HAWAII HEALTH
AND
WELFARE TRUST FUND
FOR
OPERATING ENGINEERS

SUMMARY PLAN DESCRIPTION (SPD)
FOR THE
SELF-FUNDED AND
INSURED PLAN BENEFITS

Effective January 1, 2020

HAWAII HEALTH AND WELFARE TRUST FUND FOR OPERATING ENGINEERS

2181 Lauwiliwili Street
Kapolei, HI 96707
(808) 847-1289
(800) 660-9126

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1600 Harbor Bay Parkway
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Alameda, CA 94502
(510) 433-4422
(800) 251-5014

Quick Reference Chart – Where to Call for Information

Only the Trust Fund office in California can verify your eligibility.

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Trust Fund Office • Claim Forms • COBRA Administrator • Cost of COBRA Continuation Coverage • COBRA Premium payments • COBRA Second Qualifying Event and Disability Notification • Health and Welfare Eligibility and Pension Information • Summaries of Benefits and Coverage (SBC) • Life Insurance and Weekly Income and Disability claims questions • Burial Expense benefit questions and claims • Medicare Part D Notice of Creditable Coverage	**Zenith American Solutions** 1600 Harbor Bay Parkway Suite 200 Alameda, CA 94502 800- 251-5014 or 808- 847-1289 or 800- 660-9126 **Call Fringe Benefits Service Center** at: (800) 532-2105 or (510) 748-7450 with any benefits questions you may have.

QUICK REFERENCE CHART

Information Needed	Whom to Contact
Medical PPO Plan (Self-Funded) Claims Administrator and Medical PPO Network Medical Network: o Provider Directory (free of charge) o Pharmacy Network Directory (free of charge) o Additions/Deletions of Network Providers o Information About Coverage o Medical Benefit ID Cards o Telehealth online visit Medical Plan Claims Administration: o Claims and First Level Appeal information o First Level Appeals of UM decisions	**Hawaii Medical Service Association (HMSA)** 818 Keeaumoku Street Honolulu, HI 96808-0860 **Oahu** – (808) 948-6111 **Hilo** – (808) 935-5441 **Kona** – (808) 329-5291 **Kauai** – (808) 245-3393 **Maui** – (808) 871-6295 **Well-Being Services**www.hmsa.com/myaccount (855) 329-5461 **Disease Management** Oahu: (808) 948-6079 Neighbor Islands and out-of-state: (800) 776-4672 **Blue Card (for services received on Mainland)** (800) 810- BLUE www.BCBS.com **CAUTION:** Use of a **non**-PPO network hospital, facility or Health Care Provider could result in you having to pay a substantial balance on the provider's billing (see definition of "balance billing" in the Definition chapter of this document). Your lowest out of pocket costs will occur when you use In-Network PPO providers.
Utilization Management Company for Medical PPO Plan o Preauthorization for services, supplies, outpatient prescription drugs	**Hawaii Medical Service Association (HMSA)** P.O. Box 2001 Honolulu, HI 96805-2001 **Preauthorization:** Oahu: (808) 948-6464 Neighbor Islands and Out-of-State: (800) 344-6122 Fax: (808) 944-5611 **Case Management Services** Oahu: (808) 440-7057 Neighbor Islands and Out-of-State: (855) 211-4527 Fax: (808) 944-5614

QUICK REFERENCE CHART

Information Needed	Whom to Contact
Chiropractic Care, Acupuncture and Massage Therapy (for HMSA and Kaiser enrollees) • Chiropractic Care, Acupuncture and Massage • Claims and preauthorization for chiropractic care, acupuncture and massage	**American Specialty Health Group, Inc. (ASH Group)** **HMSA Participants:** For eligibility, benefits or claim questions, call Customer Service at 1-800-678-9133 between the hours of 3 a.m. and 6 pm., Monday through Friday, Hawaii Standard Time. During Daylight Savings Time: 2 a.m. and 5 p.m., Monday through Friday and Saturday 9 a.m. and 5 p.m. Hawaii Standard Time. To find a provider, see: http://www.ashcompanies.com **Kaiser Participants:** call the Kaiser Permanente Member Services Department at 1-800-966-5955 for assistance in finding a covered provider (www.ashlink.com/ash/KaiserHIC). Members may go directly to an ASH provider for Chiropractic and Acupuncture. However, an authorized referral is needed from either a Participating Chiropractor or a Kaiser Physician for Massage Therapy. Send the *Medical Records Cover Sheet* and either the clinical information summary sheet or the pertinent medical records to: ASH Group P.O. Box 509001 San Diego, CA 92150-9001 **Fax:** California fax (877) 427-4777, all other states fax (877) 304-2746 Send Claims to: Claims Departments ASH Group P.O. Box 509001 San Diego, CA 92150-9001
HMO Plan (Fully Insured) • Medical Network Provider Directory (free of charge) • Medical Claims and Appeals • Plan Benefit Information • Chiropractic, Acupuncture and Massage benefits through ASH Group. • Outpatient Prescription Drugs and Mail Order (Home Delivery) Pharmacy for Kaiser enrollees • Telehealth online visit	**Kaiser Foundation Health Plan Hawaii Region** **Group #6592** 711 Kapiolani Blvd. Honolulu, HI 96813 www.kp.org 432-5955 (Oahu), 1-800-966-5955 (Neighbor Islands)

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Dental Plan (Fully Insured) • Dental Network Provider Directory • Plan Benefit Information • Dental Claims and Appeals	**Hawaii Dental Service (HDS)** Group No. 0067 700 Bishop Street, Suite 700 Honolulu, HI 96813-4196 www.hawaiidentalservice.com Inter-Island change to Neighbor Islands, Guam, Saipan & US Continental 1-800-232-2533 x248
Vision Plan (Self-Funded) • Vision Network Provider Directory • Plan Benefit Information • Vision Claims and Appeals	**Vision Service Plan (VSP)** One Market Street, Ste. 2625 Stuart Tower San Francisco, CA 94105 Customer Service: 800-877-7195 www.vsp.com
Assistance in finding Chemical Dependency Treatment options (for both HMSA and Kaiser enrollees) • Available to help Participants find the best Chemical Dependency treatment options available. • If you or a family member needs help, or just have a question, you may call ARP (Assistance Recovery Program).	**Assistance Recovery Program (ARP)** 1620 South Loop Road Alameda, CA 94502 **800-562-3277** **Ask for the Local 3 ARP Representative**
Life Insurance, AD&D and Weekly Disability Income Benefits (Fully Insured)	**Pacific Guardian Life Insurance Company** 808-942-1282 or toll free 800-367-5354
Burial Benefit (Engineer only)	**ULLICO** Please contact the Fund Office for any questions on the burial benefit.
HIPAA Privacy Officer and HIPAA Security Officer <u>for the Plan and the self-funded benefits</u> • HIPAA Notice of Privacy Practice	**Privacy & Security Officer** Zenith American Solutions, Inc. 1600 Harbor Bay Parkway, Suite 200 Alameda, CA 94502 Mailing Address: PO Box 24454 – Oakland, CA 94623 Telephone: 800- 251-5014 or 808- 847-1289 or 800- 660-9126 **<u>Contact your HMO for a HIPAA Privacy Notice for your HMO benefits.</u>**

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 Trust Fund Office, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of your eligible Dependents 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.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Trust 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 may not be considered a payable claim for the affected individuals.

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INTRODUCTION

WHAT THIS DOCUMENT TELLS YOU

This Summary Plan Description (SPD) describes the self-funded benefits that are part of the Hawaii Health and Welfare Trust Fund for Operating Engineers (the "Fund"), and outlines the fully insured benefits available through the various insurance companies that contract with the Fund. The Plan described in this document is effective January 1, 2020, and replaces all other plan documents, summary plan descriptions and applicable amendments to those documents previously provided to Plan participants.

This SPD and the Evidence of Coverage issued by Kaiser, and Contracts of Insurance/Evidence of Coverage issued by the Hawaii Dental Service, Vision Service Plan, Pacific Guardian Life Insurance Company, and ULLICO constitute your Plan Document. If the Evidence of Coverage documents are not attached then the Plan Document is not complete and you should contact the Trust Fund Office for a copy of the Insurance Company documents.

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears at the front of the document.

IMPORTANT INFORMATION

The Fund is committed to maintaining health care coverage for Employees and their eligible family members at an affordable cost, however, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverage at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

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 HMSA medical PPO plan benefits (including chiropractic, acupuncture, massage, and outpatient prescription drug benefits) and vision benefits are self-funded with contributions from contributing employers and eligible Employees held in a Trust to pay Plan benefits. The Kaiser medical Plan benefits (including chiropractic, acupuncture, massage and prescription drug benefits), dental benefits, life insurance, accidental death and dismemberment and the burial benefits of the Plan are fully insured with insurance companies whose names are listed on the Quick Reference Chart in this document. We have included a brief summary of each of the fully insured benefits in this document. The full descriptions of the insured benefits are in the documents created by the various insurance companies. Contact the Trust Fund office if you need help locating the documents of the insured benefits.

QUESTIONS YOU MAY HAVE

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Trust Fund Office at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, the Trust Fund Office staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to the Trust Fund Office and obtain a written response. In the event of any discrepancy between any information that you receive from the Trust Fund Office, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Trust Fund Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage.

Notify the Plan preferably within 31 days, but no later than 60 days (90 days for marriage, birth, adoption, or placement for adoption), after any of the above noted events.

Failure to give this Plan a timely notice (as noted above) may cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a participant's liability to the Plan if any benefits are paid to an ineligible person.

STATEMENT OF THE FUND'S RIGHTS

Plan benefits for active or disabled participants are not guaranteed. Also, eligibility or rights to benefits under this Plan should not be interpreted as a guarantee of employment. The Trustees reserve the right to change or discontinue:

- the types and amounts of benefits under this Plan and
- the eligibility rules, including those rules providing extended or accumulated eligibility even if the extended eligibility has already been accumulated.

You will be notified of material changes to the benefits under the Plan.

ENROLLMENT FOR FUND BENEFITS

CHOICE BETWEEN HMSA AND KAISER MEDICAL PLAN COVERAGE

If you are a newly eligible employee (see Eligibility Chapter for rules of eligibility), you will be automatically enrolled in the HMSA medical Plan unless you live within the Kaiser service area and elect the Kaiser medical plan. To elect Kaiser coverage, complete a Kaiser enrollment form and return it to your Local Union Office or the Trust Fund Office. A pamphlet describing the Kaiser Plan and an enrollment form are available from your Local Union Office or the Trust Fund Office. As a newly eligible Employee, you must also complete a death benefit Beneficiary Designation Card which is available at the Local Union Office. All completed documents should be sent to the Local Union Office or the Trust Fund Office.

You must live within Kaiser's service area in order to enroll in the Kaiser Plan. You and your Dependents must be enrolled in the same Medical Plan. If you enroll in Kaiser, your medical and prescription drug benefits are described in the ***Evidence of Coverage*** that you will receive from Kaiser. The ***Evidence of Coverage*** also provides you with all the information about how to utilize Kaiser services and the conditions that apply to Kaiser membership.

An HMSA membership card will be issued to each eligible Operating Engineer who chooses to remain enrolled in HMSA. If you enroll in Kaiser, you will receive your membership card directly from Kaiser.

A directory of Network health care providers is available (at no cost) on the HMSA PPO Plan's or the Kaiser HMO Plan's website (listed on the Quick Reference chart in the front of this document). For a paper copy of the network provider directory, at no charge, contact either HMSA or Kaiser.

The Fund allows you to change your medical plan coverage between Kaiser and HMSA at any time during the year to accommodate changes in your life (a "Special Enrollment" event which is explained later in this Chapter), for example the birth of a child or your marriage. However, once you are initially enrolled in a Plan or you change your enrollment, you must remain in your new Plan for at least the following 12 months (unless you experience a "Special Enrollment" event). After 12 months, you have the option to change your Plan, once in any 12-month period.

Following is only a summary of the Kaiser Permanente HMO benefits (and the amounts that you are responsible for). For a complete explanation, please refer to your Evidence of Coverage from Kaiser. In the event of any discrepancy between the Kaiser Evidence of Coverage and the terms of this document, the terms of the Evidence of Coverage will govern your entitlement to benefits, if any.

KAISER PERMANENTE HMO	
Description of Service	**You Pay**
Annual Deductible	None
Annual Out-of-Pocket Max	$2,500 Individual/$7,500 Family
Primary Care Office visit	$15 copay/visit
Telehealth Online visit	$15 copay/visit
Specialty Care Office Visit	$15 copay/visit

KAISER PERMANENTE HMO	
Preventive Care [1]	No Charge
Scheduled Prenatal Visits and first Postpartum visit	No Charge
Chiropractic, Acupuncture & Massage	$20 copay/visit, 20 visits per calendar year
Maternity Care	20% coinsurance
Outpatient Ambulatory Surgery	$15 copay/visit
Laboratory	No charge inpatient/20% coinsurance outpatient
X-ray	No charge inpatient/20% coinsurance outpatient
MRI/CT/PET/Nuclear Medicine	No charge inpatient/20% coinsurance outpatient
Ambulance (Ground or Air)	20% of applicable charges
Emergency Room (worldwide)	$100 copay/visit
Urgent Care	$15 copay at a Kaiser Permanente facility within the Hawaii service area; 20% of applicable charges at a non-Kaiser Permanente facility outside the Hawaii service area
Hospital Inpatient	20% coinsurance
Outpatient Mental Health	$15 per visit
Inpatient Mental Health	20% coinsurance
Outpatient Chemical Dependency Treatment	$15 per visit
Inpatient Chemical Dependency Treatment	20% coinsurance

KAISER PERMANENTE HMO	
Prescription Drug Retail (30 consecutive day supply[2]) • Generic	$10 copay per prescription (no copay for generic contraceptives)
• Generic Maintenance	$5 copay per prescription (no copay for generic contraceptives)
• Brand • Specialty	$45 copay per prescription (no copay for brand prescription contraceptive drug only if a generic contraceptive is unavailable or your doctor determines generic is medically inappropriate)
Prescription Drug Mail Order (90 consecutive day supply) • Generic [3]	$20 copay per prescription (no copay for generic contraceptives)
• Generic Maintenance	$5 copay per prescription (no copay for generic contraceptives)
• Brand [3]	$90 copay per prescription (no copay for generic contraceptives)
Skilled Nursing Facility (SNF)	No charge, limited to 120 days per calendar year
Infertility Services	$15 copay per visit for consultation, 20% coinsurance for in vitro fertilization
Hospice Care	No charge
Home Health Care	No charge
Durable Medical Equipment (DME)	20% coinsurance

1. Preventive screenings covered at no charge include Affordable Care Act (ACA) mandated preventive services.
2. Up to a 30-consecutive day supply or an amount determined by the health plan formulary.
3. Applies to refills for most maintenance drugs. The mail-order program does not apply to certain drugs and mailing is limited to addresses inside the Hawaii Service Area.

ADDITIONAL BENEFITS

When you become eligible for coverage, you have a choice of electing medical coverage with HMSA or Kaiser. You may also be eligible for the following benefits, which are provided directly or indirectly by the Trust Fund:

- Dental benefits provided by the Dental Insurance Company listed on the Quick Reference Chart at the front of this document.
- Vision benefits which are funded by the Trust Fund and administered by the Vision Plan Claims Administrator listed on the Quick Reference Chart at the front of this document.
- Life Insurance, AD&D and Weekly Disability Income Benefits provided by the Insurance Company listed on the Quick Reference Chart at the front of this document.
- A burial expense benefit for Engineers provided by the Insurance Company listed on the Quick Reference Chart at the front of this document.

Following is only a brief summary of the Dental benefits showing what the Dental Plan pays. For a complete explanation, please contact the Dental insurance company listed on the Quick Reference Chart.

Dental plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the Affordable Care Act (ACA). Dental plan claims are administered under a contract separate from claims administration for any other benefits under the plan. The Fund has decided to allow coverage for dependents up to age 26 for dental benefits even though it is not required to do so.

DENTAL BENEFITS (For All Participants)		
	Participating Provider	**Non-Participating Provider**
Annual Deductible	None	
Annual Benefit Maximum	None	
Diagnostic & Preventive Dental Services	100% of allowed charges	Reimbursed in accordance with a table of allowances
Other Dental Services	90% of allowed charges	Reimbursed in accordance with a table of allowances
Orthodontics (Dependent Children only)	100% of allowed charges, to a lifetime maximum of $2,500 per person	

Following is only a brief summary of the Vision benefits. For a complete description of coverage, please see the Vision Chapter beginning on page 100 of this SPD.

Vision plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the ACA. Vision plan claims are administered under a contract separate from claims administration for any other benefits under the plan. The Fund has decided to allow coverage for dependents up to age 26 for dental benefits even though it is not required to do so.

VISION BENEFITS (For All Participants)		
	Participating Provider	**Non-Participating Provider**
Vision Exam (one every 12 months)	$7.50 copay/exam	After a $7.50 copay, reimbursed up to $35/year
Lenses (One every 12 months, includes contact lenses)	Covered in full for single vision, bifocal, trifocal or lenticular lenses (with Tinted/Photochromic)	Reimbursed up to: $25/year for single visions lenses $40/year for bifocal lenses $50/year for trifocal lenses $100/year for Lenticular lenses $5/year for tints
Elective Contact Lenses (For vision correction only. One pair every 12 months, combined with eyeglasses)	Reimbursed up to $200/year	Reimbursed up to $200/year
Medically Necessary Contact Lenses	Paid in full	Reimbursed up to $250/year
Frames (One set of frames every 24 months. If contact lenses are provided, no benefits are payable for frames in the same calendar year.)	Selected frames covered in full ($130 retail frame allowance)	Reimbursed up to $30/year
Laser Vision Correction Surgery	$500 allowance per eye (once per lifetime)	

Following is only a brief summary of the Life Insurance, Accidental Death & Dismemberment, Weekly Disability and Burial Benefits. For a complete explanation, please contact the insurance company listed on the Quick Reference Chart at the beginning of this SPD. In the event of any discrepancy between the insurer's documents and the terms of this document, the terms of the contract with the Insurer will govern your entitlement to benefits, if any.

LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT, WEEKLY DISABILITY INCOME BENEFIT	
Life Insurance	
Engineer	$30,000
Spouse	$2,000
Children (according to age)	
➢ 14 days but less than 6 months	$100
➢ 6 months but less than 2 years	$200
➢ 2 years but less than 3 years	$400
➢ 3 years but less than 19 years	$500

LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT, WEEKLY DISABILITY INCOME BENEFIT	
Accidental Death & Dismemberment (Engineer Only)	$20,000
Weekly Disability Income Benefit (Engineer Only)	Up to $650/week for 1st 26 weeks; $200/week for 2nd 26 weeks.

Following is only a brief summary of the Burial Expense Benefit. For a complete explanation, please contact the Trust Fund Office. In the event of any discrepancy between the insurer's documents and the terms of this document, the terms of the contract with the Insurer will govern your entitlement to benefits, if any.

BURIAL EXPENSE BENEFIT	
Burial Expense Benefit (for the Engineer only)	$2,500

ELIGIBILITY RULES

INITIAL ELIGIBILITY

An employee will become eligible on the first day of the second calendar month that follows a period of not more than three (3) consecutive calendar months during which he worked at least 360 hours for Contributing Employers.

Military Service before Initial Eligibility

If an employee enters military service for at least 30 days (but less than 12 months) while accumulating the required hours for initial eligibility, the Fund will not use the time spent in the military against the three consecutive months for purposes of determining the accumulation of 360 hours for initial eligibility. Following is an example:

- Employee starts work on January 1, 201 and works 120 hours in January.
- He or she is deployed for active military service from February 1, 2018 – June 30, 2018.
- He or she returns to work on July 1, 2018 and works 120 hours in July, and 120 hours in August.
- The time in active military service (from February 1, 2018-June 30, 2018) will not be used for purposes of determining "consecutive calendar months." This means that as of August 31, the employee will have accumulated the required 360 hours in three months to establish initial eligibility. Employee becomes eligible for coverage on October 1, 2018.

If Employee's active military service begins and/or concludes mid-month, any partial month in which the Employee has worked for Contributing Employers will likewise not be counted toward the three consecutive month period, **unless** the inclusion of these partial months of work would result in the Employee accumulating 360 hours of service by the end of the second full month after the Employee has returned to work after active military service.

Following is an example:

- Employee starts work on January 1, 2018 and works 120 hours in January.
- He or she is deployed for active military service from January 25, 2018 – June 15, 2018.
- He or she returns to work on June 16, 2018 and works 80 hours in June, and 160 hours in July.

The full calendar months in active military service (February, March, April and May) will not be used for purposes of determining "consecutive calendar months" for initial eligibility. However, because including the hours worked in the partial months enabled the Employee to reach 360 sooner, the partial months will be counted in this scenario. This means that as of July 31, the employee will have accumulated the required 360 hours in three months to establish initial eligibility. Employee becomes eligible for coverage on September 1, 2018. (If the partial months had not counted, assuming the Employee works 120 hours in each August and September, the Employee would otherwise not accumulate 360 hours until September 30).

CONTINUATION OF ELIGIBILITY

Hours worked for Contributing Employers will be credited to your "Hour Bank" account. One hundred twenty (120) hours will be deducted from your Hour Bank for each month of eligibility, and you will continue to remain eligible as long as your Hour Bank contains at least 120 hours.

You will be allowed to accumulate up to a maximum of 1,080 hours in your Hour Bank (or nine (9) months of eligibility) after the deduction of 120 hours for the current month's eligibility.

TERMINATION OF ELIGIBILITY

Your eligibility will terminate on the earliest of the end of the month in which:

- The hours in your Hour Bank fall below 120 hours, after deduction of 120 hours for the current month's eligibility.

  If your eligibility terminates because the hours in your account have fallen below 120 hours, you may continue coverage for the Plan benefits described in this booklet by making self-payments to the Fund for a maximum of three (3) consecutive months. These three (3) months of self-pay coverage run concurrently with any COBRA Continuation Coverage. See *COBRA Continuation Coverage* for additional continuation coverage. The notice of your right to continue coverage under COBRA, which will be sent to you when your coverage terminates, will include the self-payment rate.

  Self-payments should be mailed to the Trust Fund Office at the address listed on the Quick Reference Chart or contact your Local Union Office.

- You enter the Armed Forces (the military) on full-time active duty.

- You are no longer eligible to participate in the Plan.

- You cease to make any contributions required for your coverage.

- The date of your death.

- The date the Plan is discontinued.

NO RESCISSION OF COVERAGE

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except, upon 30-days' advance written notice, when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact.

REINSTATEMENT OF ELIGIBILITY

If your eligibility has terminated, you will again become eligible if the hours in your account again total at least 120 hours within the 12-calendar-month period following the termination of your eligibility. Reinstatement will be effective on the first day of the second month following the month in which this requirement is met. If you are not eligible for reinstatement within a 12-month period, any hours remaining in your Hour Bank will be forfeited and you will again be required to become eligible by meeting the initial eligibility requirement for new employees.

Example: An employee is last eligible for benefits in November, 2011, and his Hour Bank next shows at least 120 work hours in April, 2012. He would be eligible for health benefits beginning on June 1, 2012. However, an employee who is last eligible in November, 2011, but does not have 120 hours in his Hour Bank until December, 2012 must re-establish initial eligibility by working 360 hours in three (3) consecutive months or less.

EXTENSION OF ACTIVE HOUR BANK UPON RETIREMENT (ELIGIBILITY EXTENSION)

When you retire, your Hour Bank will be extended to give you and your eligible Dependents a total of three months of additional eligibility under this Plan if:

- You have at least one month of eligibility in your Hour Bank when you retire, ***and***
- You qualify for and elect to participate in the Pensioned Operating Engineers Health and Welfare Trust Fund

Your eligibility under the Pensioned Operating Engineers Health and Welfare Trust Fund will become effective at the end of the 3 months of extended active Employee eligibility. You will also have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when once your 3 months of extended active Employee eligibility otherwise ends because of your retirement. See *COBRA Continuation Coverage* for additional information on this continuation coverage.

DISABLED EMPLOYEES (CREDIT FOR WORK HOURS)

If you become Disabled for a period of more than 14 days, you will receive credit for hours worked, just as if you were working, for each week of certified Disability. The Disability credits will begin with the week following the initial two-week period. Credit will be given at the rate of 30 hours per week, up to a maximum of 52 weeks of credit for each disabling illness or injury.

Note: You must be eligible for benefits in the month during which the Disability begins. To be eligible for this credit, you must be an active employee and also be eligible for benefits in the month during which the Disability begins. Retirees are not eligible for this disability credit, and credit for each disabling illness or injury will be terminated upon the retirement of the Disabled Employee, with termination effective on the date of retirement.

Credit for Disability will be given for disabilities which occur on or off the job and which are certified by your attending physician, in writing, in a form acceptable to the Fund. For the purpose of this benefit, "Disabled" and "Disability" means that you, the employee, are unable to perform the duties of your normal occupation as a result of illness or injury as certified in writing by your attending Physician.

EMPLOYEES WHO ENTER ACTIVE MILITARY SERVICE

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA?

USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because you have 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.

Your coverage under this Plan will terminate when you enter active duty in the uniformed services.

- If you elect USERRA temporary continuation coverage, you (and any eligible Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the date you stopped working.

- If you go into active military service for **up to 31 days**, you (and any eligible Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if you continue to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan

The Plan will offer you USERRA continuation coverage only after the Trust Fund Office has been notified by you in writing that you have been called to active duty in the uniformed services. You must notify the Trust Fund Office (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which you will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage

Once the Trust Fund Office receives notice that you have been called to active duty, the Plan will offer 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 the Dependents, those Dependents cannot elect USERRA separately. Additionally, you (and any eligible Dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary 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 Trust Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage:

- If you go into active military service for up to **31 days**, you (and any eligible Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if you continue to pay the appropriate contributions for that coverage during the period of that leave.
- If you elect USERRA temporary continuation coverage, you (and any eligible Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the date you stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

In addition to USERRA or COBRA coverage, your eligible Dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

If you return to work or become available for work for a Contributing Employer when you are discharged from military service (not less than honorably), eligibility will be reinstated on the day you return to work provided you return to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days, you will be eligible for the balance of the calendar month in which you return to work and for the next calendar month, provided you give written notice to the Trust Fund Office within 10 days after your return to work. After that you will be entitled to eligibility based on any accumulated hours in your frozen Hour Bank; or

- 14 days from the date of discharge if the period of service was 31 days or more but less than 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 are extended up to two years.

You must notify the Trust Fund Office in writing within the time periods listed above. Upon reinstatement, your coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

No later than 30 days after your military leave begins, you must notify the Trust Fund Office in writing whether you wish to:

- self-pay to continue Fund coverage during the military leave,
- not be covered by the Fund during your leave,
- use any accumulated Hour Bank eligibility to continue Fund coverage during your leave.
- freeze your Hour Bank to preserve your coverage until your return from military service.

If you do not choose to self-pay for health and welfare coverage during a period of military service exceeding 30 days, your eligibility under this Plan will be terminated at the end of the second month following the date you begin active military duty unless you elect to use your Hour Bank to continue your coverage. If you elect to freeze your Hour Bank, any hours in your Hour Bank at the time you entered military service will be preserved until your discharge.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Trust Fund Office.

ELIGIBLE DEPENDENTS

Your lawfully married spouse and your children, under age 26, are eligible for medical, prescription drug, dental and vision benefits coverage. Eligible children include: your natural or adopted children, stepchildren, foster children, or a child that is named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice.

There are limited life insurance benefits available for Dependent Children up to age 19. To obtain Dependent coverage, you must provide the Trust Fund Office with the name and age of each Dependent.

Adult Disabled Child: If you provide full support for your child who is unable to earn his own living because of mental or physical disability, coverage will be continued for that child beyond age 26 so long as the disability exists and you remain eligible. To qualify for this extension, the child must have been both disabled and eligible under the Fund prior to age 26. Evidence of the child's disability must be furnished to the Trust Fund Office or the insurance company within 31 days before the child's 26th birthday in order to qualify for the continued coverage. Thereafter you must provide proof of continuing disability upon request of the Trust Fund Office or the Insurance Company.

The following individuals are not eligible under the Plan: child under a legal guardianship, a spouse of a Dependent Child (e.g. employee's son-in-law or daughter-in-law) or a child of a Dependent Child (e.g. employee's grandchild), Domestic Partner or child of a Domestic partner.

Qualified Medical Child Support Orders (QMCSOs)

According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial

parent's plan. The QMCSO typically requires that the plan recognize the child as a dependent even though the child may not meet the plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care Plan or the manner in which such type of coverage is to be determined; and
- States the period for which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the Plan to provide coverage for a Dependent Child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any of the employee's Dependent Children, the Trust Fund Office will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the employee, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the employee is covered by the Plan, the Trust Fund Office will so notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the Dependent Child(ren).

If the Employee is a participant in the Plan, the QMCSO may require the Plan to provide coverage for the Employee's Dependent Child(ren) and to accept enrollment for the Child(ren) from a parent who is not a Plan participant. The Plan will accept enrollment of the Dependent Child(ren) specified by the QMCSO from either the Employee or the custodial parent. Coverage of the Dependent Child(ren) will become effective as of the date the enrollment is received by the Plan, and will be subject to all terms and provisions of the Plan, as is permitted by applicable law.

