of Eligible Medical Expenses/ Eligible Charges for which the Covered Individual has financial responsibility to pay. In most instances, the Covered Individual is responsible for paying a fixed percentage of Eligible Charges after the Plan's Deductible has been met. Coinsurance amounts are listed in the Schedule of Medical Benefits.

Contributing Employer or Employer: This means any association, individual, partnership, corporation or entity which employs Employees and is a party to the Labor Management Agreement with the PAMCAH-UA Local 675 Health and Welfare Fund.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits section in Chapter 12.

Copayment or Copay: The fixed amount that you must pay for a service, supply or prescription drug before the Plan pays its share of the cost.

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Board of Trustees or its designee.

Covered Individual: Any Employee and/or Retiree and that person's eligible spouse or Dependent Child (as these terms are defined in the Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan. A Covered Individual is also referred to as a Plan Participant.

Covered Service: A service, supply, treatment or accommodation that is listed in the Covered Services section of the Plan.

Covid-19 Test: Diagnostic tests to detect the virus that are approved, cleared or authorized by the certain sections of the Federal Food, Drug and Cosmetic Act (the Drug Act); tests for which the developer has requested, or intends to request, emergency use authorization under the Drug Act (and where such authorization has not been denied); tests developed in and authorized by a State that has notified HHS of its intention to review tests to diagnose COVID-19; and other tests determined appropriate by HHS, including the administration of such tests.

Covid-19 Test Related Visit/Services: Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the Covid-19 Test, including the administration of such test, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel.

Deductible: The amount of Eligible Medical Expenses you are responsible for paying before the Plan begins to pay benefits. The amount of Deductibles is discussed in Chapter 4 of this document.

Dental Care Provider: A Dentist, or Dental Hygienist or other Health Care Practitioner or Nurse as those terms are specifically defined in this chapter of the document, who is legally licensed and who is a Dentist or performs services under the direction of a licensed Dentist; and acts within the scope of his or her license.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Dependent: A Participant's eligible spouse and children who meet the eligibility rules of the Fund described in chapter 2.

Disabled/Disability: The inability of a person to be self-sufficient as the result of a physically or mentally disabling injury, illness, or condition (such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, or psychosis), and the person is permanently and totally disabled in that they are unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months and the condition was diagnosed by a Physician, and accepted by the Board of Trustees or its designee, as a permanent and continuing condition.

Eligible Medical Expenses/Eligible Charges: Expenses for medical services or supplies, but only to the extent that the expenses meet all of the following qualification as determined by the Plan Administrator or its designee: are Medically Necessary, as defined in this Definitions chapter; and the charges for them are an Allowed Charge, as defined in this Definitions chapter; and coverage for the services or supplies is not excluded; and the lifetime, limited overall, and/or annual maximum Plan benefits for those services or supplies has not been reached; and are for the diagnosis or treatment of an Injury or Illness (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document.)

Emergency Care/Emergency: Care provided when a prudent layperson could reasonably expect the absence of immediate medical attention to result in: 1) serious risk to the health of the person (or, with respect to a pregnant woman, the health of the woman and her unborn child); 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Emergency Period: Emergency Period means any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), beginning on or after March 18, 2020, namely, the period during which there exists an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act and a public health emergency declared by the Secretary pursuant to section 247d of the Social Security Act.

Employee or Active Employee: Any person who meets the eligibility requirement of the Fund based on employment with a Contributing Employer in a job classification covered by a Labor Management Agreement. The term "Employee" may include the Employees of the Association, the Union, the Fund Office or Training Fund, non-bargaining unit Employees of Employers and self-employed Employees and partners, if the inclusion of such Employees does not jeopardize the tax-exempt status of the Fund. See chapter 2 for more information.

Employer or Contributing Employer: Any association, individual, partnership, corporation or entity which employs Employees and is a party to the Labor Management Agreement with the Union.