Coverage of a Dependent Child under a QMCSO will terminate when coverage of the employee-parent terminates for any reason, subject to the Dependent Child's right to elect COBRA Continuation Coverage if that right applies. No eligible employee's child covered by a QMCSO will be denied coverage on the grounds the child is not claimed as a dependent on the employee's federal income tax return or does not live with the employee.

If a National Medical Support Notice is received, the Trust Fund Office will notify the employee of the requirements for compliance.

A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan benefits on account of eligible expenses incurred by Dependent Child(ren) covered by the Plan either to the provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received a QMCSO, it will pay Plan benefits on account of expenses incurred by Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO.

SPECIAL ENROLLMENT

There are three opportunities for Special Enrollment in the plan. These are on account of acquiring a new dependent, loss of other coverage, or changes to Medicaid/CHIP eligibility, as explained below.

Acquire a New Dependent:

If <u>you are enrolled</u> for coverage under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption, you may request enrollment for your new Spouse and/or any Dependent Child(ren) no later than 90 days after the date of marriage, birth, adoption or placement for adoption.

If you do not enroll your Spouse for coverage within 90 days of the date on which he or she became eligible for coverage under this Plan, and if you subsequently acquire a Dependent Child(ren) by birth, adoption or placement for adoption, you may request enrollment for your Spouse and/or your new Dependent Child(ren) and/or any Dependent Child(ren) no later than 90 days after the date of your new Dependent Child(ren)'s birth, adoption or placement for adoption. If you, the employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a new Dependent.

Loss of Other Coverage:

If you did not request enrollment under this Plan for your spouse and/or any Dependent Child(ren) within **31 days** after the date on which coverage under the Plan was previously offered because you or they 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** your Spouse and/or any Dependent Child(ren) **lose coverage** under that other group health plan or health insurance policy; you may request enrollment for your Spouse and/or any Dependent Child(ren) within **31 days** after the termination of their 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; or
- the other plan ceasing to offer coverage to a group of similarly situated individuals; or
- the loss of dependent status under the other plan's terms; or
- the termination of the benefit package option under the other plan.

Medicaid or a 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 31 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)), 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.
- **Coverage of a newborn or newly adopted newborn Dependent Child** who is enrolled within 90 days after birth will become effective as of the date of the child's birth. To be enrolled the Trust Fund Office must receive the enrollment form and required documentation. The actual birth certificate from the State or the birth certificate that the Hospital provides will be required to enroll a newborn.
- **Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption** who is enrolled more than 90 days after birth, but within 90 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. 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. To be enrolled the Trust Fund Office must receive the enrollment form and required documentation.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options at the same costs and the same enrollment requirements the Plan may require, as are available to similarly-situated Employees at initial enrollment.

To request Special Enrollment or to obtain more information about Special Enrollment, contact the Trust Fund Office at the number listed on the Quick Reference Chart.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Trust Fund Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage.

Notify the Plan preferably within 31 days, but no later than 60 days (90 days for marriage, birth, adoption, or placement for adoption), after any of the above noted events.

Failure to give this Plan a timely notice (as noted above) may cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a participant's liability to the Plan if any benefits are paid to an ineligible person.

TERMINATION OF DEPENDENT ELIGIBILITY

A Dependent's eligibility terminates on the earliest of the following dates:

- When your eligibility terminates,
- When you are divorced or legally separated, the coverage for your spouse terminates;
- The last day of the month in which the Dependent Child reaches age 26. However, eligibility may be extended beyond age 26 for an unmarried child who is disabled and unable to be self-supporting, as described above (Note: dependent life insurance coverage ends at age 19).
- The last day of the month in which the Dependent is dropped from the plan by the Employee;

- The date of the Dependent's death;
- The date Dependent coverage is discontinued under the Plan;
- The date the Plan is discontinued.

FAMILY AND MEDICAL LEAVE ACT

If your Contributing Employer approves your taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you and your eligible Dependents will continue to be covered under this Plan provided you are eligible when the leave began and your Contributing Employer makes the required contributions during the leave. It is not the role of the Fund to determine whether or not you are entitled to FMLA leave with medical coverage. Any question regarding entitlement to FMLA leave with continuing medical benefits must be resolved with the Contributing Employer.

SEPARATE PLAN FOR PENSIONERS

If your coverage terminates because of retirement, you may be eligible for coverage under the *Pensioned Operating Engineers Health and Welfare Trust Fund*, which is a separate plan and is described in another booklet. Specific conditions for eligibility apply for retirees, and the Pensioned Operating Engineers Health and Welfare Plan has different benefits than this Plan covering active employees. If you are anticipating retirement, you may request a copy of the Pensioned Operating Engineers Booklet from the Trust Fund Office or District Office of the Union. A booklet will also be provided once a pension has been awarded.

RECIPROCITY

The Operating Engineers Health Plan has reciprocal agreements covering Engineers who work in more than one area of Local 3 as well as with Southern California Operating Engineers and Western Conference of Operating Engineers.

If you have worked in more than one area of Local 3 or within the jurisdiction of any other Local Union area within the Western Conference of Operating Engineers, please notify the Trust Fund Office or Administrator of the local Fund, so that proper determination is made as to which Plan covers you.

If you have any questions on the operation of the reciprocal agreements, or require a complete listing of reciprocal agreements, please contact either the Trust Fund Office of this Plan, or of the Plan under whose jurisdiction you are working.

COBRA CONTINUATION COVERAGE

CONTINUATION OF COVERAGE (COBRA)

In compliance with a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (commonly called COBRA), eligible employees, and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

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**. 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. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. 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 plan within 30 days, even if that plan generally does not accept late enrollees.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

WHO IS ENTITLED TO COBRA CONTINUATION COVERAGE, WHEN AND FOR HOW LONG

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

Qualified Beneficiary

Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an Employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with a covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

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

Qualifying Event

Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**.

If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e.g.* employee continues working even though entitled to Medicare) then COBRA is not available.

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

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries [1]		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

1: *When a covered Employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the Employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered Spouse and Dependent Children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.*

MAXIMUM PERIOD OF COBRA CONTINUATION COVERAGE

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date the Qualifying Event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

MEDICARE ENTITLEMENT

A person becomes entitled to Medicare on the first day of the month in which he or she attains age 65, but only if he or she submits the required application for Social Security retirement benefits within the time period prescribed by law. Generally a person becomes entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

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.

PROCEDURE FOR NOTIFYING THE PLAN OF A QUALIFYING EVENT (VERY IMPORTANT INFORMATION)

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

That written notice should be sent to the Trust Fund Office whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

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

Officials of the employee's own employer should notify the Trust Fund Office of an employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the Trust Fund Office in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

NOTICES RELATED TO COBRA CONTINUATION COVERAGE

When:

a. **Your Contributing Employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to health care coverage under the Plan, you died, have become entitled to Medicare, or
b. **You notify the Trust Fund Office** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the Trust Fund Office will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered Dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

THE COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this chapter for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

- Life insurance, Weekly Disability and Burial Benefits are not included.
- Election of Dental and Vision Benefits is optional.

PAYING FOR COBRA CONTINUATION COVERAGE (THE COST OF COBRA)

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation 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 employee's 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.

NOTE: You will not receive an invoice (bill) for the initial COBRA premium payment or for the monthly COBRA premium payments. You are responsible for making timely payments for COBRA continuation coverage to the Trust Fund Office.

HEALTH COVERAGE TAX CREDIT (HCTC)

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, and extended again through 2020. For more information, visit, www.irs.gov/HCTC.

GRACE PERIODS

The initial payment for the COBRA Continuation Coverage is due to the Trust Fund Office **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After the initial COBRA payment, all subsequent payments should be in the Trust Fund Office by the 20th of the month prior to the coverage month in order to accurately reflect your eligibility. There will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

FOR MONTHLY PAYMENTS, WHAT IF THE FULL COBRA PREMIUM PAYMENT IS NOT MADE WHEN DUE?

If the Trust Fund Office receives a COBRA premium payment that is not for the full amount due, the Trust 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 Trust 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 month for which the last full COBRA premium payment was made.

CONFIRMATION OF COVERAGE BEFORE ELECTION OR PAYMENT OF THE COST OF COBRA CONTINUATION COVERAGE

If a provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Special Enrollment Rights

Addition of newly acquired dependents

If, while you (the employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 90 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the Trust Fund Office to add a Dependent.

Loss of other group health plan coverage

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

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or Dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

NOTICE OF UNAVAILABILITY OF COBRA COVERAGE

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Trust 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.

EXTENDED COBRA DURING AN 18-MONTH CONTINUATION PERIOD

A spouse and dependent children who already have COBRA coverage, and then experience a second qualifying event, may be entitled to extend COBRA, from 18 or 29 months, to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce or legal separation from the covered employee, or a dependent child ceasing to be eligible for coverage as a dependent under the group health plan.

NOTE: Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and Dependents who are Qualified Beneficiaries.

Notifying the Plan

To extend COBRA when a second Qualifying Event occurs, you must notify the Trust Fund Office in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

EXTENDED COBRA COVERAGE IN CERTAIN CASES OF DISABILITY

If, prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child is totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

This extension is available only if:

- the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and**
- the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

Notifying the Plan

You or another family member should follow this procedure (to notify the Plan) by sending a written notification to the Trust Fund Office of the Social Security Administration determination within 60 days after

that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the Trust Fund Office before the end of the 18-month COBRA Continuation period.

- The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage may be 50% higher than the cost for coverage during the first 18-month period.
- The Trust Fund Office must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

- The date the Fund no longer provides group health coverage to any of its employees;
- The date the amount due for COBRA coverage is not paid in full and on time;
- The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
- The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan. **IMPORTANT:** The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the date the Qualified Beneficiary is covered under the other group health plan.
- During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;
- 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).

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Trust Fund Office determines that COBRA coverage will terminate early.

Once COBRA coverage terminates early it cannot be reinstated.

COBRA QUESTIONS OR TO GIVE NOTICE OF CHANGES IN YOUR CIRCUMSTANCES

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

Kaiser conversion coverage after cobra eligibility terminates

You and your Dependents have 30 days immediately following termination of Trust Fund eligibility provided under COBRA to apply for transfer to the appropriate non-group membership coverage offered by Kaiser. You should request an application from Kaiser.

GENERAL INFORMATION

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

If you and/or your Dependent(s) are enrolled in either Part A or B of Medicare, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the prescription drug coverage offered by both Kaiser and the Fund's Medical PPO Plan is "**creditable**." "Creditable" means that the value of the insurance Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

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

If however you keep the Kaiser or Fund's Medical PPO Plan coverage and also enroll in a Medicare Part D prescription drug plan you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. If you enroll in a Medicare prescription drug plan 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 the Kaiser or Fund's Medical PPO Plan. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage in accordance with the Plan's enrollment/election change procedures (described on page 3).

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

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Kaiser and the Fund's Medical PPO plan generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser or HMSA at the telephone number listed on the Quick Reference Chart at the beginning of this document.
For children, you may designate a pediatrician as the primary care provider.

You do not need preauthorization from Kaiser or the Fund's Medical PPO Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining preauthorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser or HMSA.

NONDISCRIMINATION IN HEALTH CARE

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any Health Care Provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any Health Care Provider willing to abide by the terms and conditions for participation established by the plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

COORDINATION OF BENEFITS (COB)

If you or your Dependents have insurance with another plan in addition to this Plan, or are enrolled in the Kaiser option, please refer to the documents from the insurance company to determine how the insurance company will coordinate this Plan's benefits with those of the other plan so that the combined benefits are not more than the Eligible Charge for the covered service.

If you are enrolled in the HMSA option, you may have other insurance coverage that provides benefits that are the same or similar to this plan.

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

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

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

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

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

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

To help us coordinate your benefits, you should:

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

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

Which Plan Pays First: Order of Benefit Determination Rules

General Coordination Rules

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

The coverage without coordination of benefits rules pays first.

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

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

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

Dependent Children Coordination Rules

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

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

For a child who is covered by separated or divorced parents and a court decree does not stipulate which parent has health insurance responsibility, then the coverage of the parent with custody pays first. The payment order for this dependent child is as follows:

(1) Custodial parent.

(2) Spouse of custodial parent.

(3) Other parent.

(4) Spouse of other parent.

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

If You are Hospitalized When Coverage Begins

If you are an inpatient on the effective date of this coverage and you had other insurance or coverage that was not with us immediately prior to the effective date, we will work with your prior insurer or coverage to decide if our coverage will supplement the prior insurance or coverage. Please call us if this applies to you so that we can coordinate with your prior insurer or coverage. If you had coverage with us immediately prior to the effective date of this coverage, or if you had no other insurance or coverage immediately prior to the effective date, then our coverage terms for services related to the hospitalization will apply.

Motor Vehicle Insurance Rules

If your injuries or illness are due to a motor vehicle accident or other event for which we believe motor vehicle insurance coverage reasonably appears available under Hawaii Revised Statutes Chapter 431, Article 10C, then that motor vehicle coverage will pay before this coverage. You are responsible for any cost sharing payments required under such motor vehicle insurance coverage. We do not cover such cost sharing payments. Before we pay benefits under this coverage for an injury covered by motor vehicle insurance, you must give us a list of medical expenses paid by the motor vehicle insurance. The list must show the date expenses were incurred, the provider of service, and the amount paid by the motor vehicle insurance. We will

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

Please note that you are also subject to the Third Party Liability Rules at the end of this chapter if:

- your injury or illness is caused or alleged to have been caused by someone else and you have or may have a right to recover damages or receive payment in connection with the illness or injury, or
- you have or may have a right to recover damages or receive payment without regard to fault (other than personal injury protection coverage available under Hawaii Revised Statutes Chapter 431, Article 10C-103.5).

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

COVERAGE FOR INDIVIDUALS ELIGIBLE FOR MEDICARE

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

If you are age 65 or older and eligible for Medicare only because of your age, the coverage described in this plan will be provided before Medicare benefits as long as your employer or group health plan coverage is based on your status as a current active employee or the status of your spouse as a current active employee.

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

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

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

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

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

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

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

COORDINATION WITH GOVERNMENT AND OTHER PROGRAMS

Below is a discussion of coordination of benefits if you and your dependent(s) are covered by the Fund's Medical Plan and also by these other plans:

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.

TRICARE: If a Dependent is covered by both this Plan and TRICARE, that provides health care services to Uniformed Service members, retirees and their families worldwide, 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.

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.

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.

THIRD PARTY LIABILITY AND PLAN'S RIGHT TO REIMBURSEMENT**

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

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

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

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

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

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

- Give HMSA Timely Notice. You must give us timely notice in writing of each of the following:
    - your knowledge of any potential claim against any third party or other source of recovery in connection with the injury or illness;
    - any written claim or demand (including legal proceeding) against any third party or against other source of recovery in connection with the injury or illness; and
    - any recovery of damages (including any settlement, judgment, award, insurance proceeds, or other payment) against any third party or other source of recovery in connection with the injury or illness.

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

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

HMSA

Attn: 8 CA/Other Party Liability

P.O. Box 860

Honolulu, Hawaii 96808-0860

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

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

- Settlement, judgment, or award;
- Motor vehicle insurance (other than personal injury protection benefits) including liability insurance or your underinsured or uninsured motorist coverage;
- Workplace liability insurance;
- Property and casualty insurance;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowner's insurance coverage;
- Medical malpractice coverage; or
- Any other payments from a source intended to compensate you for injuries resulting from an accident or alleged negligence.

As used herein, the term "Third Party," means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as "Third Party Injuries." "Third Party" includes any party responsible for payment of expenses associated with the care of treatment of Third Party Injuries.

If this plan pays benefits under this Plan to you for expenses incurred due to Third Party Injuries, then the Plan retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the Third Party Injuries.

By accepting benefits under this plan, you specifically acknowledge the Plan's right of subrogation. In the event you suffer injuries for which a Third Party is responsible (such as someone injuring you in an accident), and the Plan pays benefits as a result of those injuries, the Plan will be subrogated and succeed to the right of recovery against such Third Party to the extent of the benefits the Plan has paid. This means that the Plan has the right, independently of you, to proceed against the Third Party responsible for your injuries to recover the benefits the Plan has paid. In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

By accepting benefits under this plan, you also specifically acknowledge the Plan's right of reimbursement. This right of reimbursement attaches when this plan has paid health care benefits for expenses incurred due to Third Party Injuries and you or your representative has recovered any amounts from a Third Party. By providing any benefit under this Guide to Benefits, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

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

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

No court costs or attorney fees may be deducted from our lien.

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

If the Plan is entitled to reimbursement of payments made on your behalf under these rules, and the Plan does not promptly receive full reimbursement pursuant to its request, the Plan shall have a right to set-off from any future payments payable on your behalf under this Plan.

The Plan's rights of reimbursement, lien, and subrogation described above, are in addition to all other rights of equitable subrogation, constructive trust, equitable lien and/or statutory lien the Plan may have for reimbursement of these payments. All of these rights are preserved and may be pursued at the Plan's option against you or any other appropriate person or entity.

For any payment made by the Plan under these rules, you are still responsible for your copayments, deductibles, timeliness in submission of claims, and other obligations under this Plan.

Nothing in these Third Party Liability Rules shall limit the Plan's ability to coordinate benefits as described in this Chapter.

MEDICAL EXPENSE BENEFITS

ELIGIBLE MEDICAL EXPENSES

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 **"Allowed 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 a maximum Plan benefit as shown in the Schedule of Medical 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 Schedule of Medical Benefits in this document 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 cost-sharing limit, applicable to deductibles, copayments and coinsurance, no further cost-sharing will apply for the calendar year. The Plan also requires preauthorization (pre-approval) for certain services as explained in the Utilization Management chapter.

NON-ELIGIBLE MEDICAL EXPENSES

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are:

1. not determined to be Medically Necessary,
2. determined to be in excess of the Allowed Charge,
3. not covered by the Plan,
4. in excess of a Maximum Plan Benefit

NETWORK HEALTH CARE PROVIDER SERVICES

- **Network (also called Preferred Provider, Participating Provider, or Contracted Provider):** If you receive medical services or supplies from a Health Care Provider that is contracted with the Plan's medical network you will be responsible for paying less money out of your pocket. Health Care Providers who are under a contract with the network 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, or workers' compensation. In those cases, the contracts of Health Care 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 Allowed Charge.

- **Out-of-Network (also called Non-Network, Non-Preferred, Non-Participating, or Non-Contracted):** refers to providers who are not contracted with the medical plan's Network and who **do not** generally offer any fee discount to the Plan participant or to the Plan. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount** for any balance that may be due **in addition to** the Allowed charge payable by the Plan, also called balance billing. **To avoid balance billing, use Network providers**.

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 any contributions for coverage, balance billing amounts or non-covered/excluded medical expenses. See also the section on Out-of-Pocket Limit that controls the amount of certain cost-sharing you pay each year.

DEDUCTIBLES

The annual deductible is the amount you must pay each calendar year, toward eligible medical expenses, before the Plan begins to pay benefits. Each calendar year, you (and **not** the Plan) are responsible for paying your Eligible Medical Expenses until you satisfy the annual Deductible and then the Plan begins to pay benefits. There are two types of annual Deductibles: Individual and Family.

- The **Individual Deductible** is the maximum amount one covered person has to pay toward Eligible Medical Expenses before Plan benefits begin for that covered person. The amount of the Individual Deductible is explained on the Schedule of Medical Benefits.
- The **Family Deductible** is the maximum amount that a family of two or more persons (a covered person with one or more dependents) is responsible for paying before the Plan begins to pay Eligible Medical Expenses for anyone in the family (covered person or dependent) who has not already met the Individual Deductible. Once the family deductible is met for the year, the individual deductible does not have to be met for any remaining individuals in that family in that year. The amount of the Family Deductible is explained on the Schedule of Medical Benefits.

COINSURANCE

Coinsurance refers to how you and the Plan will split the cost of certain covered medical expenses. Once you've met your annual Deductible, the Plan generally pays a percentage of the eligible medical expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the coinsurance. The coinsurance related to a covered benefit is described on the Schedule of Medical Benefits.

MEDICAL OUT-OF-POCKET LIMIT (ANNUAL LIMIT ON IN-NETWORK COST SHARING)

This Plan has a Medical Out-of-Pocket Limit which limits your annual cost-sharing for covered essential health benefits received from Network providers related to medical Plan deductibles, coinsurance, and copayments to the amounts permitted under the ACA and implementing regulations.

The Medical Out-of-Pocket Limit is the most you pay in cost-sharing (deductibles, copayments and coinsurance) during a one-year period (the calendar year) before your medical plan starts to pay 100% for covered essential health benefits received from Network providers. The amount of the annual Medical Out-of-Pocket Limit is explained on the Schedule of Medical Benefits.

- The Medical Out-of-Pocket Limit is accumulated on a calendar year basis.
- Covered expenses are applied to the Medical Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.
- The family Medical Out-of-Pocket Limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this plan's "per person in a family" annual Medical Out-of-Pocket limit.

- Covered medical plan expenses and covered outpatient prescription drug expenses accumulate to meet separate Out-of-Pocket Limits.

The Medical Out-of-Pocket Limit does not include or accumulate:

a. Premiums and/or contributions for coverage,

b. Expenses for medical services or supplies that are not covered by the Plan,

c. Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers,

d. Outpatient prescription drug expenses,

e. Expenses for dental plan and vision plan services.

PRESCRIPTION DRUG OUT-OF-POCKET LIMIT (ANNUAL LIMIT ON IN-NETWORK COST SHARING)

This Plan has a Prescription Drug Out-of-Pocket Limit which limits your annual cost-sharing for covered essential health benefits received from Network providers related to medical Plan deductibles, coinsurance, and copayments to the amounts permitted under the ACA and implementing regulations.

The Prescription Drug Out-of-Pocket Limit is the most you pay in copayments during a one-year period (the calendar year) before your medical plan starts to pay 100% for covered outpatient prescription drugs received from Network pharmacies. The amount of the annual Prescription Drug Out-of-Pocket Limit is explained on the Schedule of Medical Benefits.

- The Prescription Drug Out-of-Pocket Limit is accumulated on a calendar year basis.
- Covered expenses are applied to the Prescription Drug Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.
- The family Prescription Drug Out-of-Pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this plan's "per person in a family" annual Prescription Drug Out-of-Pocket Limit.
- Covered medical plan expenses and covered outpatient prescription drug expenses accumulate to meet separate Out-of-Pocket Limits.

The Prescription Drug Out-of-Pocket Limit does not include or accumulate:

f. Premiums and/or contributions for coverage,

g. Expenses for outpatient prescription drugs that are not covered by the Plan,

h. Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network pharmacies,

i. Medical expenses, services and supplies,

j. Expenses for dental plan and vision plan services.

SCHEDULE OF MEDICAL BENEFITS

A schedule of the Plan's medical benefits appears on the following pages in a chart format. Each of the Plan's medical benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column. Specific differences in the benefits when they are provided In-Network (when you use Network Providers) and Out-of-Network (when you use Non-Network Providers) are shown in the subsequent columns.

In the Schedule of Medical Benefits, Deductibles, Out-of-Pocket Limits, Hospital Services (Inpatient) and Physician and Health Care Practitioner Services are listed in the first few rows because these categories of benefits apply to most (but not all) health care services covered by the Plan. These rows are followed by

descriptions, **appearing in alphabetical order**, of the other covered medical benefits along with any limitations and exclusions to those covered benefits.

All benefits shown in the Schedule of Medical Benefits are subject to the Plan's Deductibles unless there is a specific statement that the deductible does not apply.

To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits, even if they seem to be included in Hospital Services or Physician and Health Care Practitioner Services, and you should also check the Exclusions chapter of this document to see if they are excluded.

COMPLYING WITH MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with 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.

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

All medical plan claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim or itemized bill or receipt submitted after this period. See also the Claim Filing and Appeal Information chapter for more information. Also review the section "Limitation On When A Lawsuit May Be Started" in the Claims and Appeals chapter.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*

Deductible	• The annual deductible is the fixed dollar amount you must pay each calendar year before the Plan begins to pay benefits.
	• Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan.
	• The following amounts do not count toward your annual deductible:
	  • Coinsurance or copayments for services that are not subject to the annual deductible
	  • Payments for services subject to a maximum once you reach the maximum
	  • The difference between the actual charge and the eligible charge that you pay when you receive services or supplies from an out-of-network provider (also called Balance Billing)
	  • Payments for non-covered services
	  • Any amounts you owe in addition to your coinsurance or copayments for covered services
		$150 per person
		$450 per family
		Effective only for services or supplies received between January 1, 2020 and December 31, 2020, the deductible has been decreased to:
		$100 per person
		$300 per family	

Medical Out-of-Pocket Limit The Out-of-Pocket Limit is the most you pay during a one-year period (the calendar year) before your medical plan starts to pay 100% for covered essential health benefits. • The Out-of-Pocket Limit is accumulated on a calendar year basis. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • Covered outpatient prescription drug expenses accumulate to a separate outpatient drug Out-of-Pocket limit.	**The Medical Plan Out-of-Pocket Limit does not include or accumulate:** a) Premiums and/or contributions for coverage; b) Expenses for medical services or supplies that are not covered by the Plan; c) Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers; d) Expenses for the dental plan and vision plan; and e) Expenses for outpatient drugs (these accumulate to a separate outpatient drug Out-of-Pocket Limit.) f) Payments for services subject to a maximum once you reach the maximum g) Any amounts you owe in addition to your coinsurance or copayments for covered services	$2,500 per person $7,500 per family	

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Prescription Drug Out-of-Pocket Limit The Out-of-Pocket Limit is the most you pay during a one-year period (the calendar year) before your plan starts to pay 100% for covered outpatient prescription drugs. • The Out-of-Pocket Limit is accumulated on a calendar year basis. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • **Covered medical expenses accumulate to a separate Medical Out-of-Pocket limit.**	**The Prescription Drug Out-of-Pocket Limit does not include or accumulate:** a) Premiums and/or contributions for coverage; b) Expenses for outpatient prescription drugs that are not covered by the Plan; c) Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers; d) Expenses for the dental plan and vision plan; and e) Expenses for medical services or supplies (these accumulate to a separate Medical Out-of-Pocket Limit. f) Payments for services subject to a maximum once you reach the maximum g) Any amounts you owe in addition to your coinsurance or copayments for covered services	$4,350 per person $6,200 per family	
Hospital Services (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units within the hospital (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services including surgical supplies, hospital anesthesia services and supplies, diagnostic and therapy services, drugs, dressings, oxygen, antibiotics, and hospital blood transfusion services. • Newborn care. See also the Maternity services row in this Schedule.	• Elective Hospitalization requires preauthorization by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. All Hospitalization is subject to concurrent review. See the Utilization Management chapter for details. • For some facility-billed services, the Plan uses a per case, per treatment, or per day fee (per diem) rather than an itemized amount (fee for service). This does not include practitioner -billed facility services. • If the UM Company informs you that you do not meet payment determination criteria for acute inpatient care but you meet payment determination for skilled nursing care, you must transfer to the first available skilled nursing facility bed. If you do not transfer to the skilled nursing bed, you must pay **all** acute inpatient charges beginning on the day you were informed you that you no longer meet acute inpatient payment determination criteria and a skilled nursing bed became available. • If you are hospitalized in a facility with private rooms only, or with semi-private and private rooms, coverage is based on the allowed charge for semi- private rooms and you owe the difference between the facility's charges for private and semi-private rooms. ***Exception:*** If you are hospitalized for conditions identified by the UM Company for which a private room is medically necessary, coverage is based on the facility's private room rate. • See the Eligibility chapter for how to properly enroll Newborns so coverage can be considered. • Specialty care hospitals, also called long term acute care (LTAC) hospitals, are discussed under the Skilled Nursing Facility row in this Schedule. • The professional fees for Physicians and Health Care Practitioners who deliver covered services to patients in a hospital/health care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	90% coinsurance after deductible	70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*

Physician and Other Health Care Practitioner Services
• Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, urgent care facility, outpatient/ambulatory surgery center, or other covered health care facility location.
• **Consultation services** are covered, as needed for surgical, obstetrical, pathological, radiological, or other medical conditions when all of these statements are true:
  ◦ The attending physician must require the consultation.
  ◦ If the consultation is for inpatient services, you must be confined as a registered bed patient.
  ◦ If the consultation is for inpatient services, the consultant's report must be acceptable to the Medical PPO Plan Claims Administrator. It must also be included as a part of the record kept by the hospital or skilled nursing facility.
  ◦ The consultation must be for reasons other than to comply with requirements by the hospital or skilled nursing facility
• See also the Family Planning, Maternity and Wellness rows where certain women's preventive services are payable without cost-sharing when obtained from Network providers.
	• See also the definition of Physician, Health Care Practitioner and Surgery in the Definitions chapter.
	• If required by the attending Physician and appropriate for your condition, general anesthesia, regional anesthesia and monitored anesthesia (when you meet the UM company's high-risk criteria) is covered.
	• The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "**Surgery"** in the Definitions chapter.
	• The Medical PPO Plan Claims Administrator will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure.
	• **Assistant Surgeon fees** will be reimbursed only for Medically Necessary services.
	• Under this Plan, there is no requirement to select a primary care provider (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.
	• Please refer to chapter beginning on page 94 for Chiropractic, Acupuncture and Massage benefits available through American Specialty Health.
	• **Covid-19 Test and Covid-19 Related Services, from March 18, 2020 through the end of the Emergency Period in which the federal government has announced a National Emergency.**
		Online Care visit: 100%, deductible does not apply
		
		Office visit: First visit – 100% after deductible Subsequent visits and anesthesia – 90% coinsurance after deductible
		
		Surgical Services: 80% coinsurance after deductible
		
		Covid-19 Related Services/Visit: 100%, deductible does not apply
			Online Care visit: Not covered
			
			Office visit and surgical services: 70% coinsurance after deductible
			
			Covid-19 Related Services/Visit: 100%, deductible does not apply

Advance Care Planning • Advance care planning (ACP) is a process of reflection, discussion, and communication that enables members to plan for when they're no longer able to make or communicate their decisions about medical treatment and other care.	• Covered when provided by a physician or other Health Care Practitioner. • Includes explanation and discussion of advance directives and forms, and may include completion of such forms.	100%, no deductible	30% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered when ordered by a Physician. • Desensitization injections are covered only when provided by a Physician or Health Care Practitioner. • No coverage for allergy services considered to be experimental by the Plan, such as sublingual allergy treatment. See Allergy in the Exclusion chapter.	80% coinsurance after deductible	70% coinsurance after deductible

Ambulance Services for Medical Emergency
• **Ground vehicle emergency transportation:**
  • to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency or acute illness/injury;
  • for Medically Necessary inter-health care facility transfer (e.g. transfer from one hospital to another hospital or trip to and from one hospital to another in order to obtain a special test/procedure).
• **Air emergency transportation** is payable: (1) only when Medically Necessary for treatment of a life-threatening Emergency, and (2) the air transport is required because of inaccessibility by ground transport and/or the use of ground transport would endanger the patient's health status. When air ambulance transportation is required, it is payable to the nearest acute health care facility qualified to treat the patient's emergency condition and is limited to intra-island or inter-island transportation within the state of Hawaii.
	• Expenses for ambulance services are covered only when those services are for an **Emergency,** as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care," or for Medically Necessary inter-health care facility transport.
	• **Non-emergency medical transportation** (sometimes called an ambulette) refers to transport of an individual in a vehicle because the individual cannot safely use public or private transportation due to their Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because they require the use of medical equipment or non-emergency medical monitoring during transport. **Non-emergency medical transportation services are not payable by this Plan**.
		80% coinsurance after deductible	70% coinsurance after deductible

Ambulatory Surgical Center	• See the Outpatient (Ambulatory) Surgery Facility row in this Schedule.		

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Behavioral Health Services **(Mental Health and Substance Abuse Treatment)** • **Outpatient visits:** including necessary Psychological (Psychiatric) Testing. • **Other Outpatient Services**: partial day care/partial hospitalization or intensive outpatient program (IOP) care. See the Definitions chapter for the meaning of the term partial day care and intensive outpatient program. • **Inpatient acute hospital admission**, or inpatient residential treatment program. See the Definitions chapter for the meaning of the term residential treatment.	• **Elective inpatient admission to a hospital mental health or substance abuse treatment, or admission to an inpatient residential treatment program requires preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See the Utilization Management chapter for details. • For assistance locating behavioral health providers best qualified to treat your needs please contact the Assistance and Recovery Program (ARP) at the number listed in the Quick Reference Chart at the front of this document. • Behavioral Health inpatient **residential treatment program** is covered for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. An inpatient residential treatment facility must be properly licensed in the state in which the facility operates. **Preauthorization is required**. • Outpatient prescription drugs for Behavioral Health payable under Drugs in this Schedule of Medical Benefits. • Programs based on learning theories and motivation, such as Applied Behavior Analysis (ABA) Therapy, are not a covered benefit. • See the specific exclusions related to Behavioral Health Services, in the Exclusions chapter. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospital/health care facility are usually billed separately from the facility fee. See the payment parameters detailed to the right.	After deductible met: **Outpatient visits, Professional fees:** 100% **Other Outpatient Services Facility fee:** 80% coinsurance **Psych Testing:** 100% **Inpatient: Hospital and Inpatient Residential Treatment Program facility fee:** 90% coinsurance	70% coinsurance after deductible
Birthing Center/Facility	• See the Maternity Services row of this Schedule.		
Blood Transfusions • Blood transfusions, blood bank services, blood processing, and blood products and equipment for its administration.	• Covered when ordered by a Physician or Health Care Practitioner.	80% coinsurance after deductible	70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Benefits for high-dose chemotherapy, high-dose radiation therapy, or related services and supplies are covered when provided in conjunction with stem-cell transplants. • Chemotherapy infusions and injections are covered including chemical agents and their administration to treat malignancy. Chemotherapy drugs must be FDA approved and must include at least one antineoplastic (monoclonal antibodies) drug.	80% coinsurance after deductible	70% coinsurance after deductible
Chiropractic Services	• Please refer to chapter beginning on page 94 for Chiropractic, Acupuncture and Massage benefits available through American Specialty Health.		
Circumcision • Circumcision for newborn males	• Routine circumcision other than for a newborn male is not covered.	100% after deductible	70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*

Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental)
• Coverage is provided for Medically Necessary Prosthetic and Orthotic devices as follows:
  ◦ rental (but only up to the allowed purchase price of the device).
  ◦ purchase of standard model. Rental or purchase determined by the Plan Administrator or its designee.
  ◦ repair, adjustment or servicing of the device when Medically Necessary.
  ◦ replacement of the device is payable if there is a change in the covered person's physical condition making the current device inoperable or unsatisfactory in order to perform normal daily activities (as certified by the patient's Physician), or if the device cannot be satisfactorily repaired.
• Corrective Appliances are covered when ordered by a Physician or Health Care Practitioner.
• Occupational therapy adaptive self-help supplies or devices to assist a person in performing activities of daily living such as feeding, dressing or bathing.
• Medically necessary colostomy, ostomy and/or urinary catheter supplies.
• Hearing exams and external hearing aids, including non-experimental implantable hearing devices such as cochlear implants.
	• See the exclusions related to Corrective Appliances in the Medical Exclusions chapter. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter.
	• **Please Note:** Certain prosthetics and orthotics require **preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document.
	• **Prosthetic Devices** are payable. Replacement for prosthetics only as determined to be Medically Necessary.
	• **Non-Foot Orthotics,** such as a back brace or knee brace, are payable when medically necessary to provide therapeutic support or restore function, including necessary supplies, repair and servicing.
	• **Foot Orthotics** (orthopedic or corrective shoes and other supportive appliances for the feet) are payable for specific diabetic conditions, partial foot amputations, if they are an integral part of a leg brace and are necessary for the proper functioning of the brace, or rehabilitative foot orthotics if they are being prescribed as part of post-surgical or post-traumatic casting care.
	• Supplies necessary for the effective functioning of a prosthetic or orthotic are covered subject to certain limitations and exclusions.
	• Vision appliances, including contact lenses, are covered for certain medical conditions. Covered items include scleral cover shells when medically necessary as an artificial support or as a protective barrier in the treatment of severe dry eye, and refractive lenses when medically necessary to restore the vision normally provided by the natural lens of the eye of an individual lacking the organic lens because of surgical removal or congenital absence. Vision examinations and appliances for routine refraction are not covered; please see the Vision Care Benefits chapter for additional vision benefits.
	• **Hearing exams and external hearing aids** are payable, see the Hearing row in this Schedule.
		80% coinsurance after deductible	70% coinsurance after deductible.

Diabetes Prevention Program	• A long-term lifestyle change program aimed at lowering the risk of diabetes and improving health. It is designed to prevent or delay the onset of type II diabetes among individuals diagnosed with pre-diabetes. • Limited to one program per lifetime. • Preauthorization by the UM company is required.	100%, no deductible	Not covered

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Dialysis • Dialysis (generally provided for the treatment of acute kidney failure, end-stage kidney disease, or chronic kidney disease). • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. • When you have reached the end stage of kidney failure (renal impairment) that causes your Physician to recommend a kidney transplant or regular course of dialysis, you may be eligible for Medicare. **It is important that individuals with end stage renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. If you qualify for Medicare Part A (coverage for hospitals), you can also get Medicare Part B (coverage for outpatient services, ambulance, DME). Most people must pay a monthly premium for Part B (e.g. for individuals with income of $85,000 or less, the premium is $135.50 in 2019). Enrolling in Part B is your choice, but you'll need both Medicare Part A and Part B to get the full benefits available under Medicare to cover certain dialysis and kidney transplant services. • See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare eligible. • **Medicare and ESRD:** Once you are eligible for Medicare, you should apply for enrollment in Medicare. If the application for enrollment is accepted, Medicare coverage may begin. Medicare coverage begins at different times for different people depending on the circumstances. Medicare coverage usually starts the first day of the 3rd month after the month in which a course of regular dialysis begins. All, or a portion of, the 3-month waiting period may be waived if you participate in a self-dialysis training program, or if you have a kidney transplant within the 3-month waiting period. **When you are on dialysis and covered by both Medicare and this group health plan, for the first 30 months (referred to a 30-month coordination period), your group health plan is the primary payer of your dialysis and other covered medical services.** It is important to note that the 30-month coordination period always begins on the date you are first eligible to enroll in Medicare due to ESRD. If for example, you fail to submit a timely application for Medicare or choose not to apply for Medicare, the 30-month coordination period will be calculated with a start date based on the month in which you could have been enrolled, had you made an application for Medicare. • Medicare becomes the primary payer of benefits after the 30-month coordination period ends, as long as you retain Medicare eligibility based on ESRD. A Medicare beneficiary may have more than one 30-month coordination period. Medicare entitlement (meaning eligibility and coverage under Medicare) because of ESRD, will end if you have not received dialysis for 12 months, or if 36 months have passed since you had a successful kidney transplant.	80% coinsurance after deductible	70% coinsurance after deductible
Dietitian Services	• See Nutritional Counseling row. • Certain dietary counseling may be payable as a Wellness service in accordance with requirements of the Affordable Care Act (ACA).		

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Disease Management Programs • Covered, for programs available through HMSA's Health and Well-Being services for members with asthma, diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and behavioral health conditions (mental health and substance abuse). The programs offer services to help you and your physician manage your care and make informed health choices. • You may be automatically enrolled in some of these programs or referred by your physician.	• Deductible and Coinsurance do not apply to these benefits when received In-Network.	100%, no deductible	Not covered

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*

Drugs (Outpatient Medicines)
• Coverage is provided 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 licensed Physician or other Health Care Practitioner authorized by law to prescribe them.
• Contact the Medical PPO Plan (whose phone number is listed on the Quick Reference Chart in the front of this document) for the following:
  • The list of drugs on the **HMSA Essential Prescription Formulary**.
  • Information on **drugs needing prior authorization** (pre-approval) by the clinical staff of the Medical PPO Plan.
  • Information on which **drugs have a limit to the quantity** payable by this Plan.
  • Information on which drugs are part of the **step therapy program** where you first try a proven, cost-effective medication before moving to a more costly drug option.
 	
(continued on next page)
	The Prescription Drug Program: Benefits for prescription drugs are provided through the Medical PPO Plan whose name is listed on the Quick Reference Chart in the front of this document.
	• **Retail Drugs**: To obtain up to a 30-day supply of medicine for the copay noted to the right present your ID card to any Network retail pharmacy. Contact the Medical PPO Plan (whose name is listed on the Quick Reference Chart) for the location of Network retail pharmacies.
	• **Mail Order (Home Delivery) Drug Service:** The mail order service is the easiest and least expensive way to obtain many maintenance use drugs, plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure, high cholesterol, or diabetes. Note that not all medicines are available via mail order. Check with the Medical PPO Plan for further information. To use the mail order service, have your doctor write the prescription for a 90-day supply, with the appropriate refills and call the mail order service at the number listed in the Quick Reference Chart.
	• The Plan offers up to a 90-day supply of medication at any network Retail pharmacy location. 60 day supply will be covered for two retail copayments, 90 day supply covered for three retail copayments.
	• The Plan provides a **mandatory generic program** meaning that if a brand name drug is dispensed in place of a generic drug, regardless if you or your doctor request it, you will pay the brand copay plus the difference in cost between the generic and brand name drug.
	• **Direct Member Reimbursement for use of an Out-of-Network Retail Pharmacy**: If you fill a prescription at an Out-of-Network pharmacy location, you will need to pay for the drug at the time of purchase and later (within a year), send your drug receipt to the Medical PPO Plan using the Direct Member Reimbursement (DMR) process as listed on the Quick Reference Chart. DMR forms may be obtained from the Medical PPO Plan. For eligible prescriptions, you will be reimbursed 80% of the eligible charge minus the appropriate copayment. Oral chemotherapy drugs, preferred brand diabetic supplies, and spacers and peak flow meters will be reimbursed at 100% of the eligible charge. You will be responsible for any balance billing.
	• If the cost of the drug is less than the copay/coinsurance, you pay just the drug cost.
	• No coverage for male contraceptives; over-the-counter (OTC) medications, except the Plan covers insulin, female contraceptives, and drugs required by the Affordable Care Act (ACA; non-preferred erectile dysfunction drug treatment; fertility drugs; drugs from foreign countries; convenience packaged drugs including kits; unit dose drugs; lifestyle drugs (drugs that improve a way or style of living rather than alleviating a disease); or replacements for lost, stolen, damaged, or destroyed drugs or supplies. See also the exclusions related to Drugs (Medicines) in the Exclusions chapter. See also the definition of "Experimental and/or Investigational" in the Definitions chapter.
	• Covered outpatient prescription drugs do not accumulate to meet the annual Medical Out-of-Pocket Limit but instead accumulate to the Prescription Drug Out-of-Pocket Limit. Copayments for drugs do not accumulate to meet the Plan's Deductible(s).
	
	(continued on next page)
		No deductible applies to outpatient drugs
		
		ACA Preventive Care Drugs: No charge
		
		Network Retail Pharmacy (up to a 30-day supply):
		Tier 1: $7 copayment
		Tier 2: $30 copayment
		Tier 3 $75 copayment
		Tier 4: $100 copayment
		
		Mail Order Service (up to a 90-day supply):
		Tier 1: $11 copayment
		Tier 2: $65 copayment
		Tier 3Brand: $200 copayment
		Specialty Drugs: Not covered
			Retail Pharmacy: If you fill a prescription at an Out-of-Network retail pharmacy location, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the Prescription Benefit Manager (PBM) using the Direct Member Reimbursement (DMR) process as described to the left. **The PBM will reimburse 80% of the eligible charge, less the following copayments**:
			Tier 1: $7 copayment
			Tier 2: $30 copayment
			Tier 3: $75 copayment
			Tier 4: Not covered
			
			Mail Order: Not covered

Drugs (Outpatient Medicines) (continued from previous page) • **Specialty drugs** are available on an outpatient basis only when ordered through and managed by the Medical PPO Plan. Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique or chronic conditions such as multiple sclerosis, rheumatoid arthritis, Crohn's disease, psoriasis, cancer or hepatitis. These drugs **need prior authorization**, often require special handling, are date sensitive and are generally available only in a 30-day quantity. • Drugs not yet approved by the FDA are not covered**. New FDA-approved drugs** will be covered by the Plan unless an amendment states otherwise or the class of drug is excluded.	**(continued from previous page)** • Products not approved by the U.S. Food and Drug Administration (FDA) are not covered, except for Phenobarbital and Renal Electrolyte replacements. • Compound preparations are covered if they contain at least one Prescription Drug that is not a vitamin or mineral, subject to a and b below. For compounds made with covered non-specialty drugs, you owe the Tier 3 copayment. For compounds made with a covered Specialty drug(s), you owe the Tier 4 copayment. a) Compound drugs that are available as similar commercially available prescription drug products are not covered. b) Compound drugs made with bulk chemicals are not covered. c) Non-FDA approved drugs are not covered. • Coverage of vitamins and minerals that are Prescription Drugs is limited to: a) 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 to treat cancer. b) Sodium fluoride, if dispensed as a single drug (for example, without any additional drugs such as vitamins) to prevent tooth decay. • ***NO COST DRUGS WHEN OBTAINED AT NETWORK PHARMACY***: • **FDA-approved contraceptives for females:** 100%, no cost-sharing from in-network providers for generic contraceptives submitted with a prescription. No charge for brand prescription contraceptives only if a generic contraceptive is unavailable, or generic is medically inappropriate as determined by the attending provider. If received from a Non-Network retail pharmacy you will need to pay the full cost at the time of purchase and must submit a claim for reimbursement of 80% of the eligible charge, less the applicable copayment for oral contraceptives, or a $10 copayment per device for diaphragms and cervical caps. • **Tobacco/smoking cessation benefit**: Coverage is extended for over the counter or prescription FDA-approved tobacco cessation products (such as nicotine gum or patches) or programs intended to assist an individual to stop smoking or using tobacco products at no charge as a preventive care drug up to a maximum of 180 days of treatment per person per calendar year. The drugs are payable through the Prescription Drug Program at no cost when received from a network pharmacy. Present a written prescription from a Physician for FDA-approved tobacco cessation products to the retail pharmacist. This benefit is not available through the Plan's mail order program. See also the Behavioral Health row for counseling support. If additional tobacco cessation drugs are needed beyond 180 days of treatment, benefits will be provided in accordance with the Plan's benefits for non-preventive care drugs, at the applicable copayments depending on drug Tier and Pharmacy used. • Certain Drugs to Reduce the Risk of Breast Cancer: no charge at a network Retail or Mail Order location for **generic tamoxifen** or raloxifene prescribed for women who are at increased risk of breast cancer and low risk for adverse medication effects. • Certain **CDC recommended vaccinations** are payable at 100%, no cost sharing when obtained at a network retail pharmacy. Contact the Medical PPO Plan for more information. • In accordance with the Affordable Care Act (ACA, certain **over-the-counter (OTC) and prescription drugs** are payable at no charge when prescribed and filled at a network pharmacy. • Oral chemotherapy drugs. • The following diabetic supplies: syringes, needles, lancets, lancet devices, test strips, acetone test tablets, insulin tubing, and calibration solutions. • Spacers and peak flow meters.	**No deductible applies to outpatient drugs** **ACA Preventive Care Drugs: No charge** **Network Retail Pharmacy (up to a 30-day supply):** **Tier 1**: $7 copayment **Tier 2**: $30 copayment **Tier 3** $75 copayment **Tier 4:** $100 copayment **Mail Order Service (up to a 90-day supply):** **Tier 1**: $11 copayment **Tier 2**: $65 copayment **Tier 3** : $200 copayment **Tier 4**: Not covered	**Retail Pharmacy**: If you fill a prescription at an Out-of-Network retail pharmacy location, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the Prescription Benefit Manager (PBM) using the Direct Member Reimbursement (DMR) process as described to the left. **The PBM will reimburse 80% of the eligible charge, less the following copayments**: **Tier 1**: $7 copayment **Tier 2**: $30 copayment **Tier 3**: $75 copayment **Tier 4**: Not covered **Mail Order**: Not covered

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*

Durable Medical Equipment (DME)
• Coverage is provided for:
  • rental (but only up to the allowed purchase price of the Durable Medical Equipment);
  • purchase of standard model equipment. Rental or purchase determined by the Plan Administrator or its designee, and certain items are covered only as rentals;
  • repair, adjustment or servicing of Medically Necessary DME;
  • replacement of Medically Necessary Durable Medical Equipment is payable only if there is a change in the covered person's physical condition making the equipment not functional/unsafe, or if the equipment cannot be satisfactorily repaired at a lesser expense;
  • supplies and accessories that are necessary for the function of the durable medical equipment are also covered subject to certain limitations and exclusions, so long as the equipment is medically necessary for the individual who is covered under this Plan.
• If more than one piece of DME can meet the functional needs, benefits are available only for the most cost-effective piece of durable medical equipment.
• Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for oxygen administration.
• Coverage is provided for diabetic blood glucose meter (if preauthorization is obtained) and other medically necessary diabetes durable medical equipment.
	• To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter.
	• Durable Medical Equipment (and supplies necessary for the function of the durable medical equipment) is covered only when its use is Medically Necessary and when ordered by a Physician or Health Care Practitioner.
	• **Durable Medical Equipment costing $1,000 or more per device/equipment requires preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document.
	• For females who are breastfeeding, coverage is provided for a standard manual or standard electric breast pump, plus the breast pump supplies necessary to operate the breast pump if purchased from an In-Network provider. A hospital grade breast pump is payable if the infant is unable to nurse directly on the breast due to a medical condition such as prematurity, congenital anomaly and/or an infant is hospitalized. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child. Rental, purchase and repair is payable as outlined to the left. Coverage is available at no cost from Network providers only. No coverage out-of-network.
	• You are not covered for treatments, services or supplies that are prescribed, ordered or recommended primarily for your comfort or convenience, or the comfort or convenience of your provider or caregiver. Such items may include ramps, home remodeling , hot tubs, swimming pools, deluxe/upgraded items, or supplies such as surgical stockings and disposable underpads.
	• You are not covered for duplicate durable medical equipment and supplies, orthotic and external prosthetics, and vision and hearing appliances that are intended to be used as a back-up device, for multiple residences, or for traveling, e.g., a second wheeled mobility device specifically for work or school use or a back-up manual wheelchair when a power wheelchair is the primary means of mobility.
	• See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions chapter.
		Breast pump and supplies necessary to operate pump: 100%, no deductible.
		
		All other DME: 80% coinsurance after deductible
			Breast Pump and supplies necessary to operate pump: Not covered.
			
			All other DME: 70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Emergency Room Facility, Urgent Care Facility • Hospital emergency room (ER) for "Emergency Services" (as that term is defined in this Plan). • Urgent Care facility. Common medical conditions that may be appropriate for a Physician office or Urgent Care facility (instead of an Emergency Room) include, but are not limited to, fever, sore throat, earache, cough, flu symptoms, sprains, bone or joint injuries, diarrhea or vomiting, or bladder infections. • Retail store-based medical clinic/facility. • Ancillary charges (such as lab or x-ray) performed **during** the ER visit. • (See also the Ambulance section of this schedule. • Both the emergency room visit facility and professional fees are payable as part of the emergency room visit in this row.	• If you need Emergency Services, call 911 or go to the nearest emergency room for care. • **Emergency room facility services**. The Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with Affordable Care Act (ACA) regulations. See the definition of Allowed Charge and Emergency Services. Contact the medical plan Claims Administrator for details on what the Plan allows as payment to Out-of-Network emergency service providers. • Emergency room services that are not Emergency Services (as that term is defined in this Plan) are not covered. • If you are admitted as an inpatient after a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits. • There is no requirement to preauthorize the use of a hospital-based emergency room visit. The Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with Affordable Care Act (ACA) regulations. See the definition of Allowed Charge and Emergency Services. Contact the medical plan Claims Administrator for details on what the Plan allows as payment to Out-of-Network emergency service providers. • **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.**	**Emergency Room**: 80% coinsurance after deductible **Urgent Care Facility**: 90% coinsurance after deductible **Retail Clinic Facility**: 90% coinsurance after deductible Covid-19 Related Services/Visit: 100%, no deductible	**Emergency Room**: 80% coinsurance after deductible **Urgent Care Facility**: 70% coinsurance after deductible **Retail Clinic Facility**: 70% coinsurance after deductible Covid-19 Related Services/Visit: 100%, no deductible
Endoscopy Facility (Outpatient) • Endoscopy is a procedure to evaluate the interior surfaces of an organ by inserting a device such as an endoscope into the body, including but not limited to the lungs (bronchoscopy), intestines (colonoscopy), bladder (cystoscopy), stomach (gastroscopy), etc.	• The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an endoscopy facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	Facility Fees: 80% coinsurance after deductible	Facility Fees: 70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Enteral Therapy Services • Enteral nutritional therapy provides nourishment directly (e.g. feeding tube) to the digestive tract of a person who cannot ingest an appropriate amount of calories and nutrients to maintain an acceptable nutritional status. Enteral nutritional formula is payable when medically necessary **and preauthorized** and meets this criteria: When the formula is the primary source of nutrition (i.e., 60% or more of caloric nutritional intake) and ALL of the following criteria are met: a. Without enteral feedings, the individual would be unable to obtain sufficient nutrients to maintain an appropriate weight by dietary adjustment and/or oral supplements, and b. The individual has one of the following conditions that is expected to be permanent or of indefinite duration: • an anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel; • disease of the small bowel that impairs absorption of an oral diet; • a central nervous; or system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.	• Enteral therapy services are covered when ordered by a Physician or Health Care Practitioner. • **Enteral therapy services require preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. • Coverage for a home enteral infusion pump (and associated necessary supplies) is considered payable when the use of the pump is medically necessary because the individual cannot tolerate gravity or syringe feedings or requires a controlled rate of infusion of the enteral formula. • Enteral nutritional formula that is not payable by the Plan includes: • standardized or specialized infant formula (e.g., Alimentum, Elecare, Neocate, and Nutramigen), or baby food for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitivity, or formula for protein, soy or fat digestive problems. • food thickeners, dietary and food supplements including but not limited to puddings, powders, mixes, vitamins and minerals; lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products and the like. • weight-loss or weight-gain foods, formulas or products; normal grocery items, low carbohydrate foods, nutritional supplement puddings, powders, mixes, vitamins and mineral.	80% coinsurance after deductible	70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Family Planning, Reproductive, Contraceptive, Fertility and Erectile Dysfunction Services • **Sterilization services** (e.g., vasectomy, tubal ligation, implants). No cost-sharing for female sterilization when performed by Network providers. Normal cost-sharing applies to male sterilization services. • Coverage is provided for ACA mandated (preventive service) **FDA-approved female contraceptives** such as oral birth control pills/patch, emergency contraception, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD) and removal of IUD, cervical cap, contraceptive ring (e.g. NuvaRing), diaphragm, implantable birth control device/service (e.g. Implanon, Nexplanon). See also the Drug row in this Schedule for information on FDA-approved contraceptive coverage where there is no charge for generic FDA-approved contraceptives submitted with a prescription and obtained from a network provider. No charge for a brand prescription contraceptive only if a generic contraceptive is unavailable, or medically inappropriate as determined by the attending provider. • Treatment of erectile dysfunction (impotency) including medical (e.g., prescription drugs such as Viagra or Cialis, or DME) and/or surgical services.	• For maternity coverage see the Maternity row in this schedule. • • No coverage for reversal of sterilization procedures. • There is no cost-sharing for FDA-approved female contraceptives and female sterilization services from in-network providers. Certain contraceptives are available through the Prescription Drug Program (see the Drugs row of this Schedule). • No coverage for services or supplies related to the diagnosis or treatment of infertility except as specifically noted for one in-vitro fertilization procedure, as specifically noted in this Schedule below. • For treatment of erectile dysfunction, services, supplies, prosthetic devices, and injectables approved by HMSA are covered. Benefits vary depending on the type of service received. See other sections of this Schedule for the service or supply received. • See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Erectile Dysfunction Services in the Exclusions chapter.	Female contra-ceptives and Female sterilization procedures: 100%, no deductible. For other services: 80% coinsurance after deductible.	Female contraceptive: 70% coinsurance, deductible does not apply For other services: 70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*

Genetic Testing and Counseling
• Medically necessary genetic testing payable under this Plan only if you meet the Medical PPO Plan Claims Administrator's criteria for: the following conditions:
  • Attenuated familial adenomatous polyposis (AFAP)
  • Autism Spectrum Disorder
  • BRCA1 and BRCA2 Mutations
  • Carrier Status for Genetic Diseases
  • Carrier Status for Tay-Sachs, Canavan Disease, Familial Dysautomia, Fanconi anemia, Niemann-Pick (type A), Bloom Syndrome, and Gaucher's Disease
  • Congenital Anomalies
  • Cystic Fibrosis
  • Developmental Delay/Intellectual Disability
  • Factor V Leiden, Prothrombin G20210A Mutation
  • Familial adenomatous polyposis (FAP)
  • Fragile X Syndrome
  • Hemoglobinopathies - Thalssemias and sickle-cell disease
  • HFE-associated Hereditary Hemochromatosis (HHC) Gene Mutations
  • Hypertrophic Cardiomyopathy (HCM)
  • Long QT Syndrome
  • Lynch syndrome (hereditary nonpolyposis colorectal cancer)
  • MYH associated polyposis (MAP)
  • Thiopurine Methyltransferase Gene (TPMT)
• 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).
	• See the definitions of Genetic Counseling, Genetic Testing in the Definitions chapter.
	• See the Exclusions chapter for exclusions relating to Genetic Testing and Counseling, in addition to those indicated here**.**
	• 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.
	• **Preauthorization is required for some genetic testing.** Plan participants should contact the Utilization Management Program to assist in determining if a proposed genetic test will be covered or excluded.
	• Genetic Counseling is payable only when ordered by a Physician, performed by a qualified Genetic Counselor (or other qualified health care provider) and provided with regard to a genetic test that is payable by this Plan. Certain genetic counseling is payable as a Preventive service in accordance with the Affordable Care Act (ACA) regulations.
		Affordable Care Act (ACA) Affordable Care Act (ACA) required genetic tests & counseling: 100% no deductible
		