Experimental and/or Investigational or Unproven: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational or Unproven. A service or supply will be deemed to be Experimental and/or Investigational or Unproven if, in the opinion of the Plan Administrator or its designee, the medical, surgical, diagnostic, psychiatric, substance abuse or other health care service, technology, supply, treatment, procedure, drug therapy or device, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the Managed Care Program, <u>any</u> of the following conditions were present with respect to one or more essential provisions of the service or supply:

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the Plan for the course of medical treatment that is under investigation) or consent

document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;

2. With respect to services or supplies regulated by the U.S. Food and Drug Administration (FDA), FDA approval is required in order for the service or supply to be lawfully marketed for the proposed use, and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA; or
3. Subject to review and approval by any institutional review board, as defined by federal law, for the proposed use; or
4. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations regardless of whether the trial is actually subject to FDA oversight; or
5. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational or unproven; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.
6. Note that under this medical plan, experimental, investigational or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** The routine costs that are covered by this Plan are discussed below:
    a. "**Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
    b. An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control & Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial;

and (2) either the individual's referring physician is a participating health care provider in the Plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the Plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

d. The Plan may require that an eligible individual use a Network provider as long as the provider will accept the patient. This Plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

e. The Plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process.

The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

In determining whether a service or supply is or should be classified as Experimental and/or Investigational or Unproven, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered:**

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
5. The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Centers for Disease Control & Prevention (CDC); or the Office of Technology Assessment; clinical policy bulletins of major insurance companies in the U.S., or the American Dental Association (ADA) with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare National Coverage Determinations Manual."

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Full Benefit Coverage (also referred to as "Non-New Hire Coverage"):: For Employees: Medical, prescription drug, dental, vision, life, Accidental Death & Dismemberment, Weekly

Sickness and Accident, and Temporary Disability benefits. In addition, an Active Employee's Eligible Dependents are eligible for medical, prescription drug, dental, vision, and dependent life insurance (spouse only) benefits.

Fund: The PAMCAH-UA Local 675 Health and Welfare Fund.

Generic (drug): A generic drug is one which is prescribed or dispensed under its commonly used generic (chemical) name, and is no longer protected under patent laws. A 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.

Handicap or Handicapped (Physically or Mentally): See the definition of Disabled.

Health Care Practitioner: A Behavioral Health Practitioner (including licensed psychologist, clinical specialist psychiatric registered nurse (CSPRN), mental health or substance abuse counselor or social worker who has a Master's degree), licensed clinical social worker,, Chiropractor, Dentist, Nurse (RN, LVN, LPN), Certified Nurse Midwife, Podiatrist, Pharmacist, Optometrist, Optician for vision plan benefits, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee. See also the definition of Physician. Some of the terms used in this definition are also defined separately in this chapter

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice or Skilled Nursing Facility.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency as those terms are defined in this chapter.

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

1. It is approved by Medicare; or
2. It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
    - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
    - It has a full-time administrator.
    - It is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs).
    - It maintains written clinical records of services provided to all patients.
    - Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
    - Its employees are bonded.
    - It maintains malpractice insurance coverage.

Hospice: An agency or organization that administers a program of palliative care and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. "Palliative care" refers to care of a patient whose disease is not responsive to curative treatment and includes control of pain and other symptoms along with psychological, social and spiritual support.

Hospital: An institution operated pursuant to law which meets the following requirements:

1. It is equipped with permanent facilities for diagnosis, major surgery, and 24-hour continuous nursing service by registered professional nurses (RN.) and 24-hour continuous supervision by a staff of Physicians licensed to practice medicine (other than Physicians whose license limits their practice to one or more specified fields).
2. It is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, skilled nursing facility, or a place for the aged. The term "Hospital" also includes a facility certified by the State for treatment of alcohol or substance abuse, or a place, which provides a program for the treatment of alcohol or substance abuse as part of its accredited activities.
3. For the purposes of the benefits provided for treatment of mental, nervous or emotional disorders or conditions, an institution that lacks permanent facilities for surgery will be considered a Hospital and an institution that is primarily a place for the care of persons with mental, nervous or emotional disorders or conditions will be considered a Hospital, provided that such institutions meet all the other requirements applied to Hospitals.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy of a covered Employee or covered spouse will be considered to be an Illness only for the purpose of coverage under this Plan. However, infertility is not an Illness for the purpose of coverage under this Plan.