		All other genetic testing and genetic counseling: 80% coinsurance after deductible
			Genetic testing and genetic counseling: 70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Growth Hormone Therapy Covered if you meet the Medical PPO Plan Claims Administrator's criteria and if growth hormone is for replacement therapy services to treat: • Hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy. • Turner's syndrome. • Growth failure secondary to chronic renal insufficiency awaiting renal transplant. • AIDS-wasting or cachexia without evidence of suspected or overt malignancy and where other modes of nutritional supplements (e.g., hyperalimentation, enteral therapy) have been tried. • Short stature. • Neonatal hypoglycemia secondary to growth hormone deficiency. • Prader-Willi Syndrome. • Severe growth hormone deficiency in adults.	• **Growth hormone therapy services require preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document.	80% coinsurance after deductible	70% coinsurance after deductible.
Hearing Services • An audiology (audiometry) hearing exam to screen for hearing loss. • External hearing aids	• Hearing (audiology) exam is payable. • Hearing aids are limited to one hearing aid per ear every 60 months. • Hearing aid fitting, adjustment, repair and batteries are not covered. • Medically necessary implantable hearing devices for individual with profound hearing loss (e.g. cochlear implant) are covered as a prosthetic device. See the Corrective Appliance row.	Audiology Exam: 90% coinsurance after deductible External Hearing Aid: 80% coinsurance after deductible	70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Home Health Care and Home Infusion Therapy Services • Part-time, intermittent **Skilled Nursing Care** services and Medically Necessary supplies to provide in-home Home Health Care or home infusion services, subject to an Annual Maximum Plan Benefit shown in the Explanations and Limitations column. • See also the definition of Infusion Therapy in the Definitions chapter. • **Home services other than Skilled Nursing Care are not covered.**	• **Home health care and home Infusion Therapy services for more than 30 days require preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. • See the exclusions related to Home Health Care and Custodial Care (including personal care and child care) in the Exclusions chapter of this document. • Home Health Care and Home Infusion services are covered only when ordered by a Physician or Health Care Practitioner and provided by a licensed home health care agency for a covered individual that is Homebound and who would need inpatient hospital or skilled nursing facility care without home health care, and the services are not more costly than alternate services that would be effective to diagnose and treat your condition. • Services and supplies for outpatient injections or intravenous administration of medication, biological therapeutics, biopharmaceuticals, or intravenous nutrient solutions needed for primary diet are covered. Drugs must be FDA approved. • The Annual Maximum Plan Benefit is 150 days per person per calendar year. • Home Hospice coverage is payable under Hospice benefits. • Home Physical Therapy services coverage is payable under the Rehabilitation Services benefits.	100% after deductible	70% coinsurance after deductible
Hospice • Hospice services (palliative care for terminally ill persons) include inpatient hospice care and outpatient home hospice care when the patient meets the definition of hospice in the Definitions chapter of this document. • Residential hospice room and board expenses directly related to the hospice care being provided. • Hospice referral visits during which a patient is advised of hospice care options, regardless of whether the referred patient is later admitted to hospice care.	• Covered when ordered by a Physician or Health Care Practitioner. The attending physician must certify in writing that the individual is terminally ill and has a life expectancy of six months or less. • While under hospice care, the individual is not eligible for benefits for the terminal condition except hospice services and attending physician office visits. The individual is eligible for all covered benefits unrelated to the terminal condition. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospice inpatient facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	100% after deductible	Not covered

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
In-Vitro Fertilization If you have a male partner, you and your male partner must have a five-year history of infertility or infertility is related to one or more of the following medical conditions: • Endometriosis; • Exposure in utero to diethylstilbestrol (DES); • Blockage or surgical removal of one or both fallopian tubes; or • Abnormal male factors contributing to the infertility. If you do not have a male partner, you must meet the following criteria: • You are not known to be otherwise infertile, and • You have failed to achieve pregnancy following three cycles of physician directed, appropriately timed intrauterine insemination.	• **In-vitro fertilization requires preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. • Coverage is limited to a one-time only benefit for one outpatient in-vitro fertilization procedure while you are covered. • See the exclusions related to Fertility and Infertility Services in the Exclusions chapter of this document. • The in-vitro procedures must be performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine's minimal standards for programs of in-vitro fertilization. • Benefits vary depending on the type of service received. See other sections of this Schedule for the service or supply received.	80% coinsurance after deductible	70% coinsurance after deductible
Laboratory Services (Outpatient) • Technical and professional fees. • Common Laboratory services include diagnostic testing related to chemistry, hematology, urinalysis, toxicology, microbiology, blood banking, anatomic pathology–surgical pathology and/or cytopathology. Specialty reference laboratory services can include gene-based and molecular testing, allergy testing, transplant matching, tumor tissue analysis, infectious disease testing, etc.	• Covered when ordered by a Physician or Health Care Practitioner. • Covered when related to an illness or injury. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Some laboratory services are payable under the Wellness benefits in this Schedule. • **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: 100%, deductible does not apply All other: 80% coinsurance after deductible	Covid-19 Test: 100%, deductible does not apply All other: 70% coinsurance after deductible

Maternity Services • Hospital and Birth (Birthing) Center charges and Physician and Certified Nurse Midwife fees for Medically Necessary maternity services for all covered females. Coverage for the baby is only payable if the child is a Dependent Child as defined in this Plan, and properly enrolled in a timely manner. • Hospital and Birth (Birthing) Center are payable as noted on the Hospital Services (Inpatient) row of this Schedule. • See Genetic Testing for additional information. See the Family Planning row and Drug row for information on contraceptive coverage. • See the Eligibility chapter on how to enroll a Newborn Dependent Child(ren). • Breastfeeding equipment (breast pump) and supplies needed to operate the pump are payable as noted on the Durable Medical Equipment row of this Schedule. • While obstetrical ultrasounds may be part of routine prenatal care, normal radiology cost-sharing applies to ultrasound services. See the Radiology row of this Schedule. • Elective induced (voluntary) abortion.	• See the exclusions related to Maternity Services in the Exclusions chapter. • Routine prenatal visits, delivery and one postpartum visit are covered. Providers are paid a global fee related to a bundle of maternity care. If benefit payments are made separately before delivery, payments will be considered an advance and the amount will be deducted from the global benefit payment for maternity care. • Certain prenatal care/maternity related preventive care expenses are payable for all females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to screening for gestational diabetes, HPV testing starting at age 30, blood pressure screening throughout a pregnancy to check for preeclampsia, and when breastfeeding there is coverage for breastfeeding equipment and supplies need to operate the equipment and comprehensive lactation support and counseling). These services are covered without cost sharing for a female when obtained from Network providers. • Prenatal services not covered under the women's preventive/wellness coverage include, but are not limited to, lab & radiology services, delivery and high-risk prenatal services. • There is a prenatal care program available through HMSA Well-Being Connection which helps expectant couples through normal and at-risk pregnancies with information and support services. You may be automatically enrolled in some of these programs or referred by your physician. • **Hospital Length of Stay for Childbirth:** Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans 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. If you deliver in the hospital, the 48-hour period (or 96-hour period) starts at the time of delivery. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner 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 preauthorization. **For information on preauthorization for a length of stay longer than 48 hours for vaginal delivery or 96 hours for C-section delivery, contact the UM Company to preauthorize the extended stay.** Refer to the Utilization Management chapter in this document for information on preauthorization. • **Elective induced (voluntary) abortion** is covered • You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. • Newborns are covered after the first 48 hours (or 96 hours for caesarian section) if enrollment is requested within 31 days of birth. Newborns with congenital defects and birth abnormalities are covered for the first 31 days of birth even if not added to your coverage. These newborns are covered after 31 days of birth only if enrollment is requested within 31 days of birth.	ACA mandated preventive services: 100%, no deductible Maternity Care (Prenatal visits, Delivery, and one Postpartum Visit): 100% after deductible Elective Induced Abortion: 80% coinsurance after deductible	Breast-feeding equipment and supplies not covered. Maternity Care (Prenatal visits, Delivery, and one Postpartum Visit): 70% coinsurance after deductible Elective Induced Abortion: 70% coinsurance after deductible
Medical Foods • "Medical Foods" for persons with "inherited metabolic disorders" (as those terms are defined in the Definitions	• Medical foods (defined in this Plan) are payable for persons with inherited metabolic disorders subject to the following provisions, as determined by the Plan Administrator or their designee: • Must be prescribed by a Physician to treat a diagnosis of "inherited metabolic disorder" (as that term is defined in this Plan).	80% coinsurance after deductible	80% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
chapter of this document) subject to the conditions noted to the right.	• The patient must require specially processed or treated medical foods that must be consumed throughout their life without which, the patient may suffer serious mental or physical impairment. • The patient must be under the regular supervision of a Physician to monitor the inherited metabolic disorder. • The Medical Food must be consumed or administered enterally under the supervision of a physician.		
Mental Health and Substance Abuse/Substance Use Disorder Treatment	• See the Behavioral Health row of this Schedule.		

Nondurable Medical Supplies
• Coverage is provided for Medically Necessary nondurable supplies dispensed and used by a Physician or Health Care Practitioner in conjunction with treatment of the covered individual.
• Coverage is provided for Medically Necessary:
  • Sterile surgical supplies used immediately after surgery (generally for up to a 31-day supply).
  • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances.
  • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.
  • Dialysis supplies.
  • Colostomy and ostomy supplies and/or urinary catheter supplies.
  • Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered under the Prescription Drug Program. Necessary diabetic insulin pump supplies (if not available under the Prescription Drug Program) are payable under this benefit.
	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter.	80% coinsurance after deductible	70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Nutritional Counseling • Benefits are payable for nutritional counseling to assist individuals with their nutritional health and dietary needs as medically necessary treatment of a mental health condition such as an eating disorder. • While the Plan encourages you to obtain nutritional counseling from a Registered Dietitian or licensed or certified Nutritionist, the Plan will cover nutritional counseling performed by a certified or licensed provider acting within the scope of their license.	• Nutritional counseling other than for an eating disorder or as a covered preventive care service is not covered. • Certain dietary counseling is payable as a Preventive (Wellness) service in accordance with Affordable Care Act (ACA) requirements. Please see the Wellness (Preventive) row for more information.	100% after deductible	70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*

Oral, Craniofacial Services
• Accidental Injury to Teeth/Jaw
• Oral and/or Craniofacial Surgery.
• Orthodontic services for the treatment of orofacial anomalies
• Charges by an oral maxillofacial surgeon for reduction of a facial bone fractures, removal of jaw tumors, treatment of jaw dislocations, treatment of facial and oral wounds or lacerations or infections (cellulitis), and removal of cysts or tumors of the jaws/facial bones. See also the exclusions related to Dental Services in the Exclusions chapter.
	• **Oral, craniofacial services require preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document.
	• **Treatment of Accidental Injuries to the Teeth**: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met:
	  • The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and
	  • The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and
	  • The dental treatment will return the person's teeth to their pre-injury level of health and function. The dental treatment provider is encouraged to seek pre-treatment approval from the Plan Administrator for dental work.
	  • Under this Plan, approved dental treatment is payable under the Medical Plan without regard to whether there is also associated Dental Plan coverage.
	See also the definition of Injury to Teeth in the Definitions chapter of this document.
	• See also the exclusions related to Dental Services in the Exclusions chapter.
	• Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, surgery to correct injuries; cutting and draining of cellulitis; cutting of sinuses, salivary glands, or ducts; reduction of dislocations and removal of jawbone joint; and major oral surgery for augmentation (building up) of the gum ridge.
	• Other than the services noted as covered in this row, the Plan does not cover other dental services, including but not limited to removal of impacted teeth including removal of wisdom teeth, endodontics such as root canal, gingivectomy, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement) treatment or prevention of Temporomandibular Joint dysfunction/syndrome or orthognathic surgery for treatment of malocclusion of the teeth or bones of the jaw. See also the exclusions related to Dental Services in the Exclusions chapter.
		80% coinsurance after deductible	70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Outpatient (Ambulatory) Surgery Facility/Center • Ambulatory (Outpatient) Surgical Facility/Center (e.g. surgicenter, same day surgery, outpatient surgery) that provides surgical services without an overnight stay. • Includes operating rooms, surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics, blood transfusion services, routine lab and x-ray related to surgery.	• The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an outpatient (Ambulatory) Surgery facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	80% coinsurance after deductible	70% coinsurance after deductible
Prescription Drugs (Outpatient)	• See the Drug row for information on outpatient retail and mail order prescription and medication.		
Prosthetic Devices	• See the Corrective Appliances row in this Schedule.		
Radiology (X-Ray), Nuclear Medicine, Imaging Studies and Radiation Therapy Services (Outpatient) • Radiology refers to the branch of medicine using x-rays, radiopharmaceuticals (like radioisotopes, intravenous dye or contrast materials), magnetic resonance and ultrasound to create images (pictures) of the body that are used to help in the diagnosis and treatment of disease or injury. • Common radiology services include chest x-ray, abdomen/kidney x-ray, spine x-ray, CT/MRI/PET and bone scan, ultrasound, angiography, mammogram, fluoroscopy, and bone densitometry. • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures are covered under the Wellness Programs described in this Schedule. • **MRI, CT and PET scans require preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Management chapter for details.	80% coinsurance after deductible	70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*

Reconstructive Services and Breast Reconstruction After Mastectomy
• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
  • reconstruction of the breast on which the mastectomy was performed;
  • surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  • prostheses and physical complications for all stages of mastectomy, including lymphedemas.
These benefits are covered applying the same cost-sharing as is relevant to other medical/surgical plan benefits.
• Reconstructive Surgery only if such procedures or treatment are intended to improve bodily function, repair a functional defect and/or to correct deformity or disfigurement resulting from disease, infection, trauma, congenital or developmental anomaly (when present from birth and that severely impair or impede normal, essential bodily functions) or covered surgery.
	• The Plan covers replacement external breast prostheses and mastectomy bras when medically necessary.
	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter. Most Cosmetic and Dental (including Orthognathic) services are excluded from coverage.
	• Complications of a non-covered cosmetic reconstructive surgery are not covered.
		Outpatient: 80% coinsurance after deductible
		
		Inpatient: 90% coinsurance after deductible
			70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Rehabilitation Services (Pulmonary) • **Pulmonary Rehabilitation** is available to those individuals with a chronic respiratory disorder (e.g. emphysema, COPD) who are able to actively participate in a Pulmonary Rehabilitation program that is likely to improve their respiratory condition, as determined by the Plan Administrator or its designee. • Benefits are subject to the limitations and Maximum Plan Benefit shown in the Explanations and Limitations column to the right.	• **Pulmonary rehabilitation requires preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Management chapter for details. • **Cardiac rehabilitation** and Dr. Ornish's program for reversing heart disease are not covered. • Maintenance programs are not covered. • See also the Definition of Pulmonary Rehabilitation in the Definitions chapter of this document.	80% coinsurance after deductible	70% coinsurance after deductible
Rehabilitation Services (Physical, Occupational & Speech Therapy) • Short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician or Health Care Practitioner. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.**	• **Inpatient Rehabilitation admission, outpatient physical therapy, outpatient occupational therapy, and outpatient speech therapy require preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Management chapter for details. • Maintenance Rehabilitation, coma stimulation services and Habilitation services are not covered. See specific exclusions relating to Rehabilitation in the Exclusions chapter and the definition of Maintenance Rehabilitation in the Definitions chapter. • Rehabilitation services are covered when ordered by a Physician or Health Care Practitioner under an individual treatment plan. • Rehabilitation 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, injury, or prior therapeutic intervention. • **Speech therapy** is covered if the services are provided by a licensed or duly qualified speech therapist to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure. Delays in speech development are covered when the delay is a result of an illness, injury or, a congenital defect that has been surgically repaired. • Speech therapy is not considered medically necessary and is not a covered benefit for self-correcting dysfunctions causing dysfluency or articulation disorders such as stuttering, stammering, lisping and tongue thrusting or defects in voice quality such as in pitch, loudness, or to improve public speaking. Speech therapy for developmental delay/developmental learning disabilities is not covered.	Inpatient: 90% coinsurance after deductible Outpatient: 80% coinsurance after deductible	70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility, also called Long Term Acute Care (LTAC) Facility. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a skilled nursing facility or subacute facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• Inpatient admission is subject to concurrent review. See the Utilization Management chapter for details. • Services must be ordered by a Physician. To determine if a facility is a skilled nursing facility or subacute facility/long term acute care facility, see the Definitions chapter of this document. • Room and board is covered, but only for semi-private rooms IF you are admitted by your physician, care is ordered and certified by your physician, confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care, confinement is not for custodial care, services and supplies are covered, including routine surgical supplies, drugs, dressings, oxygen, antibiotics blood transfusion services, and diagnostic and therapy services. • **Skilled Nursing Facility confinement or Subacute care facility confinement is** payable up to 120 days per calendar year. • Private duty nursing is covered if ordered by a physician for a covered health care condition.	90% coinsurance after deductible	70% coinsurance after deductible

Smoking/Tobacco Cessation Benefits
• This benefit can be used to help with nicotine addiction (to stop smoking or stop chewing tobacco).
	• Screening for tobacco use; and,
	• For those who use tobacco products, coverage is provided for at least two tobacco cessation attempts per year. Cessation attempt includes coverage for:
	  • Four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
	  • All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization. See the Drug row of this Schedule of Medical Benefits for more information.
		100%, no deductible	70% coinsurance after deductible

Substance Abuse/Substance Use Treatment	• See the Behavioral Health row of this Schedule.		
Supportive Care Services • Supportive Care is a comprehensive approach to care for members with a serious or advanced illness including Stage 3 or 4 cancer, advanced Congestive Heart Failure (CHF), advanced Chronic Obstructive Pulmonary Disease (COPD), or any advanced illness that meets the requirements of the Supportive Care policy. Members receive comfort-directed care, along with curative treatment from an interdisciplinary team of practitioners.).	• Supportive Care is only available in Hawaii and when a member is referred by his or her physician. Please note: • Supportive Care referral visits during which a patient is advised of Supportive Care options are covered, regardless of whether the referred member is later admitted to Supportive Care. • Coverage is limited to 90 calendar days of services in a 12-month period that begins the first day Supportive Care services are provided.	100%, after deductible	Not covered

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Telehealth Telehealth is the use of telecommunications services to transmit medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis when the parties are separated by distance.	• Services provided by telehealth must otherwise be covered and not excluded by the Plan. • Telecommunications services, include: - Store and forward technologies. - Remote monitoring. - Live consultation. - Mobile health. • Standard phone contacts, facsimile transmissions, or email texts, in combination or by itself, are not covered. • Benefits vary depending on the type of service received. See other sections of this Schedule for the service or supply received.	100%, deductible does not apply	Not covered
Transplants (Organ and Tissue) • Coverage is provided only for eligible services directly related to Medically Necessary and non-experimental transplants of human organs or tissue including bone marrow, peripheral stem cells, cornea, heart, heart/lung, small bowel and multivisceral, kidney, kidney/pancreas, liver, lung(s), pancreas, along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies. • Transplant Evaluations are covered, if approved by the UM Company for heart, heart-lung, liver, lung, pancreas, simultaneous kidney/pancreas, small bowel and multivisceral, or stem-cell transplants. This includes those procedures, including lab and diagnostic tests, consultations, and psychological evaluations that a facility uses in evaluating a potential transplant candidate. This coverage is limited to one evaluation per transplant request and must be rendered either at a facility that is located in the State of Hawaii and has a contract with HMSA to perform the transplant or is an approved Blue Distinction Center for Transplants. • Reasonable and necessary medical expenses incurred by a donor are payable without any cost-sharing applicable to those expenses, **but only to the extent the donor is not covered by the donor's own insurance or health care plan**.	• **Transplant services including Transplant Evaluations require preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Management chapter for details. Failure to get preauthorization for will result in a denial of benefits. • Benefits are payable only if services are provided in a Hospital or Health Care Facility approved by the Plan Administrator or its designee. • Benefits for the screening of donors are limited to expenses of the actual donor. No benefits are available for screening expenses of candidates who do not become the actual donor. • Benefits are not available for: artificial (mechanical) organs, except for artificial hearts when used as a bridge to a permanent heart transplant, non-human organs, organ or tissue transplants not listed in this row, your transportation for organ or tissue transplant services, transportation of organs or tissues, or organ or tissue transplants received out of country. • See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions chapter.	Organ Donor Services: 80% coinsurance after deductible Other Transplant services: 100% after deductible	Organ Donor Services: 70% coinsurance after deductible Other Transplant services: Not covered

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*
Weight Management • As a **preventive counseling benefit** in compliance with the Affordable Care Act (ACA), the Plan covers (for adults who a body mass index of 30 kg/m^2 or higher) **intensive behavioral counseling** interventions to promote a healthful diet and physical activity for CVD prevention. Intensive behavioral counseling interventions means the Plan will consider as medically necessary preventive services, up to a combined 26 individual or group visits per 12-month period by a network provider. • As a **preventive counseling benefit** in compliance with the Affordable Care Act (ACA), for children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician. • Weight loss surgery (bariatric surgery) is covered as explained to the right.	• **Bariatric surgery requires preauthorization** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Management chapter for details. • Bariatric surgery is covered if you meet the UM Company's criteria and when the facility is located in the state of Hawaii, has a contract with HMSA to perform bariatric surgery and has a comprehensive weight management program, or the facility is an approved Blue Distinction Center for bariatric surgery with an agreement for continuity of care in the state where the member resides. • No coverage for skin reduction procedures/surgery related to weight loss.	Bariatric surgery: 80% after Deductible is met Preventive Counseling Benefit: 100% no deductible	Bariatric surgery: Not covered Preventive Counseling Benefit: 70% coinsurance after deductible
Well-Being Connection • Covered, for you and your covered dependents age 18 and older. Well-Being Connect is an online health portal that includes a well-being assessment that evaluates your health and lifestyle. The assessment helps you design a personal well-being plan that fosters healthy behavior.	• This benefit is available to Participants and dependents 18 and older only.	100%, no deductible	Not covered

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*

Wellness (Preventive) Program Well Child Examinations and Immunizations
 	
• The wellness/preventive services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations as outlined to the right.
• Preventive services are payable without regard to gender assigned at birth, or current gender status.
• Certain prescription and non-prescription drugs, required to be covered in compliance with Affordable Care Act (ACA), are available through the Outpatient Prescription Drug program.
	• The wellness/preventive services payable by this Plan are designed 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). These websites (periodically updated) list the types of payable preventive services, including immunizations: 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.hrsa.gov/womensguidelines/, https://mchb.hrsa.gov/maternal-child-health-topics/child-health/bright-futures.html, https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/ (A and B rated recommendations).
	• If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual deductible and/or copay/coinsurance.
	• When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. deductible, copay, coinsurance) for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. deductible, copay, coinsurance) will apply to the diagnostic or therapeutic services provided.
	• If an Affordable Care Act (ACA) preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters.
	• Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required.
	• In addition to the wellness services listed on the websites above, the Plan will pay for these wellness services:
	  • well child immunizations
	  • well child office visits
	  • Preventive health evaluation, which may include a physical examination, one per calendar year
	  • Disease management programs are available for asthma, diabetes, cardiovascular disease, COPD, and behavioral health conditions.
	  • Travel immunizations.
	• Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions.
		ACA preventive services, disease management services: 100%, no deductible
		
		Well Child Immunizations, Office visits: 100%, no deductible
		
		Annual preventive health evaluation: 100%, no deductible
		
		PSA test: 100%, no deductible
			ACA preventive services for children, disease management services: not covered
			
			Well Child Immunizations: 100%, no deductible
			
			Well Child Office visit: 70% coinsurance, no deductible
			
			Annual preventive health evaluation: not covered
			
			PSA test: 70% coinsurance after deductible

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*

Wellness (Preventive) Program: Well Woman Care
• The wellness/preventive services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations as outlined to the right.
• Preventive services are payable without regard to gender assigned at birth, or current gender status.
• Certain prescription and non-prescription drugs, required to be covered in compliance with Affordable Care Act (ACA), are available through the Outpatient Prescription Drug program.
• Travel immunizations, and immunizations for high risk conditions such as Hepatitis 8 and other vaccines in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP).
	• The wellness/preventive services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations and the current A and B 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 (such as immunizations, mammogram, pap smear, screening colonoscopy with anesthesia and colon polyp removal): https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.hrsa.gov/womensguidelines/.
	• If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual deductible and/or copay/coinsurance.
	• When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. deductible, copay, coinsurance) for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. deductible, copay, coinsurance) will apply to the diagnostic or therapeutic services provided.
	• If an Affordable Care Act (ACA) preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters.
	• Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required.
	• Additional coverage is provided for:
	  ◦ Annual preventive health evaluation, which may include a physical exam, one per calendar year.
	  ◦ Coverage is provided for **one gynecology exam** per calendar year, and **one Pap smear lab test** every three years from age 21 to 65.
	  ◦ Chlamydia screening and tubal ligation are also covered. Reversal of tubal ligation is not covered.
	  ◦ Coverage is provided for a **screening mammogram** and interpretation of it once per calendar year for women age 40 and older.
	  ◦ Disease management programs are available for asthma, diabetes, cardiovascular disease, COPD, and behavioral health conditions.
	• Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions.
		100%, no deductible	ACA preventive services, disease management services, Annual preventive health evaluation: Not covered
			
			Chlamydia screening, pap smear, well woman exam, tubal ligation: 70% coinsurance after deductible
			
			Mammogram: 70% coinsurance, no deductible

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. **See also the Exclusions and Definitions chapters of this document for important information**.
All benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network	Out-of-Network*

Wellness (Preventive) Program: Adult Well Man Care
• The wellness/preventive services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations as outlined to the right.
• Preventive services are payable without regard to gender assigned at birth, or current gender status.
• Certain prescription and non-prescription drugs, required to be covered in compliance with Affordable Care Act (ACA), are available through the Outpatient Prescription Drug program.
• Travel immunizations, and immunizations for high risk conditions such as Hepatitis 8 and other vaccines in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP).
	• The wellness/preventive services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations and the current A and B 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 (such as immunizations, mammogram, pap smear, screening colonoscopy with anesthesia and colon polyp removal): https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.hrsa.gov/womensguidelines/.
	• If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual deductible and/or copay/coinsurance.
	• When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. deductible, copay, coinsurance) for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. deductible, copay, coinsurance) will apply to the diagnostic or therapeutic services provided.
	• If an Affordable Care Act (ACA) preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters.
	• Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required.
	• Additional coverage is provided for:
	  ◦ Annual preventive health evaluation, which may include a physical examination, one per calendar year.
	  ◦ Prostate Specific Antigen (PSA) screening test for men age 50 or older, limited to one per calendar year.
	  ◦ Chlamydia and Gonorrhea screenings
	  ◦ Disease management programs are available for asthma, diabetes, cardiovascular disease, COPD, and behavioral health conditions.
	• Additional diagnostic exams and tests that are Medically Necessary because of the patient's condition are covered, subject to the Plan's Deductibles, Coinsurance or Copayments and all other Plan provisions.
		ACA preventive services, preventive health evaluation, chlamydia or gonorrhea screenings, disease management: 100%, no deductible
		
		PSA screening test: 80% coinsurance, no deductible
			ACA preventive services, preventive health evaluation, chlamydia or gonorrhea screenings, disease management services, Annual physical exam: Not covered
			
			PSA screening test: 70% coinsurance after deductible

Preventive Services Benefit

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010. Coverage is provided on an in-network basis only, with no cost-sharing (for example, no deductibles, coinsurance, or copayments), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics *Bright Futures* guidelines and HRSA guidelines relating to services for women

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the participant or dependent. This means that the service will be covered at 100% of the Plan's allowable charge, with no coinsurance, copayment, or deductible.

If preventive services are received from a non-network provider, they will not be eligible for coverage under this Preventive Services benefit unless there is no provider in the Plan's network who can provide the particular service.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

Preventive Services Coverage Limitations and Exclusions

1. Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Service covered for diagnostic reasons are covered under the applicable plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the participant or dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.
2. Services covered under the Preventive Services benefit are not also payable under other portions of the Plan.
3. The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.
4. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations (e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.
5. Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan.
6. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:
    a. When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;

b. When related to judicial or administrative proceedings;

c. When related to medical research or trials; or

d. When required to maintain employment or a license of any kind.

7. Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit, except as stated above.

8. Services related to a man's reproductive capacity, such as vasectomies and condoms.

UTILIZATION MANAGEMENT

Purpose of the Utilization Management (UM) Program: Your plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. The development of new drugs, medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for the Fund to afford the cost of maintaining your plan.

To enable your plan to provide coverage in a cost-effective way, your plan has adopted a Utilization Management Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Fund is better able to afford to maintain the Plan and all its benefits. If you follow the procedures of the Plan's Utilization Management Program, you may avoid some out-of-pocket costs. However, if you don't follow these procedures, your plan provides reduced benefits, and you'll be responsible for paying more out of your own pocket.

Management of the Utilization Management Program: The Plan's Utilization Management Program is administered by an independent professional Utilization Management Company operating under a contract with the Plan (hereafter referred to as the UM Company). The contact information for the UM Company appears in the Quick Reference Chart in the front of this document.

The health care professionals in the UM Company focus their review on the necessity and appropriateness of hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical, surgical and prescription drug services. In carrying out its responsibilities under the Plan, the appropriate UM Company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan.

Medical management requirements described in this chapter do not apply when coverage under this Plan is secondary to another plan providing benefits for a covered individual. **Elements of the Utilization Management Program**: The Plan's Utilization Management Program consists of:

1. **Preauthorization (preservice) review**: review of proposed health care services before the services are provided;
2. **Concurrent (continued stay) review**: ongoing assessment of the health care as it is being provided, typically involving inpatient confinement in a hospital or health care facility or review of the continued duration of healthcare services;
3. **Second and third opinions**: consultations and/or examinations designed to take a second, and, when required, a third look at the need for certain elective health care services;
4. **Retrospective review**: review of health care services after they have been provided; and
5. **Case Management**: a process whereby the patient, the patient's family, Physician and/or other Health Care Providers, and the Fund work together under the guidance of the Plan's independent Utilization Management Company to coordinate a quality, timely and cost-effective treatment plan. Case Management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

Restrictions and Limitations of the Utilization Management Program (Very Important Information):

1. The fact that your Health Care Provider recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that your Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the Medical Plan.
2. The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's certification that a

service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.

3. All treatment decisions rest with you and your Health Care Provider. You should follow whatever course of treatment you and your Health Care Provider believes to be the most appropriate, even if the UM Company does not certify a proposed surgery/treatment/service or admission as Medically Necessary or as an eligible expense. However, the benefits payable by the Plan may be affected by the determination of the UM Company.
4. With respect to the administration of this Plan, the Fund, the Claims Administrator and the UM Company are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM Company as Medically Necessary, or for the results if the patient chooses to receive health care services that have not been certified by the UM Company as Medically Necessary.
5. **Preauthorization of a service does not guarantee that the Plan will pay benefits for that service** because, other factors, such as ineligibility for coverage on the actual date of service, the information submitted during preauthorization varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

PREAUTHORIZATION (PRESERVICE) REVIEW

How Preauthorization Review Works: Preauthorization Review is a procedure, administered by the UM Company, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are Medically Necessary. **The following services must be preauthorized BEFORE the services are provided:**

WHAT SERVICES MUST BE PREAUTHORIZED BY THE UTILIZATION MANAGEMENT COMPANY:

For a current list of services and supplies that require preauthorization, contact the Medical PPO Plan at the contact information shown on the Quick Reference Chart in the front of this document.

1. **Elective Hospital admissions for medical or surgical care**. (*Note: for delivery of a child, preauthorization is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section*);
2. All **Elective inpatient Hospital admissions and inpatient residential treatment program admissions for behavioral health (mental health or substance abuse) care**;
3. Bariatric surgery
4. An upcoming **transplant** as soon as the participant is identified as a potential transplant candidate;
5. Growth hormone therapy
6. Orthodontic services for the treatment of orofacial anomalies
7. Orthotics and external prosthetics
8. Admissions to any type of Health Care Facility for **Inpatient Rehabilitation**.
9. Outpatient physical and occupational therapy
10. In vitro fertilization
11. **Diagnostic tests** that are estimated to cost $1,000 or more, (such as MRI, CT and PET scans, etc.)
12. **Durable Medical Equipment**
13. **For individuals who plan to participate in a clinical trial**, preauthorization is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
14. Disease management programs
15. Diabetes Prevention Program

Prior notification does not mean benefits are payable in all cases.
Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations.
There is no requirement to preauthorize the use of a hospital-based emergency room visit.

WHAT SERVICES MUST BE PREAUTHORIZED BY THE PRESCRIPTION DRUG BENEFIT OF THE MEDICAL PPO PLAN
(whose contact information is listed on the Quick Reference Chart in the front of this document):

Certain medications such as Specialty drugs and compound drugs require preauthorization by contacting the Prescription Drug Program. For a current list of prescription drugs that require preauthorization, contact the Medical PPO Plan's Prescription Drug Benefit as shown on the Quick Reference Chart in the front of this document.

Preauthorization does not mean benefits are payable in all cases.
Coverage depends on the drug(s) that are actually provided, your eligibility status at the time the drug is provided, and any benefit limitations.

How to Request Preauthorization (Pre-service Review):

REMINDER: It is YOUR RESPONSIBILITY to assure that preauthorization occurs when it is required by this Plan. Any penalty for failure to preauthorize is on you, not the Health Care Provider.

You or your Health Care Provider must call the appropriate UM Company at the telephone number shown in the Quick Reference Chart in the front of this document.

1. **Calls for elective (non-emergency) services should be made at least 10 days before the expected date of service or drug start date.**
2. The caller should be prepared to provide all of the following information: the Fund's name, employee's name, patient's name, address, and phone number and social security number; Health Care Provider's name, and phone number or address; the name of any Hospital or outpatient facility or any other Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
3. When calling to preauthorize, **if the preservice review process was not properly followed** the caller will be notified as soon as possible but no later than 5 calendar days after your request.
4. If additional information is needed, the UM Company will advise the caller. The UM Company will review the information provided, and will let you, your Health Care Provider and the Hospital or other Health Care Provider, and the Claims Administrator know whether or not the proposed health care services have been certified as Medically Necessary. The UM Company will usually respond to your treating Health Care Provider **by telephone within 3 working days (but no later than 15 calendar days) after it receives the request and any required medical records and/or information**, and its determination will then be confirmed in writing.
5. **Note that an approved preauthorization does not guarantee payment of benefits.** This could be for a variety of reasons such as: the information submitted during preauthorization varies from the actual services performed on the date of service, the service performed is not a covered benefit, and/or you are ineligible for benefits on the actual date of service.
6. If your admission or service is determined not to be Medically Necessary, you and your Health Care Provider will be given recommendations for alternative treatment. You may also pursue an appeal. See the Claims and Appeals Procedures chapter regarding appealing a UM determination.

EMERGENCY HOSPITALIZATION

If an emergency requires hospitalization, there may be no time to contact the UM Company before you are admitted. If this happens, the UM Company must be notified of the hospital admission within 48 hours. You, your Health Care Provider, the hospital, a family member or friend can make that phone call to the UM Company. This will enable the UM Company to assist you with your discharge plans, determine the need for continued medical services, and/or advise your Health Care Providers of the various Network support providers and benefits available for you and offer recommendations, options and alternatives for your continued medical care.

CONCURRENT (CONTINUED STAY) REVIEW

How concurrent (continued stay) review works:

1. When you are receiving medical services in a hospital or other inpatient health care facility, the UM Company will monitor your stay by contacting your Health Care Providers to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.
2. Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your Health Care Providers of various options and alternatives for your medical care available under this Plan.

3. If at any point your stay your services are found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your Health Care Provider will be notified. This does not mean that you must leave the hospital or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility. If it is determined that your hospital stay or services were not Medically Necessary, no benefits will be paid on any related hospital, medical or surgical expense.

SECOND AND THIRD OPINIONS

1. At any time during the review process, you may be asked by the UM Company to obtain a Second Opinion about a proposed health care service to help determine if the health care service is Medically Necessary, or if an alternative effective approach to the individual patient's health care management exists. A Second Opinion may be requested when it appears that there may be a question regarding the effectiveness or reliability of a proposed service, the proposed service involves a high risk in relation to the anticipated benefit; or there appear to be conflicting diagnoses, vague indications, or possible inadequate clinical management.
2. If a Second Opinion is requested, the UM Company will arrange for an examination by a Health Care Provider who is certified by the American Board of Medical Specialists in the field related to the proposed service, is independent of the Health Care Provider who proposed the service; and will not be eligible to perform the service.
3. The Second Opinion Health Care Provider may review past medical records along with clinical findings from the provider's own examination of the patient, and will report their findings to the UM Company. If the Second Opinion recommendation differs from the treating Health Care Provider's recommendation, you may be requested to obtain a Third Opinion from another Health Care Provider who will be selected in the same manner as the Second Opinion Health Care Provider. The results of the Third Opinion will be reviewed by the UM Company, and the recommendation of the majority of the Health Care Providers (the attending Health Care Provider, and the Second and Third Opinion Health Care Providers) will prevail.
4. If, as a result of the Second and/or Third Opinion, it is determined that the procedure recommended by the treating Health Care Provider is not Medically Necessary, **no benefits will be payable if you choose to undergo the procedure**. See also the section of this chapter regarding Appealing a UM Determination.
5. **Patient-Requested Second and Third Opinions**: If the UM Company does not require a Second Opinion, but you or your covered Dependent requests one, it will be provided in the manner described in the preceding section, except that you or your covered Dependent may get the Second Opinion from any Network Health Care Provider. If the Second Opinion differs from the treating Health Care Provider's recommendation, you may request a Third Opinion in the manner described above.
6. **Cost of the Second and Third Opinions**: The Plan will pay the full cost for any Second and Third Opinion; and a percentage of the cost (set forth in the Schedule of Medical Benefits describing the Second and Third Health Care Provider Opinions) for any Second and Third Opinion not required by the Plan but requested by the patient.

RETROSPECTIVE (POST-SERVICE) REVIEW

Claims for medical services or supplies that have not been reviewed under the Plan's Preauthorization, Concurrent (Continued Stay) Review, or Second and Third Opinion Programs may, at the option of the Claims Administrator, be subject to retrospective review to determine if they are Medically Necessary. If the Claims Administrator receives a determination from a UM Company or other designated medical review firm that services or supplies were not Medically Necessary, **no benefits will be provided by the Plan for those services or supplies.** See also the section of this chapter regarding Appealing a UM Determination. For complete information on claim review and claim appeals, see the Claim Filing and Appeals Information chapter of this document.

CASE MANAGEMENT

Sometimes navigating the world of health care is confusing and a bit overwhelming. It's helpful to have a knowledgeable professional guide (a case manager) to help you and your family through the maze of health care options, decisions and confusing health care terms. Case management support services may be particularly helpful for patients who require complex, high-technology health care services.

How Case Management Works: Case Management is a voluntary process, administered by the UM Company. Its medical professionals work with the patient, family, caregivers, Health Care Providers, Claims Administrator and the Fund to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers. See the section titled Restrictions and Limitations of the Utilization Management Program in this chapter.

Working with the Case Manager: Any Plan Participant, Physician, or other Health Care Provider can request Case Management services by calling the UM Company at the telephone number shown on the Quick Reference Chart in the front of this document. However, in most cases, the UM Company will be actively searching for those cases where the patient could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Manager of the UM Company will work directly with your Health Care Provider, Hospital, and/or other Health Care Facility to review proposed treatment plans and to assist in coordinating services, locating Network providers, and obtaining discounts from Non-Network Health Care Providers, as needed. From time to time, the Case Manager may confer with your Health Care Providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your Health Care Provider may call the Case Manager of the Utilization Management Company at any time at the telephone number shown on the Quick Reference Chart in the front of this document to ask questions, make suggestions, or offer information.

Under this Plan, if during the course of case management, the case manager identifies opportunities that may result in savings to the member or the Fund, the case manager will present these opportunities to the Plan for their consideration.

APPEALING A UM DETERMINATION (APPEALS PROCESS)

You may request an appeal of any adverse review decision made during the preauthorization, concurrent review, retrospective review, Case Management or second opinion review process described in this chapter. To appeal a denied preservice, urgent, concurrent care or post-service claim/bill, see the Claims and Appeals Procedures chapter of this document.

DISEASE MANAGEMENT (DM) AND WELLNESS PROGRAMS

Disease management and Wellness Programs support the patient/Health Care Practitioner relationship and the plan of care, emphasize techniques for prevention of disease progression and disease complications, and help the patient with strategies to improve self-care. Individuals who properly manage their conditions have fewer complications, shorter and fewer hospital stays and emergency room visits, are more productive and improve the quality of their life.

WELL-BEING CONNECTION

Well-Being Connection is an online health portal that includes a well-being assessment that evaluates your health and lifestyle and is available for you and your covered dependents age 18 and older. The assessment helps you design a personal well-being plan that fosters healthy behavior.

As part of Well-Being Connection, HMSA member get the personalized support of Hawaii-based health coaches over the phone at no cost. This confidential, voluntary program gives you access to coaches who are registered nurses, exercise physiologists, health educators, registered dietitians, or other health care professionals.

During 10-15 minute calls, a health coach can help you:

- Set and achieve your health goals.
- Manage stress.
- Lose weight.
- Create a healthy eating plan.
- Find fun, simple fitness routines.
- Quit tobacco use. Quitting tobacco is hard to do. Get the support you need from Hawai'i Tobacco Quitline. Call 1 (800) QUIT-NOW.

A health coach will call you to help you get started. Or, call 1 (855) 329-5461, option 1, toll-free Monday through Friday, 8 a.m.-5 p.m., to talk to a health coach.

DISEASE MANAGEMENT

Disease Management (DM) refers to a health education and self-care promotion program offered at no cost to Plan Participants diagnosed with the following chronic health conditions:

- Asthma
- Diabetes
- Cardiovascular disease
- Chronic obstructive pulmonary disease (COPD), and
- Behavioral health conditions (mental health and substance abuse).

The program is managed by HMSA Well-Being Connection and offers services to help you and your physician manage your care and make informed health choices. You may be automatically enrolled in this program or referred by your physician.

DIABETES PREVENTION PROGRAM

The Diabetes Prevention Program provides individuals with information and resources to help them change their lifestyle to improve their health. This program consists of 16 sessions during the first six months. After this time individuals may participate in maintenance sessions and follow-up meetings. A lifestyle coach provides support to help participants achieve their goals and maintain their progress.

Participants and Dependents may be eligible to participate if they:

- Are 18 years or older.
- Have a body mass index of at least 25 (or at least 23 if they identify as Asian).
- Meet at least one of the following three blood test requirements within the 12 months of the first core session:
    - A hemoglobin A1C test with a value between 5.7 and 6.4 percent.
    - A fasting plasma glucose of 100-125 mg/dl.
    - A two-hour plasma glucose of 140-199 mg/dl (oral glucose tolerance test).
- Haven't been diagnosed with type 1 or type 2 diabetes (other than gestational diabetes).
- Don't have end-stage renal disease.
- Haven't enrolled in the program before.

The program is available at no charge for eligible HMSA members. However, you can attend the program only once and only in Hawaii. If you are at risk for diabetes, ask your doctor if this program is right for you.

PREGNANCY SUPPORT PROGRAM

The prenatal care program is available through HMSA Well-Being Connection and it helps expectant couples through normal and at-risk pregnancies with information and support services, and the stop smoking program which offers support for those wanting to quit. To help you, the program pairs you with your own maternity nurse who will call you to provide personalized education and counseling to support the care you receive from your Ob-Gyn.

This program is voluntary and available at no cost. You may be automatically enrolled in the program, or referred by your physician. You may also contact a customer service representative at 948-6079 (Oahu) or 1 (800) 776-4672 toll free on Neighbor Islands to ask for an enrollment form. Enroll as soon as your pregnancy is confirmed. Prenatal care should start in the first three months of your pregnancy.

As part of this program, you will also receive:

- A copy of Your Pregnancy and Childbirth: Month to Month, published by the American College of Obstetricians and Gynecologists. This book is a trusted resource written by women's health experts.
- Referrals to community resources.
- Coordination with your health care provider.
- Additional nurse support over the phone after delivery.

Take advantage of this program at no cost to you. We'll do all we can to ensure that your pregnancy is healthy and happy.

HMSA365

With HMSA365, you are also eligible for additional benefits (see www.hmsa.com/hmsa365).

Fitness

Choose a gym membership discount through Active&Fit Direct™. And save money on health, fitness, and well-being products and services through HMSA365. You are also eligible for discounted fitness classes and equipment and access to more than 9,000 fitness centers nationwide with Active&FitDirect™.

Healthy living

This includes discounts on vision and hearing products and services, transportation, and more.

Specialty services

You will receive up to 25% off services like massage therapy, chiropractic care, and acupuncture nationwide with ChooseHealthy™.

Well-being products

You receive up to 55% off on health and fitness accessories such as activity trackers, equipment, and more with ChooseHealthy. Get access to online health and wellness classes at no additional cost.

EEOC WELLNESS NOTICES

The HMSA Well-Being Connection and Disease Management Programs are voluntary wellness programs available to all employees. These programs are administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the Well-Being Connection, you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA.

However, employees who choose to participate in the wellness program will receive incentives of access to coaches who are registered nurses, exercise physiologists, health educators, registered dietitians, or other health care professionals. Although you are not required to complete the HRA, only employees who do so will receive the incentives. Employees who participate in the Pregnancy Support Program will receive an incentive of access to a maternity nurse and a copy of Your Pregnancy and Childbirth: Month to Month, published by the American College of Obstetricians and Gynecologists.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching and access to a dietician. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Hawaii Operating Engineers may use aggregate information it collects to design a program based on identified health risks in the workplace, it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are coaches who are registered nurses, exercise physiologists, health educators, registered dietitians, or other health care professionals in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions

will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Trust Fund Office at (800) 251-5014.

MEDICAL PLAN EXCLUSIONS

The following is a list of services and supplies or expenses **not covered (excluded) by the Medical Plan**. See also the specific exclusions related to Dental, Vision, and Life Insurance benefits located in their respective chapters/articles in this document. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical program has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. General Exclusions are listed first followed by specific medically related plan exclusion.

GENERAL EXCLUSIONS (applicable to all medical services and supplies)

1. **Autopsy:** Expenses for an autopsy, forensic examination and any related expenses, except as required by the Plan Administrator or its designee.
2. **Costs of Reports, Bills, etc.:** Expenses for preparing or completing forms, medical/dental reports/records, bills, disability/sick leave/claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, e-mailing charges, prescription refill charges, disabled person license plates/automotive forms, interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement/direct primary care fees, membership/surcharge fees or provider's special plan charging fees to access added benefits and/or photocopying fees.
3. **Educational Services:** Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: educational services that are not listed as a covered benefit, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids, communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with tactile systems like Braille or sign language education for a patient or family members, and implantable medical identification/tracking devices. Certain educational services may be listed as a covered benefit in the Schedule of Medical Benefits and under the Disease Management Program.
4. **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by the Fund, or if benefits are otherwise provided under this Plan or any other plan that the Fund contributes to or otherwise sponsors, such as HMOs.
5. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation or Maximum Plan Benefit as described in the Medical Expense Benefits chapter and Schedule of Medical Benefits section of this document.
6. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Charge as defined in the Definitions chapter of this document.
7. **Expenses for Which a Third Party Is Responsible:** 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 provisions relating to Third Party Liability in the chapter on Coordination of Benefits in this document 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.

8. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the person became covered under the medical program; or after the date the person's coverage ends, except under those conditions described in the COBRA chapter of this document.

9. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational or Unproven as defined in the Definitions chapter of this document.

10. **Military service related injury/illness**: 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.

11. **Illegal Act:** Services, supplies or expenses incurred in the treatment of any condition, injury or disability that in the opinion of the Plan Administrator or its designee, has arisen from participation in, or commission or attempted commission of, a felony, or criminal act that endangers their health. This provision does not apply if the condition, injury or disability results from being the victim of domestic violence, or if the commission of the illegal act was a direct result of an underlying health factor.

12. **Medically Unnecessary Services:** 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. Medically Necessary includes wellness/preventive services as noted in the Schedule of Medical Benefits in this document and includes prophylactic surgery/treatment that is determined to be Medically Necessary by the Plan Administrator or its designee. For example, surgery to remove the breasts and/or ovaries of a woman who has a genetic mutation demonstrating a significant genetic or hereditary predisposition of breast and/or ovarian cancer, may be determined by the Plan Administrator or its designee to be Medically Necessary even though at the time the surgery is to be performed there is no objective evidence of the presence of cancer. When a prophylactic mastectomy is determined to be Medically Necessary, the Plan complies with the Women's Health and Cancer Rights Act (WHCRA) in covering reconstruction. Reconstruction is explained in the Schedule of Medical Benefits in the Reconstructive Services row.

13. **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.

14. **No-Cost Services:** Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay, or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan, or for which the Covered Individual is not billed by the health care provider.

15. **Non-Participating Provider Waived Cost Sharing**. For any cost sharing for which you are responsible to pay under the terms of the Plan (such as a copayment, deductible or coinsurance) that is waived by a non-participating (non-network) provider.

16. **Services Not Prescribed by a Physician/Health Care Practitioner**: Expenses for services/supplies that are not recommended or prescribed by a Physician, except for those covered services provided by a licensed or certified Health Care Practitioner.

17. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals, airfare, and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual.

18. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law.

19. **Personal Comfort Items:** Expenses for convenience, comfort, hygiene, or beautification including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals or beds, television, DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, admission or bedside kits, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

20. **Physical Examinations, Tests, Immunizations for Employment, School, etc.:** Expenses for physical examinations, screenings, testing and immunizations such as required for functional capacity/job analysis examinations and testing required for employment/career, commercial driving, government or regulatory purposes, insurance, school, camp, recreation, sports, vocation, workers' compensation, retirement/disability status or pension, required by any third party, education, marriage, adoption, judicial or administrative proceedings/orders, medical research or to obtain or maintain a license of any type.

21. **Private Room in a Hospital or Health Care Facility:** The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is Medically Necessary as determined by the Plan Administrator or its designee.

22. **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis.

23. **Services Excluded Because of Failure to Follow Medical Advice**

    a. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by a covered individual who fails to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.

    b. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician within 72 hours after admission.

    c. **Travel Contrary to Medical Advice:** Expenses incurred by a covered individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the covered individual.

24. **Telephone Calls:** Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management Company, or any representative of the Plan for any purpose whatsoever, including, without limitation: communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of a Covered Individual, consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members. Note however, the Plan does pay for a telehealth visit as explained on the Schedule of Medical Benefits.

25. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

26. **Self-Inflicted Injury or Attempted Suicide:** Expenses incurred by any Covered Individual arising from an attempt at suicide or from a self-inflicted injury or illness, including complications thereof, unless the attempt arises as a result of a physical or mental health condition.

27. **Expenses directly related to complications of a non-covered service** (except the Plan does pay for covered services resulting from complications related to an approved Clinical Trial). Directly related means that the care took place as a direct result of the non-covered service and would not have taken place without the non-covered service.

28. Expenses for treatment of medical/surgical and mental health/substance use disorders in these non-hospital settings: wilderness therapy program, outdoor behavioral health program, boot camp-type program, boarding school, military school, foster home/care, group home, memory care/dementia care facility, assisted living arrangement, half-way/quarter-way house, or sober living/transitional living environment.
29. Expenses for **biofeedback**.
30. Expenses for **hypnosis/hypnotherapy** (following a hypnotic induction technique performed by the provider, hypnosis produces a wakeful state of focused attention and heightened suggestibility with diminished peripheral awareness).
31. Expenses for educational services related to **reading, learning disorders, dyslexia, educational delays, or vocational disabilities**.
32. Expenses for **court-ordered services unless the services are both Medically Necessary and a covered benefit of the Plan.** Expenses for parental custody services or adoption services are not covered.
33. Expenses for **programs based on learning theories and motivation, such as Applied Behavioral Analysis (ABA) Therapy,** and related services.
34. Developmental delay or services related to developmental delay that are available through government programs or agencies.
35. Expenses for **equine (horse) assisted therapy**.
36. Expenses for **bereavement counseling** or **marriage and family counseling** other than medically necessary counseling specifically covered in the Behavioral Health Services row of the Schedule of Medical Benefits.
37. Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. For individuals who will participate in a clinical trial, preauthorization is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
38. **Untimely Filed Claims**: Expenses for services or supplies that would otherwise be covered by the Plan will not be covered or payable by the Plan if a claim for payment of such services is not submitted to the Claims Administrator within 12 months from the date that the service is rendered or the supply provided.
39. Expenses for individuals who perform services as a **scribe for electronic health records** (EHR), including electronic documentation and related services.
40. Expenses related to **ambulance transport that is not medically necessary** for the treatment of an emergency condition, such as when the patient wants to be at a certain hospital or facility for personal preference reasons, patient is in foreign country, or out of state, and wants to return home or want to return to a network health care facility to continue non-emergency treatment, the patient who is not having an emergency condition wants to be transported from a health care facility to home or from home to a health care facility, or the patient is deceased (i.e., transportation to the coroner's office or mortuary).
41. Expenses related to a nursing home (that is not a skilled nursing facility), an assisted living arrangement or a memory care/dementia care facility.
42. Expenses incurred while a plan participant was **incarcerated** (in prison) or in custody under a penal statute or rule (e.g. in jail) at the time the services or supplies were furnished.

43. Expenses for any service, procedure, or supply that is directly or indirectly related to a non-covered service, procedure, or supply.

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

A. Alternative/Complementary Health Care Services Exclusions

1. Expenses for chelation therapy, except the Plan covers Medically Necessary treatment of acute arsenic, gold, mercury or lead poisoning, or diseases of excess copper or iron.
2. Expenses for prayer/faith, religious healing, or spiritual healing.
3. Naturopathic, naprapathic and/or homeopathic supplies or products.
4. Acupuncture services except as provided in the Chiropractic/Acupuncture/Massage Therapy Benefit.

B. Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions

1. Expenses for any items that are **not** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions chapter of this document, including but not limited to air purifiers, swimming pools, spas, saunas, escalators, lifts, pillows, mattresses, water beds, and air conditioners.
2. Expenses for **replacement of lost, missing, or stolen**, **duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment. See the Corrective Appliances row and Durable Medical Equipment row of the Schedule of Medical Benefits for information on repair, adjustment, servicing and replacement of a device under certain situations.
3. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.
4. Expenses for **occupational therapy adaptive supplies and devices** used to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools, devices to assist in dressing and undressing, shower bench, raised toilet seat, etc.
5. Expenses for **nondurable supplies,** except certain services are payable under Nondurable Supplies in the Schedule of Medical Benefits.
6. **Orthopedic shoes**.

C. Cosmetic Services Exclusions

1. Cosmetic surgery or treatment includes surgery or medical treatment to improve or preserve physical appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance, but not to treat physical function.

   No benefits are available for surgery or treatments to change the texture or look of the skin or to change the size, shape or look of facial or body features (including but not limited to the nose, eyes, ears, cheeks, chin, chest or breasts).

   Note: The Medical Program **does** cover Medically Necessary Reconstructive Services. Reconstructive Surgery is payable only if required by law (e.g., breast symmetry after a mastectomy), or the procedure or treatment is intended to improve bodily function, repair a functional defect and/or to correct deformity or disfigurement resulting from disease, infection, trauma, congenital anomaly (birth defect) or covered surgery. To determine the extent of this coverage, see Reconstructive Services in the Schedule of Medical Benefits. Plan Participants should use the Plan's Preauthorization procedure to determine if a proposed surgery or service will be considered Cosmetic Surgery or will be considered as a Medically Necessary Reconstructive Service.

   Cosmetic Surgery or Treatment that is not covered includes, but is not limited to:

   - removal of tattoos, ear or body piercing, electrolysis hair removal

- breast augmentation or mastopexy (except the Plan covers reconstructive services after a mastectomy),
- breast reduction (including treatment of benign gynecomastia in males),
- removal of redundant or excessive skin including elimination of redundant skin of the abdomen, abdominoplasty,
- treatment of varicose veins,
- skin resurfacing, body sculpting, chemical skin peel, cosmetic skin products such as Restylane and Renova, collagen and other filler injectable products such as Juvederm, Perlane, Radiesse,
- face/forehead/brow/eyelid/neck lift, upper eyelid blepharoplasty, nose/lip/cheek/malar/chin enhancement, reduction or implant, facial bone reduction,
- calf/buttocks/pectoral implants/lift/augmentation,
- liposuction body contouring,
- reduction thyroid chondroplasty,
- testicular implant (unless due to a congenital anomaly in a covered child)
- voice modification surgery (laryngoplasty or shortening of the vocal cords), voice therapy/voice lessons,
- drugs for hair loss, hair growth, hair removal, hair implantation,
- or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

D. Custodial Care Exclusions

1. Expenses for Custodial Care as defined in the Definitions chapter of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or housekeeper, or personal care, sitter/companion/caregiver service, or when the services of Home Health aides are payable under Home Health Care Services in the Schedule of Medical Benefits.
2. Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are **not** considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are Medically Necessary.