Injury: Any damage to a body part resulting from trauma from an external source.

Investigational: See the definition of Experimental and/or Investigational.

Labor Management Agreement: The Agreement between the Union and any Contributing Employer, including any extension thereof or any new Agreement, which provides for contributions to the Fund.

Maximum Benefit: When payments equal the specified amount or when benefits have been provided for a specified number of days, visit, or services, no more payments will be made by the Plan. When the Maximum Benefit is for a specified time period such as a Calendar Year, no more payments will be made during the remainder of the specified time period.

Medically Necessary: A medical service or supply which has been determined by the Plan Administrator or its designee to be:

1. Provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it; and
2. Necessary in terms of generally accepted medical standards; and

3. Is determined by the Plan Administrator or its designee to meet all of the following requirements:
    - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
    - It is not provided solely for the convenience of the patient, Physician, Hospital, Health Care Provider, or Health Care Facility; and
    - It is an "Appropriate" service or supply given the patient's circumstances and condition; and
    - It is a “Cost-Efficient” supply or level of service that can be safely provided to the patient; and
    - It is safe and effective for the illness or injury for which it is used.

A medical service or supply will be considered to be "Appropriate" if it is called for by the health status of the patient, or it is likely to result in information that could affect the course of treatment, or it is care or treatment that is as likely to produce a significant positive outcome as any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition. A medical or dental service or supply will be considered to be “Cost-Efficient” if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your Physician may provide, order, or recommend a service or supply does not mean that the service or supply will be considered to be Medically Necessary by the Plan.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Mental Health; Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

New Hires - Employees only will be provided Hawaii Prepaid Health Care benefit coverage, effective on the first day of the second calendar month following a period of two consecutive calendar months during which an Employee worked at least 120 hours for a Contributing Employer and the Employer has made the required contributions to the Fund. New Hires are eligible for Medical benefits only; New Hires are NOT eligible for outpatient prescription drug, dental, or vision benefits, and their dependents are not eligible for coverage, unless and until the Initial Eligibility requirements outlined on page 4 are satisfied.

Non-Covered Employment or Non-Covered Service: Any kind of work (including self-employment) under the jurisdiction of Local Union 675 or for a contractor doing Local Union 675 jurisdictional work in the geographical jurisdiction of Local 675, for an employer which does not have or which is not covered by a Labor Management Agreement with Local Union 675 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

Office Visit: A direct personal contact between a Physician and a patient in the Physician’s office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association. The following are not considered to be an office visit: a telephone discussion with a Physician or other Health Care

Practitioner, internet/virtual office visit, a visit to a Health Care Practitioner's office where no office visit code is billed or a visit to a Health Care Practitioner's office for blood drawing, leaving a specimen, or receiving a routine injection.

Out-of-Network Services (Non-Network): Services provided by a Health Care Provider that is not a member of the Plan's Preferred Provider Organization (PPO) as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO.

Out-of-Pocket Limit: The maximum amount of Coinsurance each Covered Individual or family is responsible for paying during a Calendar Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Limit is reached, the Plan will pay 100% of additional Coinsurance related to most Eligible Charges for the remainder of the Calendar Year. See the section on Annual Out-of-Pocket Limit in the Medical Plan Benefits chapter (Chapter 4) for details about what expenses do not count toward the Out-of-Pocket Limit.

Participant: An individual eligible for benefits under the Plan, whether as an eligible Employee, eligible Retiree, or eligible Dependent.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist: A person legally licensed as a professional physical therapist who acts within the scope of their license and is not the patient or the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, and acts under the direction of a Physician to perform physical therapy services including the evaluation, treatment and education of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical functional disability/impairment. Physical therapists may also perform testing and retraining of muscle strength, joint motion, or sensory and neurological function along with balance, coordination, and flexibility in order to enhance mobility and independence.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform certain activities of daily living such as walking and getting in and out of bed.