E. Dental Services Exclusions

1. Expenses for Dental services, Dental exams, Dental diagnostic services, and Dental supplies of any kind, except the Plan covers Treatment of Accidental Injuries to the Teeth and Orthodontic services for treatment of orofacial anomalies as explained in the Schedule of Medical Benefits, (even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth or another part of the body) including but not limited to exclusion of dental prosthetics, splints, retainers, oral appliances, gingival and periodontal treatments, orthodontia services, treatment for bruxism (teeth grinding), endodontics such as root canal, dental restorations, CT scanning ordered and/or performed by a dentist, and dental services for the care, filling, removal or replacement of teeth including removal of wisdom teeth, or the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. Expenses not covered also include dental services such as gingivectomy, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement).

   Expenses for certain Dental services may be covered under the Medical Plan if they are incurred for the repair or replacement of Accidental Injury to Teeth or restoration of the jaw if damaged by an external object in an accident, or for an oral appliance as treatment for obstructive sleep apnea. For the purposes of this coverage by the Plan, an accident does not include any injury caused by biting or chewing. See Oral, Craniofacial Services in the Schedule of Medical Benefits regarding coverage guidelines.

2. Expenses for the treatment or prevention of Temporomandibular Joint (TMJ/TMD) Dysfunction or Syndrome.
3. Expenses for Orthognathic services/surgery for treatment of aesthetic malposition of the bones of the jaw such as with Prognathism, Retrognathism, Temporomandibular Joint dysfunction/syndrome or other cosmetic reasons.
4. Oral cancer screening services/products such as ViziLite, oral brush biopsy.

F. Diagnostic Testing Exclusions

1. Carcinoembryonic antigen when used as a screening test.
2. Ductal lavage
3. Electron beam computed tomography for coronary artery calcifications.
4. Enzyme-potentiated desensitization for asthma.

G. Drugs, Medicines and Nutrition Exclusions

1. Pharmaceuticals requiring a prescription that have not been approved by the US Food and Drug Administration (FDA); or are Experimental and/or Investigational as defined in the Definitions chapter of this document.
2. Non-prescription (or non-legend or over-the-counter - OTC) drugs or medicines, except the Plan covers insulin and syringes and certain OTC and prescription medication in accordance with Affordable Care Act (ACA) regulations, at no cost when prescribed by a Physician or Health Care Practitioner and filled at a network pharmacy.
3. Drugs requiring a prescription by state law, but not by federal law, are not covered.
4. Foods and nutritional/dietary supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except the following are payable:

   (a) foods and nutritional supplements provided during a covered hospitalization

   (b) when prescribed in compliance with Affordable Care Act (ACA) regulations,

(c) nutritional support may be payable when it is determined by the Plan Administrator or its designee to be Medically Necessary, and is the sole or primary means of adequate nutritional intake and is administered enterally (i.e., by feeding tube) or parenterally (i.e., by intravenous administration such as total parental nutrition/TPN) and is not considered a food thickener, infant formula, specialized infant formula, donor breast milk, baby food, or other non-prescription product/substance that can be mixed in a blender. See the Enteral therapy row in the Schedule of Medical Benefits.

5. Naturopathic, naprapathic or homeopathic products and substances.
6. The following drugs, medicines or devices:
   (a) drugs for anti-aging, bodybuilding/athletic enhancement or to improve physical performance including but not limited to androgen products, anabolic steroids;
   (b) male contraceptives, such as condoms;
   (c) fertility drug products or agents;
   (d) dental products (except as required to be covered in compliance with the Affordable Care Act (ACA)) and products for periodontal disease;
   (e) hair removal or hair growth products (*e.g.,* Propecia, Rogaine, Minoxidil, Vaniqa);
   (f) erectile dysfunction (*e.g.,* Viagra, Cialis, Muse, Caverject);
   (g) cosmetic products such as Restylane and Renova and collagen and other filler injectable products such as Juvederm, Perlane, Radiesse and/or
   (h) drugs distributed as manufacturer samples.
7. Compound prescription drugs unless there is at least one ingredient that requires a prescription as defined by federal law. Note that some compound prescription drugs are payable only when precertified by the Prescription Drug Program. Certain substances added to compound drugs are not covered by the Plan. Contact the Prescription Drug Program for information on which substances are not payable.
8. Take-home drugs or medicines provided by a Hospital, emergency room, Ambulatory Surgical Facility/Center, or other Health Care Facility.
9. Any prescription drug or medicine not provided by the Plan's prescription drug program.
10. **Self-help devices** such as a scale for weight or body fat measurement, pill crusher, pill splitter, magnifying glass/device, etc.
11. **Certain Topical Analgesics (pain patches)** containing ingredients (alone or in combination) in strengths typically used over the counter for the temporary relief of minor aches and muscle pains. Such ingredients include, but are not limited to, menthol, capsaicin or methyl salicylate.
12. This Plan has adopted the Prescription Drug Program's current formulary, including its preferred formulary drug list, as the Plan's covered formulary of covered drugs. Based on the Prescription Drug Program's formulary (which is updated from time to time), certain drugs are not covered by the Plan, or are covered only when they are pre-approved by the Prescription Drug Program. Contact the Prescription Drug Program for information about the formulary or Drug Exception Process.
13. **Drug Exception Process**: The Plan has an exception process managed by the Prescription Drug Manager (whose contact information is listed on the Quick Reference Chart in the front of this document). The exception process allows a member's physician to contact the Prescription Drug Manager to request that a non-covered drug be payable under the Plan. The physician is to fax the request for a drug exception and the clinical reasons why the drug is needed, including why a

formulary (Preferred Formulary drug) cannot be used in its place, to the clinical team of the Prescription Drug Manager who will review and respond to the physician with their determination.

H. Durable Medical Equipment Exclusions

See Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions.

I. Fertility and Infertility Services Exclusions

1. Expenses for the diagnosis and treatment of infertility along with services to induce pregnancy and complications thereof, including, but not limited to services, prescription drugs, procedures or devices to achieve fertility (except one outpatient in vitro fertilization (IVF) procedure per lifetime is covered as noted in the Schedule of Medical Benefits); low tubal transfer; artificial insemination; embryo transfer; gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); collection/storage/processing/purchase of donor egg/oocytes/sperm; cryostorage (freezing) of egg/sperm/oocytes/embryos; ovum transplant; any donor-related services, including but not limited to collection, storage and processing of donor oocytes and donor sperm; fetal implants; fetal reduction services; surgical impregnation procedures; in-vitro fertilization when services of a surrogate are used; and reversal of sterilization procedures.
2. Expenses for and related to adoption.
3. With respect to a surrogacy or gestational carrier arrangement, no coverage for maternity or delivery expenses of a woman who is not a covered plan participant or beneficiary.
4. Expenses for Pre-implantation Genetic Diagnosis (PGD) where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal prior to implantation for a fertility service.

J. Foot Care/Hand Care Exclusions

1. Expenses for **routine foot care**, (routine foot care includes but is not limited to hygienic cleaning of the feet with trimming of toenails, removal or reduction of corns and callouses, removal of thick/cracked foot skin, preventive care with assessment of pulses, skin condition and sensation).
2. Expenses for hand care including manicure and skin conditioning and other hygienic/preventive care performed in the absence of localized illness, injury or symptoms involving the hand.

K. Genetic Testing and Counseling Exclusions

1. **Genetic Testing:** The following expenses for genetic tests are not covered, including obtaining a specimen and laboratory analysis to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics. (Certain genetic tests are covered as listed as payable in the Genetic Testing row in the Schedule of Medical Benefits.) Genetic services that are **not covered** include:

   a. Expenses for **Pre-Implantation Genetic Diagnosis (PGD)** where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;

   b. No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the medically necessary treatment of a plan participant;

   c. **Paternity testing and Direct to Consumer (DTC) genetic testing kits/services** are not covered.

   d. Genetic testing determined by the Plan Administrator or its designee to be **not medically necessary or is determined to be experimental or investigational**.

   See the Genetic Services row of the Schedule of Medical Benefits for a description of the genetic services that are covered by the Plan.

Plan Participants should contact the Utilization Management program for assistance in determining if a proposed Genetic Test will be covered with preauthorization or excluded.

L. Hair Exclusions

1. Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees, hairpieces, hair cranial prosthesis, or hair analysis.

M. Hearing Care Exclusions

1. Bone anchored hearing aids are not covered except when either of the following applies: for covered persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; and for covered persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
2. Expenses for and related to repairs to external hearing aids including replacement parts, lost, stolen or missing hearing aids, hearing aid batteries and other hearing aid accessories including Dri-Aid kits for hearing aid moisture removal and phone ear pads.

N. Home Health Care Exclusions

1. Expenses for any Home Health Care services other than part-time, intermittent **skilled nursing** services and supplies.
2. Expenses for a homemaker, custodial care, child care, adult day care, caregiver or personal care attendant services, except as provided under the Plan's Hospice coverage.
3. Expenses for supervising services by a physician or nurse for a person who is not under specific medical, surgical, or psychiatric care to improve that person's condition and to enable that person to live outside a facility providing this care.

O. Maternity/Family Planning/Contraceptive Exclusions

1. **Home Delivery:** Expenses for pre-planned home delivery/home birth.
2. Expenses for **childbirth education, Lamaze classes, and breast-feeding/lactation** classes. This exclusion does not apply to the extent that breastfeeding support, supplies and lactation counseling are covered for women (as discussed under the Durable Medical Equipment row and Maternity row of the Schedule of Medical Benefits).
3. Expenses related to **cryostorage of umbilical cord blood or other tissue or organs, or expenses related to storage and shipping breast milk.**

P. Nondurable Supplies Exclusions

See Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions.

Q. Rehabilitation Services Exclusions (Inpatient or Outpatient)

1. Expenses for educational, job training, vocational rehabilitation, or recreational therapy.
2. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to cognitive rehabilitation, coma stimulation programs and like services.
3. Speech therapy is not considered medically necessary and is not a covered benefit for self-correcting dysfunctions causing dysfluency or articulation disorders such as stuttering, stammering, lisping and tongue thrusting, defects in voice quality such as in pitch, loudness, or to improve public speaking,

or for conditions of psychoneurotic origin. Delays in speech development are not covered unless the delay is a result of an illness, injury or, a congenital defect that has been surgically repaired.

4. Expenses for Habilitation services (to help individuals attain certain functions that they never have acquired) including treatment of delays in childhood speech and physical development, unless the delay in development is a direct result of an injury, surgery or as a result of a treatment that is the type that is covered by this Plan.
5. Rehabilitation services that do not require the skills of a licensed therapist, and/or rehabilitation services performed when there is no expectation of significant improvement.
6. Expenses for massage therapy, rolfing (deep muscle manipulation and massage), craniosacral therapy (noninvasive rhythmic manipulation of the craniosacral areas) and related services, except as provided in the Chiropractic/Acupuncture/Massage Therapy Benefit.
7. Cardiac rehabilitation and Dr. Ornish's program for reversing heart disease are not covered.

R. Sexual/Erectile Dysfunction Services Exclusions

1. **Treatment of Gender Dysphoria/Gender Incongruence:** Expenses for medical, surgical or prescription drug treatment related to treatment of gender dysphoria/gender incongruence including transgender/transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures or reversal of any such procedures.
2. Surgery to reverse a prior genital surgery or reversal of surgery to revise secondary sex characteristics (physical changes related to puberty).

S. Spinal Manipulation Exclusions

1. Expenses for Spinal Manipulation, including, but not limited to, care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the body in order to remove nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column, except as provided in the Chiropractic/Acupuncture/Massage Therapy Benefit.

T. Transplant (Organ and Tissue) Exclusions

1. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, postoperative services and drugs/medicines and all complications thereof, except the Plan covers Transplant Services and their complications as listed under Transplantation in the Schedule of Medical Benefits.
2. Expenses related to non-human (Xenografted) organ and/or tissue transplants.
3. 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 the transplant row of the schedule of medical benefits, your transportation for organ or tissue transplant services, transportation of organs/tissues, or organ or tissue transplants received outside of the United States.
4. Peripheral stem-cell transplants except as otherwise described as covered in the Transplant Services row of the Schedule of Medical Benefits.
5. For plan participants who serve as a donor, donor expenses are not payable by this Plan unless the person who receives the donated organ/tissue is a person covered by this Plan.

U. Vision Care Exclusions

1. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures (procedures to reshape the cornea of the eye) including, but not limited to, Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), Laser-Assisted In-Situ Keratomileusis (LASIK).
2. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies except as provided by the Vision Care Benefit.
3. Vision therapy (orthoptics) and supplies.
4. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

V. Weight Management and Physical Fitness Exclusions

1. Expenses for weight loss programs (e.g. Weight Watchers, Jenny Craig, meal replacement drinks), dietary instructions, skin reduction procedures/treatment and any complications thereof. See also the Plan's coverage for screening and intensive behavioral counseling for obesity under the Weight Management or Wellness and Preventive Services rows of the Schedule of Medical Benefits.
2. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, fitness instructors, work hardening and/or weight training services, ergonomic chairs/desks, exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless or wearable sensors/trackers.

CHIROPRACTIC / ACUPUNCTURE / MASSAGE BENEFITS THROUGH AMERICAN SPECIALTY HEALTH

The following is only a summary of the American Specialty Health Plan (ASH) benefits (and the amounts that you are responsible for) when you are enrolled in the Fund's Medical PPO Plan or the Kaiser HMO Plan. For a complete explanation, please refer to Your Evidence of Coverage and Plan Certificate from ASH. In the event of any discrepancy the ASH Evidence of Coverage and/or Plan Certificate and the terms of this document, the terms of the Evidence of Coverage and/or Plan Certificate will govern your entitlement to benefits, if any.

YOUR OUT-OF-POCKET COST

These benefits are not subject to the Medical Plan's annual deductible, but do accumulate to your Medical Plan Out-of-Pocket Limit.

ASH Providers

When you use an American Specialty Health Group (ASH) provider, you pay only a $20 copayment each visit. You also pay any amount that exceeds the Allowed Charges or the maximum benefit payable as shown in the Schedule of Benefits.

Non-ASH Providers

HMSA Participants: When you use Non-ASH providers, the Plan pays 50% of Allowed Charges up to a maximum of $30 per visit.

Kaiser Participants: There are no benefits available for services with a Non-ASH provider.

ANNUAL MAXIMUM VISITS

Each visit to a Participating provider in a calendar year will reduce the number of visits available under the Non-Participating benefits for the rest of that calendar year.

HMSA Participants: There is a combined maximum of 24 visits each calendar year for services of all participating network providers for these benefits. Each visit to a Non-Participating provider in a calendar year will reduce the number of visits available under the Participating benefits for the rest of that calendar year. You will not be reimbursed for more than 12 visits in each calendar year if you use only Non-Participating providers. Also, please note that you need pre-approval for any more than five (5) visits per year from a Non-Participating provider. See also the other plan limits noted below.

Kaiser Participants: There is a combined maximum of 20 visits each calendar year for services of all participating network providers for these benefits.

COVERED SERVICES

Chiropractic Covered Services

The following services are covered for treatment of neuromusculoskeletal disorders:

- **Initial new patient exam** (for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of chiropractic services);
- **Established patient exams** (to assess the need to initiate, continue, extend, or change a course of treatment);

- **Follow up visits** (including adjunctive modalities and procedures provided during an exam or follow-up visit);
- **X-rays, radiological consultations, and clinical lab studies;**
- **Supports and appliances.**

Acupuncture Services

The following services are covered for treatment of neuromusculoskeletal disorders, nausea, or pain:

- **A new patient exam or an established patient exam** for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of acupuncture services.
- **Established patient exams** as needed to assess the need to initiate, continue, extend, or change a course of treatment. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, additional coinsurance applies.
- **Follow-up office visits** (including Acupuncture Services and/or reevaluation).
- **Adjunctive therapies or modalities** such as acupressure, cupping, moxibustion, or breathing techniques are covered only when provided during the same Course of Treatment and in support of acupuncture services. However, the following exception applies for the application of acupressure if: 1) a Participating Provider of Acupuncture Services recommends acupuncture services for a Member but cannot do so in accordance with professionally recognized, valid, evidence-based standards of practice because the insertion of needles is contraindicated (e.g., for a patient with a bleeding disorder); and 2) professionally recognized, valid, evidence-based standards of practice indicate that acupressure would be effective in the treatment of the member, then acupuncture services will include acupressure in that circumstance even if acupuncture services are not provided to the Member at the same time and the Member is entitled to receive other adjunctive therapies or modalities in conjunction with the provision of acupressure in that circumstance to the same extent as would be the case if the Member were receiving acupuncture services.

Massage Therapy Services

The following services are covered for treatment of myofascial/musculoskeletal disorders, musculoskeletal functional disorders, or pain syndromes only upon written referral from your primary physician or from a chiropractor who is contracted with ASH.

- **A new patient exam or an established patient exam** as needed for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of massage therapy services.
- **An established patient exam** when needed to assess the need to initiate, continue, extend, or change a course of treatment (only covered when used to determine the appropriateness of massage therapy services).
- **Massage therapy sessions** that include the application of massage therapy techniques to the musculoskeletal soft tissue in various combinations. Massage therapy sessions must include the provision for application of massage therapy techniques to the musculoskeletal soft tissue.

Members receiving treatment who are under the age of 18 require parental participation.

PREAUTHORIZATION REQUIRED

- For covered services you receive from a **Participating Provider**, utilization review requirements are the responsibility of your provider, not you.
- **HMSA Participants only:** For services you receive from a **Nonparticipating Provider**, utilization review requirements are **your responsibility** and include a post-service review of medical records after the fifth visit per calendar year. The five-visit waiver applies to all nonparticipating providers who work in the same office under the same tax identification number. The utilization review process requires that

you submit specific information. Without complete information, services may not be approved for reimbursement).

- Complete a Medical Records Cover Sheet or a Clinical Information Summary Sheet (one per patient), both of which are available at www.ashcompanies.com. To ensure your claim is reviewed without delay and to prevent denials resulting from a lack of information, provide complete information on the form.
- Date of service and what services should be reviewed
- Patient Age and Gender
- Chief Complaint
- Pain Severity
- Mechanism or Onset
- Pertinent findings supporting the patient's diagnosis and treatment plan as identified from the physical examination including, at a minimum, Inspection and Palpation findings.
- National Provider Identifier (NPI) number.

Send the *Medical Records Cover Sheet* and either the clinical information summary sheet or the pertinent medical records to:

ASH Group
P.O. Box 509001
San Diego, CA 92150-9001
Fax: California fax (877) 427-4777, all other states fax (877) 304-2746

Send Claims to:

Claims Departments
ASH Group
P.O. Box 509001
San Diego, CA 92150-9001

ASH Group will respond within one week of receipt of the completed form. Notification of the clinical decision will be mailed or faxed directly to the provider and will include the name and phone contact information of the peer-clinician who rendered the decision. Services provided during the review period will be reimbursed if they are approved by ASH Group.

EXCEPTIONS, REDUCTIONS, AND LIMITATIONS

Covered services are limited to the diagnosis and treatment of the specified conditions. Exclusions, reductions and limitations include, but are not limited to the following:

General Exclusions Applicable to Chiropractic, Acupuncture and Massage Benefits

- BlueCard program
- Services provided in excess of any benefit maximum.
- Any service or supply that is not permitted by state law with respect to the practitioner's scope of practice.
- Any service or supply that is not medically necessary.
- Any services provided for elective or maintenance care (e.g., services provided to a patient whose treatment records indicate he or she has reached maximum therapeutic benefit).
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services.
- Hypnotherapy, behavior training, sleep therapy, and weight problems.

- Thermography, magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacements products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostimulation, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Education programs, non-medical lifestyle or self-help, or self-help physical training or any related diagnostic testing.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Any services or treatments for conditions caused by or arising out of the course of employment or covered under Worker's Compensation or similar laws.
- Air conditioners /purifiers, therapeutic mattresses, supplies, or any other similar devices or appliances or durable medical equipment.
- Auxiliary aids and services, including but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.
- Transportation costs, including local ambulance charges.
- Expenses for services or supplies for which a third party is required to pay are not covered.
- Additional exclusions specifically noted below.

Chiropractic Exclusions

- Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, therapeutic radiology and any diagnostic radiology other than covered plain film studies.
- Adjunctive physiotherapy modalities and procedures unless provided during the same course of treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

Acupuncture Exclusions

- Services, exams (other than the initial examination to determine the appropriateness of acupuncture services), and/or treatments for the conditions other than musculoskeletal and related disorders, nausea, pain or pain syndromes.
- Services, examinations, and/or treatments for asthma or addiction, such as nicotine addiction.
- Radiological x-rays (plain film studies), magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology, and laboratory services.
- Adjunctive therapy not associated with acupuncture.
- Acupuncture performed with reusable needles.

Massage Therapy Exclusions

- Services or treatments for conditions other than myofascial/musculoskeletal disorders, musculoskeletal functional disorders, pain syndrome, or lymphedema.
- Massage Services provided by a provider of massage therapy services that are not delivered in accordance with the massage therapy benefit plan, including, but not limited to, massage therapy services provided directly in conjunction with chiropractic or acupuncture services.
- Adjunctive therapy whether or not associated with massage therapy services.

FILING CLAIMS

All health claims must be submitted to the Plan within 12 months from the date of service unless it is determined that the claim was not timely for good cause. No Plan benefits will be paid for any claim submitted after this period. For services you receive from a provider who does not file claims for you, follow these steps to receive reimbursement for covered services:

- Complete a separate claim form for each provider of service. If you were treated by a provider for both chiropractic and acupuncture services, you'd need to submit two claim forms, one for chiropractic services and one for acupuncture services.

For post-service claims, provide all of the following information on the claim form (your treating provider can help you get this information):

  - Itemized date(s) of service.
  - Diagnosis code.
  - Procedure code.
  - Billed charge per service.
  - Provider's name and credentials.
  - Provider's full address.
  - Provider's tax ID, employer identification number or Social Security number.
  - National Provider Identifier (NPI) number.

- Attach the itemized bill from the provider of service with a claim form.
- Send the claim form and bill to:

American Specialty Health Group, Inc.
P.O. Box 509077
San Diego, CA 92150

For pre-service and concurrent claims, complete a Medical Records Cover Sheet or a Clinical Information Summary Sheet (available at www.ashcompanies.com), and provide all of the following information on the form (your treating provider can help you get this information):

  - Date of service and what services should be reviewed
  - Patient Age and Gender
  - Chief Complaint
  - Pain Severity
  - Mechanism or Onset
  - Pertinent findings supporting the patient's diagnosis and treatment plan as identified from the physical examination including, at a minimum, inspection and palpation findings
  - National Provider Identifier (NPI) number.

- Send the Medical Records Cover Sheet and either the Clinical Information Summary Sheet or the pertinent medical records to:

ASH Group
P.O. Box 509001
San Diego, CA 92150-9001
Fax: California: (877) 427-4777, all other states: (877) 304-2746

Send Claims to:
Claims Departments
ASH Group
P.O. Box 509001
San Diego, CA 92150-9001

- ASH will respond within one week of receipt of the completed form.

Please review to your Evidence of Coverage and Plan Certificate from ASH for a complete description of this benefit's claim procedures. Appeals will be filed with the Board of Trustees in accordance with the procedures outlined in the Claims and Appeals Procedures: chapter beginning on page 137.

VISION CARE BENEFITS

(Vision Benefits are available to both HMSA and Kaiser Enrollees)

Vision Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. Vision plan claims are administered under a contract separate from claims administration for any other benefits under the plan.

OVERVIEW OF THE VISION PLAN

The Vision Plan is designed to provide for standard vision examinations and eyewear materials such as eyeglasses or contact lenses. Vision benefits are administered by VSP, an independent vision claims administrator whose contact information is listed in the Quick Reference Chart at the front of this document.

VISION NETWORK

VSP contracts with vision providers who extend a discount to you for covered vision services. Covered vision expenses are noted in the Schedule of Vision Benefits in this chapter and refer to the Allowed Charge for covered services up to the maximum allowed as payable under this Vision Plan.

- **Network Providers:** Network providers (licensed ophthalmologist, optometrist or dispensing optician) have a contract to provide discounted fees to you for services covered under this Vision Plan. By using the services of an In-Network provider, both you and the Plan pay less (see the In-Network column of the Schedule of Vision Benefits). A current list of network vision providers is available free of charge when you call the Vision Plan whose name, address and telephone number are listed on the Quick Reference Chart in the front of this document. To receive services, simply call a network vision provider and identify yourself as a member of this Vision Plan.

  NOTE: <u>You must identify yourself as a member of the Vision Plan at the time that you make the appointment with the Network provider or you may not receive the discounted rates</u>.

- **Non-Network Providers:** Services may be received from any licensed optometrist, ophthalmologist and/or dispensing optician; however, this Plan will pay at the non-network benefit level as noted in the Schedule of Vision Benefits. The itemized paid bill reflecting the non-network provider's fees must be submitted to VSP for reimbursement. You will be reimbursed according to the Allowed Charge or the schedule below, whichever is less. Non-network provider services may cost you more than if those same services were obtained from an In-Network provider. **Non-Network Providers may bill the Plan Participant for any balance that may be due in addition to the Allowed Charge amount payable by the Plan, also called balance billing.**

  <u>You can avoid balance billing by using In-Network providers</u>. (See the definitions of Allowed Charge and Balance Billing in the Definitions chapter of this document.)

SCHEDULE OF VISION BENEFITS

This chart shows what the Plan pays.

Covered Vision Benefits	Explanations and Limitations *See also the Vision Plan Exclusions section.*	Plan Pays	
		In-Network Provider	**Non-Network Provider**
Vision Examination	• One comprehensive vision exam is payable every 12 months.	100% after a $7.50 copay per exam.	After a $7.50 copay the plan pays 100%, up to $50 per exam.
Frames for Eyeglasses This program provides a wide selection of quality frames. Because of the cosmetic nature of frames and rapidly changing styles, this plan has a limit (determined by the Vision Plan administrator) on the reimbursement for frames.	• One frame is payable every 24 months.	Up to a retail allowance of $130	The plan pays 100% to a maximum of $70
Lenses for Eyeglasses	• A single vision, lined bifocal, lined trifocal, lined lenticular and tints payable once every 12 months. • If only one lens is needed, the Non-Network Provider allowance will be one-half the pair allowance.	Covered in full after vision exam copay for: *Single Vision (Standard)* *Lined Bifocal* *Lined Trifocals* *Lined Lenticular* *Tints*	The Plan pays 100% up to the following benefit maximums: *Single Vision:* $50. *Lined Bifocals*: $75. *Lined Trifocals:* $100. *Lined Lenticular:* $125 *Tints*: $5
		Lens enhancements are covered in full after the following copays for: *Anti-reflective coating*: $37 copay *Polycarbonate*: for children: no copay; for adults: $23 copay for single vision lenses, $28 copay for multifocal lenses *Progressive multifocal lenses*: $50 copay *Scratch-resistant coating*: $15 copay	For the following lens enhancements, the Plan pays: *Anti-reflective coating*: not covered *Polycarbonate*: not covered *Progressive multifocal lenses*: 100% up to $75 *Scratch-resistant coating*: not covered

SCHEDULE OF VISION BENEFITS

This chart shows what the Plan pays.

Covered Vision Benefits	Explanations and Limitations *See also the Vision Plan Exclusions section.*	Plan Pays	
		In-Network Provider	**Non-Network Provider**
Contact Lenses: Medically necessary contact lenses are considered for the following reasons: • Following cataract surgery; or • Visual acuity cannot be improved to at least 20/70 in the better eye even with the use of eyeglasses. Contact lenses that do not meet the above criteria are considered "not Visually Necessary" or Elective (Cosmetic).	• The participant is to pay the difference between the cost of contact lenses and the amount allowed under this Vision Plan. • One set of Visually Necessary contact lenses are payable every 12 months, in lieu of all other lens and frame benefits. • One set of Elective contact lenses are payable in lieu of eyeglasses. • You may use your annual contact lens allowance toward permanent and/or disposable lenses.	*Contact Lenses (Visually Necessary):* Covered in full after vision exam copay *Elective Lenses (not Visually Necessary):* After vision exam copay covered up to an allowance of $200 for professional fees and materials. There is a 15% discount applied to the Allowed Charge for contact lens evaluation and fitting.	The Plan pays: *Contact Lenses (Visually Necessary):* 100%, up to $250 (to include professional fees and material) *Elective Lenses (not Visually Necessary):* 100%, up to $200 (to include professional fees and materials)
Laser Vision Correction Surgery	VSP provides discounted charges for these services. You are responsible for the difference between the negotiated rate and the allowance. If services are received from a non-VSP provider, the provider can charge his normal fees and you will be responsible for all amounts that exceed the Allowed Charge.	$500 allowance per eye (once per lifetime)	
Diabetic Eyecare Plus Program	Provides coverage for additional eyecare services targeted specifically for members with type 1 and type 2 diabetes, glaucoma, age-related macular degeneration (AMD) and retinal screening for eligible members with diabetes	$20 copayment	Not covered
Low Vision Benefit The low vision benefit is available to individuals who have severe visual problems that are not correctable with regular lenses.	• Low Vision Benefit Maximum is $1,000 every two years.	Supplemental Testing: 100% Supplemental Care Aids: Plan pays 75% of cost	Supplemental Testing: 100% up to $125 Supplemental Care Aids: Plan pays 75% of cost

VISION PLAN LIMITATIONS AND EXCLUSIONS

The following is a list of services and supplies or expenses **not covered (excluded) by the Vision Plan**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Vision Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

1. Vision services and supplies that cost more than the Plan's allowance as noted in the Schedule of Vision Benefits.
2. Orthoptics or vision training and any associated supplemental testing.

3. Plano lenses (less than a +/.50 diopter power).
4. Two pair of lenses or eyeglasses in lieu of bifocals.
5. Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
6. Medical or surgical treatment of the eyes.
7. Corrective vision treatment of an Experimental nature.
8. Costs for services and/or materials above Plan benefit allowances listed on the summary of benefits.
9. Services/materials not indicated as covered Plan benefits.
10. The Vision Plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the Vision Plan will pay the cost of the allowed vision service/supply and the covered person will pay the additional cost for the extras, such as:
    - Oversize lenses
    - Optional cosmetic processes
    - Color coating
    - Mirror coating
    - Blended lenses
    - Cosmetic lenses
    - Laminated lenses (covered from Network providers for children and Adults with a disability)
    - UV (ultraviolet) protected lenses
    - Certain limitations on low vision care

Benefits for lenses and frames from Participating Providers are for standard lenses and a frame from the Participating Provider's "designated group." If the lenses you select are nonstandard lenses or the frames are outside the "designated group," the Plan will pay the provider up to 100% of the maximum charges for standard-size lenses or a "designated group" frame. You then pay the balance of the charges.

LASER VISION BENEFIT

The Vision Plan will provide participants and their dependents with an allowance of $500 per eye toward the cost of PRK, LASIK or Custom LASIK surgery to correct vision problems such as nearsightedness, farsightedness and astigmatism. When services are provided by a VSP Primary Eye Care Doctor, Participating Surgeon and Participating Laser Vision Correction Surgery Facility, VSP has negotiated discounted charges for these services. You are responsible for the difference between the negotiated rate and the allowance.

If services are received from a non-contracted provider, you will still receive the $500 allowance per eye but the provider can charge his normal fees and you will be responsible for all amounts that exceed the Allowed Charge.

Preoperative exams and consultations are provided at no cost from contracted providers. However, if the surgery is not performed, the cost of these services will be applied against the $500 allowance. No benefit will be available if the person attempts to obtain these services at a later date.

FILING A VISION CLAIM/APPEALING A DENIED CLAIM

When you use the services of a Network vision provider, you should pay the provider for your appropriate copay. The provider will typically send the remainder of their bill directly to the Vision Plan for reimbursement. Note however that you will need to pay the provider for any services you purchased that are in excess of the benefit allowed under the Vision Plan or are not covered by the Vision Plan.

If you use the services of a non-network vision provider, you will need to pay the provider for all services and then, at a later date but within 12 months of the date of service, submit the bill to the Vision Plan Claims Administrator (whose name and address are listed on the Quick Reference Chart in the front of this SPD). You will be reimbursed up to the amount allowed under the Vision Plan as noted in the Schedule of Vision Benefits.

Vision claims submitted beyond 12 months of the date of service may not be considered for reimbursement.

Appeals will be filed with the Board of Trustees in accordance with the procedures outlined in the Claims and Appeals Procedures: chapter beginning on page 137.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The **Plan's self-funded group health benefits** (the Fund's Medical PPO Plan including chiropractic, acupuncture, massage and outpatient prescription drug benefits, and the Vision Care Benefit) will use Protected Health Information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

(1) Payment. "Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- (a) Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim),
- (b) Coordination of benefits,
- (c) Adjudication of health benefit claims (including appeals and other payment disputes),
- (d) Subrogation of health benefit claims,
- (e) Establishing Employee contributions,
- (f) Risk adjusting amounts due based on enrollee health status and demographic characteristics,
- (g) Billing, collection activities and related health care data processing,
- (h) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments,
- (i) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance).
- (j) Medical necessity reviews, or reviews of appropriateness of care or justification of charges,
- (k) Utilization review, including Precertification, Preauthorization, concurrent review and retrospective review,
- (l) Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health Plan), and
- (m) Reimbursement to the Plan.

(2) Health Care Operations. "Health Care Operations" include, but are not limited to, the following activities:

- (a) Quality Assessment,
- (b) 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,
- (c) Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
- (d) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing

a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance),

(e) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,

(f) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies,

(g) Business management and general administrative activities of the entity, including, but not limited to:

- Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,
- Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers,
- Resolution of internal grievances, and
- Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.
- Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, SAR's, and other documents.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the Plan will disclose PHI to the pension plan for purposes related to administration of that plan.

The Board of Trustees of the Hawaii Health and Welfare Trust Fund for Operating Engineers is the "Plan Sponsor." 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:

(1) Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law,

(2) Ensure that any agents, including a subcontractor, 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,

(3) Not use or disclose the information for employment-related actions and decisions unless authorized by the individual,

(4) 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,

(5) 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,

(6) Make PHI available to the individual in accordance with the access requirements of HIPAA,

(7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,

(8) Make available the information required to provide an accounting of disclosures,

(9) 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 HHS for the purposes of determining compliance by the Plan with HIPAA, and

(10) If feasible, return or destroy all PHI received from the Plan that the sponsor still 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 infeasible.

(11) If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees may be given access to PHI:

(1) The Privacy Officer, and

(2) The staff designated by the Plan Administrator to administer the group health plan

The persons described above may only have access to and use and disclose PHI for Plan administration functions for the Plan.

If the persons described above do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and no other plan functions or benefits.

In compliance with **HIPAA Security** regulations, the Plan Sponsor will:

(1) 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,

(2) Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

(3) 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

(4) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

A copy of the group health plan's Privacy Notice appears on the next pages.

Hawaii Health and Welfare Trust Fund for Operating Engineers (The Plan)

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Effective Date of Notice: September 23, 2013, Revised on March 1, 2018.

SUMMARY

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- As a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you are not the participant and you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.,* an Explanation of Benefits, or "EOB"). *Unless* you agree that you will be responsible for benefit payments, a copy of the EOB (in which your PHI might be included) will be released to the plan participant.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the Quick Reference Chart.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We contract with vendors to perform various functions on our behalf. These entities are known as Business Associates and in order to provide these services, those entities will receive, create, maintain, transmit, use and/or disclose your health information, but only after they agree in writing to implement appropriate safeguards regarding your health information.

Example: We may disclose your health information to a Business Associate to process your claims for health plan benefits or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

Other Uses and Disclosures

Any other use or disclosure not described in the Notice will only be made with your authorization.

Revocation of Prior Authorization.

You may revoke a prior authorization granted for psychotherapy notes, marketing, sales or any other authorized use and disclosure.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Officer, specified below, at the Trust Fund Office:

The Privacy Officer
Zenith American Solutions, Inc.
1600 Harbor Bay Parkway, Suite 200
Alameda, CA 94502

Phone: (877) 217-2676
Fax: (702) 216-0885

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

CLAIMS AND APPEALS PROCEDURES

Please refer to your fully insured plan document(s) for a complete explanation of your claim filing and claim appeal rights under ERISA for Kaiser medical, dental, life insurance, accidental death and dismemberment, weekly disability income benefit and the burial benefit.

This chapter applies only to the self-funded benefits of the Plan. The claims and appeals for the following benefits will be outlined in this chapter:

- HMSA PPO Medical Plan including Outpatient Prescription Drug Benefits
- ASH Chiropractic/Acupuncture/Massage
- Vision Care Benefits

Claim filing and claim appeal procedures for Kaiser medical, dental, life insurance, accidental death and dismemberment, weekly disability income benefit and the burial benefit are described in the fully insured plan documents.

The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan participants. The claims procedures outlined in this chapter are designed to **afford you a full, fair and fast review of the claim to which it applies**.

This chapter also discusses the process the Plan undertakes on **certain appealed claims, to consult with a Health Care Professional** with appropriate training and experience when reviewing an Adverse Benefit Determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary, is experimental or investigational).

The Plan will take steps to ensure that claims and appeals 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 expert) will not be made based upon the likelihood that the individual will support the denial of benefits. Health care claim review experts will be selected based on their professional qualifications.

When You Must Repay Plan Benefits

If it is found that the Plan benefits paid by the Plan are too much because:

- some or all of the health care expenses were not payable by you or your covered Dependent; or
- you or your covered Dependent received money to pay some or all of those health care expenses from a source other than the Plan; or
- you or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the health care expenses for which Plan benefits were paid (See also the Coordination of Benefits chapter); or
- the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan; or

- the Plan erroneously paid benefits because of false information entered on your enrollment form, claim form or required documentation;

then, the Plan will be entitled to:

1) recover overpayments from the entity to which the overpayment was made, or on whose behalf it was made; or from the participant directly;
2) a refund from you or your Health Care Facility or Health Care Provider/Practitioner for the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;
3) offset future benefits (that would otherwise be payable on behalf of you or your dependents) if necessary in order to recover such expenses; and/or
4) its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

TIME LIMIT FOR INITIAL FILING OF CLAIMS

All health claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period unless it is determined that the claim was not timely submitted for good cause.

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after the stated timeframe.

Key Definitions

You should refer to these definitions below when reviewing particular claim filing and appeal information in this chapter:

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an Adverse Benefit Determination is defined as:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit; and
- a reduction in a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate; or
- a Rescission of coverage whether or not there is an adverse effect on any particular benefit at that time.

Appropriate Claims Administrator: The various organizations under contract to the Fund to perform claims adjudication services to administer health claims and/or claim appeals. "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. (For contact information for each claims administrator, see the Quick Reference Chart in the front of this document.)

Appropriate Claims Administrator	Types of Claims Processed
HMSA	• Medical post-service claims • Urgent, Concurrent and Pre-service medical claims • Pre-service drugs (drugs requiring pre-approval) • Post-service claims for out-of-network retail drugs • First level appeals of medical, prescription drug claims
ASH	• Chiropractic, acupuncture, and massage claims
Vision Service Plan	• Pre-service (also called preauthorization review) of certain vision services/supplies as noted in the Vision Care Benefits. • Post-service vision claims
Trust Fund Office	• Eligibility claims, including extensions of eligibility for Dependent Children due to Disability
Board of Trustees	• Appeals of Eligibility Claims • Appeals of Chiropractic, Acupuncture, and/or Massage claims • Second Level Appeals of Medical, Prescription Drug, and/or Vision Claims

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined later in this chapter) in accordance with the Plan's claims procedures, described in this chapter.

A claim must include the following elements to trigger the Plan's claims processing procedures:

a. be **written or electronically** submitted (oral communication is acceptable only for urgent care claims),
b. be **received by the Appropriate Claims Administrator** as that term is defined in this chapter;
c. **name a specific individual**,
d. **name a specific medical condition or symptom**,
e. **name a specific treatment, service or product** for which approval or payment is requested,
f. **made in accordance with the Plan's claims filing procedures described in this chapter**; and
g. **includes all information required by the Plan and its Appropriate Claims Administrator, such as the existence of additional health coverage that would assist the Plan in coordinating benefits**.

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:

- Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim.
- A request for an advance determination regarding the Plan's coverage of a treatment or service that does not require preauthorization.

  NOTE: You may request a written determination from the Trust Fund Office regarding the Plan's coverage of the treatment or service. However, getting an advance determination (like getting preauthorization) does not guarantee payment of Plan benefits. For example,

benefits would not be payable if Youryour eligibility for coverage ended before the services were rendered or the maximum benefit had already been paid.

- a request made by **someone other than** the individual or their authorized representative;
- a request made by a **person who will not identify themselves** (anonymous);

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.

TYPES OF CLAIMS

There are five types of claims applicable to the self-funded benefits described in this booklet. The type of claim is determined as of the time the claim or review of denial of the claim is being processed.

Pre-service claims: A pre-service claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before care is obtained (also called "prior-authorization").

Urgent claims: Your request for a required preauthorization will be considered an urgent claim if it needs expedited handling—if applying the time frames allowed for a pre-service claim *(generally 15 - 30 days for a request submitted with sufficient information):*

- could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

The Appropriate Claim Administrator, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will determine whether your claim is an urgent claim. Alternatively, any claim that a physician with knowledge of your medical condition determines is an urgent claim within the meaning above will be treated as an urgent claim.

Concurrent (ongoing treatment) decisions: A concurrent care decision is a decision that is reconsidered after an initial approval was made, resulting in a reduction, termination, or extension of a benefit. In this situation, a decision to reduce, terminate, or extend treatment is made concurrently with the provision of treatment. This category also includes requests by you or your provider to extend care or treatment approved under an urgent claim.

Post-service claims: Any other type of health care claim is considered a post-service claim—most commonly a claim submitted for payment after health care services and treatment have been obtained.

Disability claim: A Disability Claim is a claim for which the plan must make a determination of disability in order for the participant to receive the benefit (including the Plan's determination of disability related to eligibility for a dependent over age 26 based on disability, and eligibility credits during periods of disability).

Other claims: The category "other claims" includes claims for Employee and dependent life insurance benefits, Employee accidental death and dismemberment (AD&D) benefits, and Employee burial expense benefits.

FILING A CLAIM

Filing Pre-service claims, urgent claims, and concurrent claims to extend approved urgent claim treatment:

- For coverage of contact lenses on a "necessary" basis or coverage of the low vision benefit, **VSP** providers will have a prior certification form they can use for this purpose. Non-VSP providers should contact VSP to find out what information they need to submit to VSP.
- For PPO Plan medical, chiropractic/acupuncture/massage, and prescription drug claims, have your Physician call HMSA. If your doctor thinks the request for preauthorization needs to be handled as an urgent care claim, he or she should indicate this to HMSA.

> **"Urgent Claim" Does Not Mean Emergency Care**
>
> **or Care at an Urgent Care Facility**
>
> Urgent claims should not be confused with emergency care or treatment at an urgent care facility, which do not require preauthorization. See "Urgent Claims" under "Types of Claims" above for an explanation of when a request for preauthorization might need to be handled as an urgent claim.

- **Disability claims:** Contact the Trust Fund Office to get a claim form. The form should be completed and returned with applicable documentation to the following address: Operating Engineers Health and Welfare Trust Fund, P.O. Box 23190, Oakland, CA 94623-0190.

- **Other claims:** You or your beneficiary should contact the Trust Fund Office to get a claim form for life insurance, AD&D, or burial expense benefits. The form should be completed and returned with applicable documentation to the following address: Operating Engineers Health and Welfare Trust Fund, P.O. Box 23190, Oakland, CA 94623-0190.

USING AN AUTHORIZED REPRESENTATIVE

An authorized representative may submit a claim (or later an appeal) for you if you are unable to complete it yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Trust Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

In the case of an urgent claim, a health care professional with knowledge of your medical condition may act as an authorized representative without your having to complete the special authorization form.

WHEN CLAIMS MUST BE FILED

Your claim will be considered to have been filed as soon as it is received by the applicable organization (VSP, HMSA or the Trust Fund Office). Pre-service and urgent claims must be filed before services are obtained.

You must submit all post-service claims no later than one year after the date charges were incurred.

ELIGIBILITY DISPUTES

If your claim is denied because you are not shown as eligible in the records of the Trust Fund Office, your eligibility status will be resolved by the Trust Fund Office, working with any service provider as necessary, to resolve your claim in accordance with the time lines described under *Appealing an Adverse Benefit Determination* below.

TIMING OF INITIAL CLAIMS DECISIONS

A determination on your claim will be made within the following time frames:

- For properly filed Urgent Care Claims, the Appropriate Claim Administrator will respond to the claimant and provider with a determination by telephone as soon as possible, taking into account the medical exigencies, but not later than ***72 hours*** after receipt of the Claim. The determination will also be confirmed in writing.

  If an Urgent Care Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Appropriate Claim Administrator will notify the claimant as soon as possible, but not later than ***24 hours*** after receipt of the claim, of the specific information necessary to complete the claim. The claimant must provide the specified information within ***48 hours*** after receiving the request for additional information. If the information is not provided within that time, the claim will be denied.

  During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either ***48 hours*** or the date claimant responds to the request, whichever is earlier. Notice of the decision will be provided no later than ***48 hours*** after receipt of the specified information.

  If a claimant improperly files an Urgent Care Claim, the Appropriate Claim Administrator will notify the claimant as soon as possible but not later than ***24 hours*** after receipt of the claim of the proper procedures required to file an Urgent Care Claim. Improperly filed claims include, but are not limited to:

  - claims that are not directed to a person or organizational unit customarily responsible for handling benefit matters; or
  - claims that do not name a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

  The notification may be oral unless the claimant or authorized representative requests written notification. Unless re-filed properly, an improperly filed claim will not constitute a claim.

- **Pre-service claims**: If your **pre-service** claim has been improperly filed, the Appropriate Claim Administrator will notify, in writing, the claimant and, if requested, the claimant's doctor within 15 days after receipt of the claim, of the proper procedures to be followed in filing a claim. You and/or your doctor will receive notice that the pre-service claim has been improperly filed only if the claim includes your name, your specific medical condition or

symptom, and a specific treatment, service, or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

Any Pre-Service Claim Urgent Care claim requested in writing should prominently designate on its cover that it is an "Urgent Care claim" requiring immediate attention. Pre-Service Claims that are an Urgent Care Claims will be processed according to the procedures and timeframes noted in the above Section for Urgent Care Claims.

If your pre-service claim has been properly filed, the Appropriate Claim Administrator will ordinarily notify you of its decision within **15 days** from the date your claim is filed, unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Appropriate Claim Administrator. If an extension is necessary, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which the Appropriate Claim Administrator expects to make a decision.

If an extension is needed because the Appropriate Claim Administrator needs additional information from you, the Appropriate Claim Administrator will notify you as soon as possible, but no later than 15 days after receipt of the claim, of the specific information necessary to complete the claim. In that case you and/or your doctor will have 45 days from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Appropriate Claim Administrator then has 15 days to make a decision and notify you of the determination. If the requested information is not provided within the time allowed, the claim will be denied.

- **Concurrent Care Claims:** A claim involving concurrent care may be filed orally or in writing to the Appropriate Claim Administrator. If a decision is made to reduce or terminate an approved course of treatment, the participant will be notified sufficiently in advance of the reduction or termination to allow the Participant or Beneficiary to appeal and obtain a determination of that Adverse Benefit Determination before the benefit is reduced or terminated.

  Concurrent Care Claims that are an Urgent Care Claim will be processed according to the procedures and timeframes noted in this Section for Urgent Care Claims. Concurrent Care Claims that are not an Urgent Care Claim will be processed according to the procedures and timeframes noted in this Section for Pre-Service and Post-Service Claims.

  If the Concurrent Care Claim is approved, the participant will be notified orally followed by written notice provided no later than ***3 days*** after the oral notice. If the Concurrent Care Claim is denied, in whole or in part, the participant will be notified orally followed by written notice.

- **Post-service health care claims**: A Post-Service Claim must be submitted in writing to the Appropriate Claim Administrator in writing, using an appropriate claim form or appropriate electronic claims procedure, **within one (1) year after expenses are incurred**. Failure to file a Post-Service Claim within the time required will not invalidate or reduce any claim if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible after the date the charges were incurred. The Board of Trustees has absolute discretion to make a determination as to whether benefits are to be issued after the one (1) year time period has elapsed.

  A Post-Service Claim is considered to have been filed upon receipt of the claim by the Appropriate Claim Administrator. The Appropriate Claim Administrator will notify claimants of decisions on Post-Service Claims in writing within ***30 days*** of receipt of the claim by Blue

Cross, OptumRx or ARP. This period may be extended one time for up to 15 days if the extension is necessary due to matters beyond the control of the Appropriate Claim Administrator. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Appropriate Claim Administrator expects to make a decision.

If an extension is needed because the Appropriate Claim Administrator needs additional information from you, the Appropriate Claim Administrator will notify you as soon as possible, but no later than **30 days** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor, dentist, or other provider will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). The Appropriate Claim Administrator then has **15 days** to make a decision on your post-service claim and notify you of the determination. If the requested information is not provided within the time allowed, the claim will be denied.

- **Disability Claims:** A Disability Claim must be submitted in writing to the Trust Fund Office, in writing, using an appropriate claim form or appropriate electronic claims procedure, **within one (1) year after expenses are incurred**. The Board of Trustees has absolute discretion to make a determination as to whether benefits are to be issued after the one (1) year time period has elapsed.

  The written claim must be completed in full and requested documentation must be attached to the written claim in order for the request for benefits to be considered a claim. The written claim must include all required information for the request to be considered a claim and for the Plan to be able to decide the claim.

  A Disability Claim is considered to have been filed upon receipt of the claim by the Trust Fund Office. The Trust Fund Office will notify claimants of decisions on Disability Claims in writing within ***45 days*** of receipt of the claim. The Trust Fund Office may extend this period up to two times for up to ***30 days*** if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Trust Fund Office will notify claimants, in writing, of the need to extend the initial ***45 day*** period prior to the expiration of the initial ***45 day*** period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. If a second extension is necessary, the Trust Fund Office will notify claimants, in writing, of the need to extend the 30 day extension prior to the expiration of the initial 30 days extension, of the circumstances requiring the second extension, and the date by which a decision is expected to be rendered.

  If an extension is required because the Plan needs additional information from the participant, the Trust Fund Office shall request additional information from provider and/or claimant via fax, telephone, or letter within 45 days of the receipt of the claim or within ***75 days*** if a ***30 day*** extension is taken. The request for additional information shall specify the information needed. Claimant has ***45 days*** from receipt of the request for additional information to supply the additional information. If the information is not provided within that time, the claim will be denied. During the ***45 day*** period in which the participant is allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the request for additional information until the earlier of: (i) ***45 days*** from receipt of the request for additional information; or (ii) the date the participant responds to the request. The Trust Fund Office shall notify, in writing, the claimant of a decision within ***15 days*** after receipt of any additional information.

EXPIRATION OF TIME PERIODS

If a claim is not acted upon within the time periods prescribed in this chapter, you may proceed to the appeal procedure as if the claim were denied.

RIGHT TO CONTINUED COVERAGE

If you initiate an internal appeal in compliance with the internal appeals process described in this chapter and if the appeal concerns a previously approved ongoing course of treatments to be provided over a period of time or number of treatments, the Plan will continue to provide such coverage pending the outcome of the internal appeal.

DENIED CLAIMS (ADVERSE BENEFIT DETERMINATIONS)

An "adverse benefit determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an adverse benefit determination:

- a payment of less than 100% of a claim for benefits,
- a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any decision on a required preauthorization or concurrent authorization,
- a failure to cover an item or service because VSP considers it to be Experimental, Investigational, not Medically Necessary or not medically appropriate or specifically not covered under the Plan,
- a decision that denies a benefit based on a determination that you or a Dependent is not eligible to participate in the Plan.
- a Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time is considered an Adverse Benefit Determination.

You will be provided with written notice of the initial decision on your claim. If the decision is a denial of the claim (an adverse benefit determination), this notice will include:

- identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
- state 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 an internal appeal or an external review;
- the specific reason(s) for the determination including the denial code and its corresponding meaning as well as an Plan standards used in denying the claim,
- reference to the specific Plan provision(s) on which the determination is based,
- a description of any additional material or information necessary if you want a further review of the claim and an explanation of why the material or information is necessary,
- a description of the Plans internal appeal procedures and external review processes and applicable time limits,
- a statement of your right to bring a civil action under ERISA Section 502(a) following the appeal of an adverse benefit determination,
- if an internal rule, guideline, or protocol was relied upon in deciding your claim, a statement that a copy of the rule is available upon written request at no charge, and

- if the determination was based on the absence of medical necessity or the treatment's being Experimental or Investigational or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon written request at no charge; and
- if ten-percent or more of the population residing in the county to which an adverse determination is being sent is literate only in a non-English language (as determined in guidance published by the federal government) then:
  - the Notice of Adverse Benefit Determination must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language;
  - upon request the Plan shall provide a Notice of Adverse Benefit Determination in that non-English language;
  - the Notice of Adverse Benefit Determination must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language;
  - any customer assistance services provided by the Plan shall be provided in that non-English language;
- a statement of the availability of assistance from and the contact information for any applicable offices of health insurance consumer assistance and/or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) concerning questions about: (1) claimant's rights, (2) the notice, or (3) other assistance; and
- disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

For urgent claims, the notice will describe the expedited review process applicable to urgent claims. For urgent claims, the required determination may be provided orally and followed with written notification.

For pre-service and urgent claims, you will receive notice of the determination even when the claim is approved.

If the decision is a denial of a Disability Claim, this notice will include:

- A statement that the claimant is entitled to receive access to and copies of all relevant documents upon request and without charge.
- A discussion of the decision, including the basis for disagreeing with or not following the views of a treating physician or vocational professional; the views of medical or vocational experts obtained by the plan; or a disability determination by the Social Security Administration.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination as applied to the claimant's medical circumstances will be provided free of charge upon request.

If you are not proficient in English and have questions about a claim denial, contact the Administrative Office to find out if assistance is available.

APPEALING AN ADVERSE BENEFIT DETERMINATION

For vision claims, you must exhaust the appeals process with VSP first. You may then file an appeal with the Plan's Board of Trustees.

If you disagree with the decision made on a claim, you may appeal the decision.

First Level Appeals of decisions on **urgent claims** should **not** be submitted via the US Postal Service. They should be made by telephone or fax the Appropriate Claims Administrator. The Appropriate Claims Administrator will respond to your request for an expedited appeal as soon as possible, taking into account your medical condition, but not later than 72 hours of receipt of your request. All necessary information, including the Plan's determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile, e-mail or other available similarly expeditious method, with written notice to follow within *48 hours*.

First Level Appeals of **pre-service claims, concurrent claims,** or **post-service claims** decisions must be in writing and sent by fax or mail sent to the Appropriate Claims Administrator.

A Pre-Service Claim appeal that is received with additional information which, upon review, allows additional benefits to be approved by the Appropriate Claim Administrator in accordance with Plan provisions will not be considered an appeal, but a new Pre-Service Claim.

Second Level Appeals (where available) should be submitted in writing to the Trust Fund Office (at the address listed on the Quick Reference Chart).

Appeals of Adverse Benefit Determinations regarding **Disability Claims** must be submitted in writing to the Trust Fund Office via mail or fax.

You must submit your written appeal within **180 days** after you receive the notice of denial of a claim. When appealing you should include a copy of the Adverse Benefit Determination, which will have the information needed to identify the claim you are appealing. You must state your reason for disputing the denial and furnish any pertinent material not already furnished. You have the right to submit comments, documents, records, and other information in support of your claim for benefits.

Failure to file an appeal that meets the criteria above will constitute a waiver of your right to a review of the denial of your claim.

APPEAL PROCESS

You will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. You will be provided, upon request and free of charge, reasonable access to and copies of all relevant documents pertaining to your claim.

You will be provided, 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 denied 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 filing or 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.

Your appeal will be decided by an individual or individuals who did not take part in the original claim denial and are not subordinates of the person who originally denied the claim. No deference will be given to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments as may be submitted by you.

If your claim was denied 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), a health care professional who has appropriate training and experience in a relevant field of medicine and did not take part in the original claim denial will be consulted. The professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination, nor the subordinate of that individual. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice on your claim, without regard to whether their advice was relied upon in deciding your claim.

NOTICE OF DECISION ON APPEAL

You will receive notice of the decision made on your appeal according to the following timetable:

- **Pre-service claims**: You will be sent a notice of a decision on review within **30 days** of receipt of the appeal.
- **Urgent claims**: You will be sent a notice of a decision on review within **72 hours** of receipt of the appeal.
- **Concurrent claims**: If the claim concerns a reduction or termination of an initially approved course of treatment, you will receive notice of a decision on review prior to the termination of the benefit. For all other claims to extend a concurrent care treatment, the decision must be made in the time periods: 1) for urgent care appeals the notification period is based on the current urgency of the claim; or 2) for non-urgent pre-service and post-service concurrent appeals the time periods set forth under each standard.
- **Post-service health care claims**: You will receive a decision on review on First Level Appeals of Medical, Prescription Drug, Chiropractic/Acupuncture/Massage, or Vision benefits from the Appropriate Claim Administrator within **60 days** of receipt of your appeal.
- Decisions on appeals of **Eligibility, Disability claims**, or Secondary Level Appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal may be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal 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, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

IF YOUR APPEAL IS DENIED

The decision on any review of your claim will be given to you in writing. If your appeal is denied, the notice will include:

- identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
- state 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 an internal appeal or an external review;

- the specific reason(s) for the determination including the denial code and its corresponding meaning as well as an Plan standards used in denying the claim,
- reference to the specific Plan provision(s) on which the determination is based,
- a description of any additional material or information necessary if you want a further review of the claim and an explanation of why the material or information is necessary,
- a description of the Plans internal appeal procedures and external review processes and applicable time limits,
- a statement of your right to bring a civil action under ERISA Section 502(a) following the appeal of an adverse benefit determination,
- if an internal rule, guideline, or protocol was relied upon in deciding your claim, a statement that a copy of the rule is available upon written request at no charge, and
- if the determination was based on the absence of medical necessity or the treatment's being Experimental or Investigational or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon written request at no charge; and
- disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
- if ten-percent or more of the population residing in the county to which an adverse determination is being sent is literate only in a non-English language (as determined in guidance published by the federal government) then:
    - the Notice of Final Internal Adverse Benefit Determination must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language;
    - upon request the Plan shall provide a Notice of Final Internal Adverse Benefit Determination in that non-English language;
    - the Notice of Final Internal Adverse Benefit Determination must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language; and
    - any customer assistance services provided by the Plan shall be provided in that non-English language;
- a statement of the availability of assistance from and the contact information for any applicable offices of health insurance consumer assistance and/or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) concerning questions about: (1) claimant's rights, (2) the notice, or (3) other assistance;
- a statement of your right to external review if the final adverse benefit determination involves either 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; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; or a rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time and, if applicable, a description of the external review process processes along with time limits and information regarding how to initiate an external review;

- a statement of your right for Urgent Care claims or when you are receiving an ongoing course of treatment, that you shall be allowed to proceed with expedited external review if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but have not been discharged from a facility; and a description of the expedited review process.