Physician: A licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Dentistry or Dental Surgery (D.D.S.), and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Plan, This Plan: The programs, benefits and provisions described in this document.

Plan Year: The twelve-month period from August 1 through July 31.

Precertification: Precertification is a review procedure performed by the Utilization Management Company before services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and medically necessary. Precertification is also referred to as pre-service review, prior authorization, precert, prior auth or preapproval.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. Compound Drug: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.
2. Generic drug: Means a generic version of a brand-name drug. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA), and is basically a "copy" of a brand name drug. Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.
3. Brand drug: means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. Specialty drug: Refers to high-cost, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injected, infused, taken oral or inhaled, may need to be administered by a Health Care Practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before administration, and/or have unique manufacturing, handling, distribution and administration issues that make them unable to be purchased from a retail and/or mail order service. Examples of specialty drugs can include medications (and the supplies necessary to administer them) to treat multiple sclerosis, rheumatoid arthritis, Crohn's disease, psoriasis, hepatitis, cancer or immunity disorders.

Provider: A Hospital, Skilled Nursing Facility, Physician, Health Care Practitioner or other individual or organization that is duly licensed to provide medical or surgical services.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child. See also the Eligibility chapter of this document.

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an Accidental Injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license.

Rehabilitation does not have the same meaning as Habilitation. Rehabilitation focuses on restoring/regaining functions that have been lost due to injury or illness, while Habilitation focuses on therapy to help an individual attain certain functions that have never have acquired, such as speech therapy to assist a child in learning to talk. See also the definition of Habilitation.

See the Schedule of Medical Benefits and the Exclusions chapter of this document to determine the extent to which Rehabilitation Therapies are covered.

1. Active Rehabilitation refers to therapy in which a patient, who has the ability to learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. Maintenance Rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. Maintenance Rehabilitation is not covered by the Plan.
3. Passive Rehabilitation refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan.

Retiree or Retired Employee: Each person who meets the applicable Eligibility Rules for Retired Employees.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility (SNF): A facility that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

1. It is accredited by The Joint Commission (TJC) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
3. It is not (other than incidentally) a home for maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; and
4. A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Speech Therapist: A person legally licensed as a professional speech therapist who acts within the scope of their license and is not the patient or the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, and acts under the direction of a Physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to restore normal speech or to correct dysphagic or swallowing defects and disorders lost due to illness or injury.

Spouse: An employee's or retiree's Spouse means a person of the opposite gender or same gender who is legally married under State law. The Plan follows the IRS guidance that a same gender couple is married for federal tax purposes if the couple was married in a state that allows same gender marriage, regardless of the laws of the state in which the married couple resides or the foreign jurisdiction in which the individuals' marriage was entered into. The Plan may require proof of the legal marital relationship. The following are not defined as a Spouse under this Plan: a domestic partner, a civil union partner, or a divorced former Spouse of an employee or retiree, or a spouse of a Dependent Child. An ex-spouse is not eligible even if an employee or retiree is required by a divorce decree, court order or other legal action to continue coverage for the ex-spouse.

Substance Abuse / Substance Use Disorder: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofacial pain (pain in the muscles of the face), headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Totally Disabled/Total Disability: The inability of a covered Employee to perform all the duties of his or her occupation as a result of a non-occupational illness or injury, or the inability of a covered Dependent or Retiree to perform the normal activities or duties of a person of the same age and sex.

Transplant, Transplantation: The transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, peripheral stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

- **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow, peripheral stem cells and skin transplants are often autologous.
- **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are allogenic.

- **Xenographic/xenotransplant** refers to transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human). Expenses related to xenographic services are **not** covered by this Plan.

See the Medical Plan Benefits Chapter for additional information regarding Transplants, or information about precertification requirements for transplantation services.

Utilization Management Company/UM Company: The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan's Precertification services.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary even though they are not provided as a result of illness, injury or congenital defect

You, Your: When used in this document, these words refer to the Employee or Retiree who is covered by the Plan. They do not refer to any Dependent of the Employee or Retiree.

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