DEEMED EXHAUSTION OF THE PLAN'S INTERNAL DISABILITY CLAIMS AND APPEALS PROCEDURES

If the Plan fails to strictly adhere to all rules for processing claims and/or appeals, a claimant will be deemed to have exhausted the Plan's administrative procedures for internal claim appeal and will be entitled to take legal action, unless there was only a minor error violation of the required claims procedures, with minor being: (1) de minimis, (2) non-prejudicial, (3) attributable to good cause or matters beyond the plan's control, (4) in the context of an on-going good faith exchange of information, and (5) not reflective of a pattern or practice of noncompliance. A claimant is entitled, upon request, to an explanation of the minor error violation from the Plan, and the Plan has 10 days to respond. A claimant who is not satisfied with the Plan's explanation, or who does not even request an explanation, may take legal action.

EXTERNAL REVIEW OF CLAIMS

This 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).

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:

- 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, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and/or
- 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** Medical, Dental, Life insurance, Accidental Death and Dismemberment, Weekly Disability Income benefit and the Burial benefit.

There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document. The Plan retains at least three IROs from which it can select an IRO to perform external reviews. The Plan requires its contracted IROs to maintain written records for at least three years.

Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

1. **External Review of Standard (Non-Urgent) Claims**.

   Your request for external review of a standard (not urgent) claim must be made, in writing, **within four (4) months of the date that you receive notice** of an Initial Claim Appeal Benefit Determination (first level of appeal) or adverse Claim Appeal Benefit Determination (second level of appeal) . For convenience, these determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

   A. **Preliminary Review of Standard Claims**.

      1. Within five (5) business days of the Plan's receipt of your request for an external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

         (a) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

         (b) The denial satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;

         (c) You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when you are not required to do so); and

         (d) You have provided all of the information and forms required to process an external review.

      2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

         (a) If your request is complete and eligible for external review; or

         (b) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

         (c) If your request is not complete, the notice will describe the information or materials needed to complete the request, and allow you to complete the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

   B. **Review of Standard Claims by an Independent Review Organization (IRO)**.

      1. If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

         a. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit

additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

b. Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

c. If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. **Reconsideration** by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

d. 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).

e. The assigned IRO will provide written notice of its final external review decision to you and the Plan **within 45 days** after the IRO receives the request for the external review.

   1) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

   2) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

f. The assigned IRO's decision notice will contain:

   1.) 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);

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

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

4.) 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;

5.) 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);

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

7.) 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.

2. **External Review of Expedited Urgent Care Claims**.

A. You may request an expedited external review if:

(a) You receive a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

(b) You receive a claim denial that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive a claim denial that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

B. **Preliminary Review for an Expedited Claim**.

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met. The Plan will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information.

C. **Review of Expedited Claim by an Independent Review Organization (IRO)**.

Following the preliminary review that a request is eligible for expedited external review, the Plan will assign an IRO (following the process described under Standard Review above). The Plan will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a

decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not 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.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than **seventy-two (72) hours** after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

(a) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(b) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a)

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain benefits or request arbitration, 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 after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision.

No lawsuit may be started more than three years after the end of the year in which services were provided. The denial of a claim to which the right to review has been waived, or the decision of the Board or its designated Appeals Committee 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.

In carrying out their responsibilities under the Plan, the Board of Trustee or its delegate, other Plan fiduciaries, and the insurers or administrators of each Benefit 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.

Maximum Times for Processing of Claims for Self-Funded Benefits, Eligibility Claims, and Disability Claims (Times are suspended during waits for additional information requested of you)					
	Pre-Service Claims	**Urgent Claims**	**Concurrent Claims**	**Post-Service Claims**	**Disability Claims**
Appropriate Claim Administrator makes initial determination (provided all necessary information is submitted)	Within 15 days of claim's receipt (can be extended for another 15 days)	Within 72 hours of claim's receipt	In time for you to appeal before benefit is reduced or terminated Within 24 hours of request for extension of urgent claim care	Within 30 days of claim's receipt (can be extended for another 15 days)	Within 45 days of claim's receipt (can be extended up to 2 extensions, each of 30 days)
Appropriate Claim Administrator notifies you that a claim has been improperly filed	Within 5 days of claim's receipt	Within 24 hours of claim's receipt	Not applicable	Not applicable	Not applicable
The Appropriate Claim Administrator requests additional information	Within 15 days of claim's receipt	Within 24 hours of claim's receipt	Not applicable	Within 30 days of claim's receipt	Within 45 days of claim's receipt
You respond to request for information	Within 45 days of request	Within 48 hours of request	Not applicable	Within 45 days of request	Within 45 days of request
The Appropriate Claim Administrator makes determination after requesting information	Within 15 days of your response or expiration of time allowed	Within 48 hours of your response or expiration of time allowed	Not applicable	Within 15 days of your response or expiration of time allowed	Within 30 days of your response or expiration of time allowed
You make request for appeal	Within 180 days of receiving notice of denial	Within 180 days of receiving notice of denial	Within a reasonable time for your situation	Within 180 days of receiving notice of denial	Within 180 days of receiving notice of denial
Board of Trustees makes decision on appeal	Within 30 days of your requesting appeal	Within 72 hours of your requesting appeal	Within a reasonable time for type of care decision	At next regular Board meeting or, if appeal is received less	At next regular Board meeting or, if appeal is received less

Maximum Times for Processing of Claims for Self-Funded Benefits, Eligibility Claims, and Disability Claims (Times are suspended during waits for additional information requested of you)					
	Pre-Service Claims	**Urgent Claims**	**Concurrent Claims**	**Post-Service Claims**	**Disability Claims**
				than 30 days in advance, at subsequent meeting (may be delayed until third such meeting)	than 30 days in advance, at subsequent meeting (may be delayed until third such meeting)

PROHIBITION ON ASSIGNMENT

The Plan prohibits and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Plan Participant, a Participant's dependent or creditor of the Plan Participant without the express written permission of the Plan; however, a Plan Participant may direct that benefits due him/her, be paid to a healthcare provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a healthcare provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan, and in no way shall be construed or interpreted as a waiver on the Plan's prohibition on assignments. The Plan are not responsible for paying healthcare provider invoices that are balance billed to a Plan Participant.

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

NAME OF THE PLAN

Hawaii Health and Welfare Trust Fund for Operating Engineers.

NAME, ADDRESS AND TELEPHONE NUMBER OF THE PLAN SPONSOR

Board of Trustees
Hawaii Health and Welfare Trust Fund for Operating Engineers
1600 Harbor Bay Parkway, Suite 200
Alameda, California 94502
Telephone Number: (510) 433-4422

PLAN ADMINISTRATOR

The Board of Trustees is the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan Participants and Beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974.

The Board of Trustees has engaged the following Trust Fund Manager named below to provide routine administrative services to the Plan:

Zenith American Solutions
C/O Administrator
1600 Harbor Bay Parkway
Suite 200
Alameda, CA 94502

THE INTERNAL REVENUE SERVICE HAS ASSIGNED TO THE BOARD OF TRUSTEES THE (EIN) NUMBER

94-6182984.

PLAN NUMBER

501

TYPE OF PLAN

This is a Welfare Plan providing the following kinds of benefits:

- **Fully Insured:** Death, accidental death and dismemberment, AD&D, burial, weekly disability income, comprehensive medical (HMO), chiropractic/acupuncture/massage, and dental.
- **Self-Funded:** Vision, comprehensive PPO medical and prescription drug.

NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR THE SERVICE OF LEGAL PROCESS.

Zenith American Solutions
C/O Administrator
1600 Harbor Bay Parkway
Suite 200
Alameda, CA

The service of legal process may also be made upon a Plan Trustee, or the Board of Trustees at the address shown above.

NAME AND BUSINESS ADDRESS OF EACH TRUSTEE:

Employer Trustees	Employee Trustees
Mr. Lance Inouye Ralph S. Inouye Co., Ltd. 500 Alakawa Street, Room 220E Honolulu. Hawaii 796817	Mr. Dan Reding Operating Engineers Union Local 3 1620 South Loop Road Alameda, California 94502
Mr. Rodney H. Nohara Jayar Construction, Inc. 1176 Sand Island Parkway Honolulu. Hawaii 96819	Mr. Pane Meatoga Operating Engineers Local 3, District 17 2181 Lauwiliwili Street Kapolei, HI 96707
Ms. Kathleen Thurston Thurston-Pacific, Inc. P.O. Box 607 Kailua, Hawaii 96734	Mr. Steve Ingersoll Operating Engineers Union Local 3 1620 South Loop Road Alameda, California 94502
Mr. Randall Ching, Alternate Highway Construction Co. Ltd. 720 Umi Street Honolulu, Hawaii 96819	Mr. Justin Diston Operating Engineers Union Local 3 1620 South Loop Road Alameda, California 94502
Mr. Corey Yamashita, Alternate Goodfellow Bros, Inc. 1300 N. Holopono Street, Ste 201 Kihei, Hawaii 96753	Mr. Analesea Tuiasosopo, Alternate Operating Engineers Local 3, District 17 2181 Lauwiliwili Street Kapolei, Hawaii 96707

AVAILABILITY OF COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to collective bargaining agreements. A copy of the collective bargaining agreements is available for examination and may be obtained upon written request to the Fund Manager.

SOURCE OF CONTRIBUTIONS:

Contributions to provide Plan benefits are paid by the Contributing Employers in accordance with their bargaining agreements, at fixed rates per hour.

The Trust Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the collective bargaining agreement, and if the particular employer is contributing to the Plan, the employer's address.

IDENTITY OF ORGANIZATIONS THAT PROVIDE BENEFITS AND/OR ADJUDICATE CLAIMS:

American Specialty Health Plan (ASHP) 777 Front Street San Diego, CA 92101 *Provides chiropractic and alternative medical benefits with guaranteed payment of these benefits to HMSA Plan Participants.*	**Assistance Recovery Program (ARP)** 1620 South Loop Road Alameda, CA 94502 *Helps to arrange chemical dependency treatment benefits for Participants. (Benefit is self-funded by the Trust Fund.)*
Hawaii Dental Service (HDS) 700 Bishop Street, Suite 700 Honolulu, HI 96813-4196 *Provides dental benefits with guaranteed payment of these benefits.*	**Hawaii Medical Service Association (HMSA)** 818 Keeaumoku Street Honolulu, HI 96808-0860 *Administers medical, prescription drug and vision benefits for participants who select the Plan for medical coverage; does not guarantee payment of these benefits (Benefit is self-funded by the Trust).*
Kaiser Foundation Health Plan Hawaii Region 711 Kapiolani Blvd. Honolulu, HI 96813 *Provides prepaid medical, prescription drug and vision benefits with guaranteed payment of these benefits for participants who select this Plan for medical coverage.*	**Pacific Guardian Life Insurance Company** 1440 Kapiolani Blvd., Suite 1700 Honolulu, Hawaii 96814 *Insures the life insurance, accidental death & dismemberment and weekly disability benefits with guaranteed payment of these benefits.*
Vision Service Plan (VSP) One Market Street, Ste. 2625 Steuart Tower San Francisco, CA 94105 *Administers vision benefits; does not guarantee payment of these benefits. (Benefit is self-funded by the Trust Fund.)*	**Union Labor Life Insurance Company** 8403 Colesville Rd Silver Spring, MD 20910 *Insures the burial expense benefit.*

Each of these benefits has restrictions as to eligibility and cost sharing arrangements which are described in detail in this Summary Plan Description or in the *Evidence of Coverage* or other brochures available from the organization providing the benefits.

PLAN YEAR

The Fund's fiscal Plan year-end date is December 31.

CLAIMS AND APPEALS PROCEDURES:

The procedures to follow for filing a claim for self-funded benefits are set forth in the sections of this booklet titled *Claims and Appeals Procedures*.

Any denial of a claim for benefits will be explained in writing and the explanation will include the specific reason for the denial, reference to the Plan provisions upon which the denial was based, a description of any additional information you might be required to provide and an explanation of why it is needed, and an explanation of the Plan's claim review procedure.

You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a review to the Board of Trustees or to the insurance carrier. In connection with such a request, documents pertaining to the administration of the Plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure.

STATEMENT OF ERISA RIGHTS:

As a participant in the Hawaii Health and Welfare Trust Fund for Operating Engineers you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The 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

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event, as described in the COBRA chapter. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health Plan if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable

coverage, you may be subject to a Pre-Existing Condition exclusion for 12 months after your Enrollment Date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries.

No one, including your Contributing Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. See the Plan's *Claims and Appeals* information on the requirement to appeal a denied claim before filing a lawsuit.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor. The regional office for Hawaii is located at: Suite 514, 790 East Colorado Blvd., Pasadena, CA 91101. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN AMENDMENTS OR TERMINATION OF PLAN

The Board of Trustees reserves the right to amend or terminate this Plan, or any part of it at any time. Amendments will be made in writing and become effective on the date the Amendment is signed by the Chairman and Co-Chairman 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 coverage may be added by the Board of Trustees.

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 Plan may be terminated by the Board of Trustees, provided that the termination is not effective until 60 days after the mailing of such notice. 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. Upon termination of the Plan, the Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

DISCRETIONARY AUTHORITY OF BOARD OF TRUSTEES

In carrying out their responsibilities under the Plan, the Board of Trustee or its delegate, other Plan fiduciaries, and the insurers or administrators of each Benefit 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.

For additional information concerning claims and benefits, please contact the Local #3 office nearest you.

Oahu and Kauai

OPERATING ENGINEERS LOCAL #3
2181 Lauwiliwili Street
Kapolei, HI 96707
(808) 847-1289
(800) 660-9126

Hawaii

OPERATING ENGINEERS LOCAL #3
99 Aupuni Street, Suite 101
Hilo, Hawaii 96720
(808) 935-8709
toll-free (877) 935-8709

Maui, Molokai and Lanai

OPERATING ENGINEERS LOCAL #3
2145 Wells Street, Suite 405
Wailuku, HI 96793
(808) 871-1193
(877) 871-1193 toll-free for Molokai and Lanai

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 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. Neither the Plan, Board of Trustees, the Trust Fund Office nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles, copayment and coinsurance applicable to other medical and surgical benefits provided by the Fund.

NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT (NEWBORNS' ACT)

Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan may pay for a shorter stay if the attending physician, after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans 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, the plan may not, under federal law, require that a physician or other 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 preauthorization. For information on preauthorization, refer to the Certificate of Coverage from the insurance company listed on the Quick Reference Chart.

DEFINITIONS

Acupuncture is a technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow. When benefits for acupuncture are payable by this Plan, such services may be rendered by a Physician (MD or DO) or Chiropractor with proper credentials to perform acupuncture in the state in which they are licensed and for an Acupuncturist who is properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing of an acupuncturist is not required, be certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM).

Allowed Charge/Allowed Amount/Allowable Charge means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. The allowed charge amount is determined by the Plan Administrator or its designee to be the **lowest** of:

- With respect to a network provider the negotiated fee/rate set forth in the agreement between the participating network and the Plan; or
- With respect to a non-network 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
- For Network 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 a Network claim; or
- The provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even after you have paid any applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "allowed charge" amount for services or supplies.

In accordance with federal law, with respect to emergency services performed in a Non-Network Emergency Room (ER), the Plan's allowance for ER visit facility fees and ER professional fees is to pay the **GREATER** of:

a) the negotiated amount for Network providers (the median amount if more than 1 amount to Network providers), or
b) 100% of the Plan's usual payment formula (called Allowed Charge in this Plan), reduced for cost-sharing, or
c) (when such database is available), the amount that Medicare Parts A or B would pay, reduced for cost-sharing.

See also the definition of emergency services in this chapter.

NOTE: Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. If you use a non-network provider you may be balance billed by that provider. Balance billing might not apply to emergency services in a hospital emergency room in cases where state law prohibits a person from being required to pay balance-billed charges or where the Plan is contractually responsible for such charges.

Balance Billing: A bill from a 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. **Out-of-Network providers commonly engage in balance billing**. This means a plan participant may be billed for any balance that may be due in addition to the amount payable by the Plan. Generally, you can avoid balance billing by using Network providers. Typically, Network providers do not balance bill except in situations of third party liability claims.

Chiropractor means a person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license.

Contributing Employer means any employer who is required by any of the collective bargaining agreements to make contributions to the Fund, or who does in fact make one or more contributions to the Fund.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Covid-19 Test: Diagnostic tests to detect the presence of, or antibodies to, the virus causing Covid-19 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 individuals who are not trained or licensed medical or nursing personnel.

Dependent means your legal Spouse and your eligible children, under age 26, are eligible for medical, prescription drugs, dental and vision benefits coverage. Eligible children are your:

- natural children;
- legally adopted children;
- stepchildren;
- foster children; or
- a child that is named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice.

The following individuals are not eligible under the Plan: child under a legal guardianship, a spouse of a Dependent Child (e.g. employee's son-in-law or daughter-in-law) or a child of a Dependent Child (e.g. employee's grandchild), Domestic Partner or child of a Domestic partner.

Disabled Adult Child: Dependent Children up to age 26 will be covered for medical, prescription drug, vision, and dental benefits. In addition, there are limited life insurance benefits available for Dependent Children up to age 19.

If you provide full support for your child who is unable to earn his own living because of mental or physical disability, coverage will be continued for that child beyond age 26 so long as the disability exists and you remain eligible. To qualify for this extension, the child must have been both disabled and eligible under the Fund prior to age 26. However, evidence of the child's disability must be furnished to the Trust Fund Office or the insurance company within 31 days of the child's 26th birthday in order to qualify for the continued coverage. Thereafter you must provide proof of continuing disability upon request of the Trust Fund Office or the Insurance Company.

Durable Medical Equipment (DME): Equipment that is FDA-approved for the purpose that it is being prescribed; 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; is necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body part; 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. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Emergency Medical Condition: means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a **prudent layperson** who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to a) result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or the woman's unborn child), b) serious impairment to bodily functions or c) 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.

Emergency Services: means with respect to an Emergency Medical Condition (defined above), a medical screening examination **within the emergency department of a hospital** including

ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

Employee means any person employed by a Contributing Employer in a job classification covered by a collective bargaining agreement with the Union and who meets the eligibility requirements of the Fund. The term "Employee" may include the Employees of the Fund, the Union, or the Trust Fund Office, 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 Trust.

Experimental or Investigational Treatment means treatments, procedures, drugs, devices, or care, and all related services or supplies that are experimental or investigational as determined by the Board of Trustees or its designee. A treatment, procedure, drug, device or care is experimental or investigative if, in the opinion of the Plan Administrator:

a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished (unless the off-label use is approved by the Plan), or

b) the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

c) Reliable Evidence* shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is for the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

d) 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 Reliable Evidence* shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

e) 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.

* Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or

procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

f) 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. For individuals who will participate in a clinical trial, preauthorization is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:

1) "**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.

2) 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's study 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 and 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.

3) 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.

4) The plan may require that an eligible individual use an in-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.

5) 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. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial.

In determining if 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 for Preauthorization under the Plan's Utilization Management program:**

1. Medical 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; or clinical policy bulletins of major insurance companies in the US.
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."

Fund means the Hawaii Health and Welfare Trust Fund for Operating Engineers.

Genetic Counseling: Counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and their family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or

disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Health Care Practitioner: Acupuncturist, Behavioral Health Practitioner (including licensed psychologist (PhD), 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, certified registered nurse anesthetist(CRNA), Chiropractor, Dentist, Nurse (RN, LVN, LPN), Nurse Practitioner, Licensed Midwife, Certified Nurse Midwife, Breastfeeding/Lactation Educator, Physician Assistant (PA), or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, Optometrist, Optician for the Vision Benefit, Registered Dietitian, Certified Diabetes Educator, or Pharmacist 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 the provider's license and/or scope of practice.

Health Care Provider means any individual 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, as well as or a Hospital, Ambulatory Surgical Facility/Center, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility/Long Term Acute Care facility, or other facility licensed and legally authorized to provide certain health care services under the laws of the state or jurisdiction where the services are rendered.

Homebound: means that due to an illness or injury, the individual is unable to leave home, or if he/she does leave home, doing so requires a considerable and taxing effort.

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 their 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. Many hospice organizations are members of the National Hospice and Palliative Care Organization (NHPCO).

The hospice agency must meet one of the following tests:

1. It is approved by Medicare; or is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. If licensing is not required, it meets all of the following requirements:
    - provides 24 hour-a-day, 7 day-a-week service.
    - is under the direct supervision of a duly qualified Physician.
    - has a full-time administrator.
    - has a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
    - the main purpose of the agency is to provide Hospice services.
    - maintains written records of services provided to the patient.
    - maintains malpractice insurance coverage.

A Hospice that is part of a Hospital, as defined in this chapter, will be considered a Hospice for the purposes of this Plan.

Hour Bank means the account established for an Employee to which all hours worked are credited for Contributing Employers for which contributions are made or are required to be made to the Fund on his behalf.

Hour Bank Employee means a person who is an employee of one or more Contributing Employers with respect to whose work contributions are made to the Fund.

Illness: Any bodily sickness or disease, including any congenital abnormality of an eligible newborn child, as diagnosed by a Physician and as compared to the person's previous condition. **Pregnancy 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.

Infusion Therapy: Infusion therapy involves the administration of medication or nutrition through a needle or catheter. It is prescribed when a patient's condition is so severe that the condition cannot be treated effectively by oral medications or other nutrition routes. Commonly administered infusion therapy includes infusion of antibiotic, antifungal, antiviral, chemotherapy, hydration, pain management, parenteral nutrition, and total parenteral nutrition or TPN. Diseases commonly requiring infusion therapy include infections that are unresponsive to oral/intramuscular antibiotics, cancer and cancer-related pain, dehydration, gastrointestinal diseases or disorders which prevent normal functioning of the gastrointestinal system, etc.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This **does not include** an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for Accidental Injury to Teeth may be payable under Oral services in the Schedule of Medical Benefits.

Intensive Outpatient Program (IOP): means providing treatment in a structured therapeutic outpatient (non-residential) behavioral health environment with individual and/or group counseling treatment on a schedule that is typically no less than six hours per week (e.g. counseling provided at least 2-4 hours/day or evening, and held 3-7 times a week). Certain intensive outpatient programs can be structured to allow an individual to be able to participate in their daily affairs, such as work or school, and then participate in IOP treatment program in the morning or at the end of the day. The IOP is an outpatient program and does not include an overnight stay in a facility or an inpatient hospital admission. An IOP may be appropriate for individuals who do not require medically-supervised inpatient treatment (including detoxification) and is an enhanced level of behavioral health support as compared to the standard outpatient visits that involve one 30/45/60 minute visit or two 30/45/60 minute visits per week to an outpatient behavioral health provider's office for counseling and/or medication management. Through a "step down" process, an IOP progressively transitions individuals to require less therapeutic support, to help the individual become more independent.

Local Union means the Operating Engineers Local Union No. 3 of the International Union of Operating Engineers, AFL-CIO.

Maintenance Rehabilitation: Rehabilitation services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Massage (or therapeutic massage or massage therapy) refers to the use of structured palpation or movement of the soft tissues of the body to enhance the muscle and skin tone, flexibility/mobility, circulation, and general health/well-being of the patient. Massage services include, but are not limited to, such techniques as effleurage (stroking the skin), gliding, friction, vibration, compression, passive or active stretching within the normal anatomical range of movement;

petrissage (kneading, lifting or picking up muscles and rolling the folds of skin) and tapotement (percussion and rhythmic movements of the hand).

Medically Necessary means a treatment, service or supply that meets all of the following criteria as determined by the Board of Trustees or its designee:

- For the purpose of treating a medical condition.
- The most appropriate delivery or level of service, considering potential benefits and harms to the patient.
- Known to be effective in improving health outcomes; provided that:
    - Effectiveness is determined first by scientific evidence;
    - If no scientific evidence exists, then by professional standards of care; and
    - If no professional standards of care exists or if they exist but are outdated or contradictory, then by expert opinion; and
- Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

Services that are not known to be effective in improving health outcomes include, but are not limited to, services that are experimental or investigational.The fact that a physician may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply medically necessary, even if it is listed as a covered service.

Except for BlueCard participating and BlueCard PPO providers, In-Network providers may not bill or collect charges for services or supplies that do not meet HMSA's Payment Determination Criteria unless a written acknowledgement of financial responsibility, specific to the service, is obtained from you or your legal representative prior to the time services are rendered.

In-Network providers may, however, bill you for services or supplies that are excluded from coverage without getting a written acknowledgement of financial responsibility from you or your representative.

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

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

To be covered, the care you get must be consistent with the provider's scope of practice, state licensure requirements, and HMSA's medical policies. These are policies drafted by HMSA Medical Directors, many of whom are practicing physicians, with community physicians and nationally recognized authorities. Each policy provides detailed coverage criteria for when a specific service, drug, or supply meets payment determination criteria. If you have questions about the policies or would like a copy of a policy related to your care, please call HMSA at the number provided in the Quick Reference Chart.

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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.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, syringes (except to administer covered drugs), diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device) and Prosthetic appliance (or Device). Only those nondurable supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not covered.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does **not** include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

Partial Day Care/ Partial Hospitalization: means treatment of mental, nervous, or emotional disorders and substance abuse at a hospital (on an outpatient basis) for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period, and the care does not include an overnight stay in a hospital/facility. Partial day care is active treatment that incorporates individualized treatment plans that describe the type, frequency, and duration of services as well as coordination of services around each patient's needs. The services must require a multidisciplinary team approach under the direction of a physician and reflect structure and scheduling. Treatment goals should be measurable, functional, regularly scheduled, medically necessary, and directly related to the partial day care program. Patients must be under care of a physician who certifies the medical necessity of the services. Patient must be able to participate and tolerate a minimum of 20 hours per week of therapeutic services. The services must be comprehensive, structured, multimodal treatment that necessitates medical supervision and coordination due to a mental disorder (i.e., mental health diagnosis) that severely interferes with daily life. Partial day care should include: individual or group psychotherapy, family counseling services, patient training and education and medically necessary diagnostic services related to mental health and/or substance abuse treatment.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM) 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 their license.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs and eyes, heart pacemaker. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

Pulmonary Rehabilitation: Pulmonary Rehabilitation refers to a formal program of controlled exercise training and respiratory education under the supervision of qualified medical personnel capable of treating respiratory emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to their highest functional level of activity/endurance, decrease respiratory symptoms/complications, and encourage self-management and control over their chronic lung problems. Patients are to continue at home, the exercise and educational techniques they learn in this program. Pulmonary rehabilitation services are payable for patients who have a chronic respiratory disorder such as chronic obstruction pulmonary disease (COPD), emphysema, pulmonary fibrosis, asthma, etc.

Residential Treatment Program/Facility/Care: is an intermediate non-hospital inpatient setting with 24-hour care that operates 7 days a week, for individuals with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be considered payable by this Plan, a facility must be licensed as a residential treatment facility (licensure requirements for this residential level of care may vary by state). In addition to licensure, the residential treatment facility must also have evidence the patient admission was ordered by a Physician, comprehensive written patient assessment upon admission to include eligibility and suitability for admission, onsite licensed behavioral health providers providing at least 20 hours/week of individual and group counseling, and 24/7 access to necessary medical and prescription drug services, along with discharge criteria with a written discharge summary.

Skilled Nursing Facility (SNF): A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to individuals who require medical or nursing care and that rehabilitates injured, disabled or sick individuals, 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 provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with at least one licensed Registered Nurse on duty at all times; and
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
6. It is not (other than incidentally) a home for maternity care, rest, domiciliary care (non-skilled/custodial care, assisted living care facility, memory care/dementia care facility), or care of individuals who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or mentally ill, and
7. It is not a hotel or motel.

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.

Spouse means the Employee's lawful Spouse under state law who is neither divorced nor legally separated from the Employee.

Subacute Care Facility: A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility or as a stand-alone facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:

1. It is accredited by The Joint Commission (TJC) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of Physicians; and

4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and
5. It is not (other than incidentally) a place for rest, domiciliary care (non-skilled/custodial assisted living care facility), or care of individuals who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
6. It is not a hotel or motel.

Subacute care facility is sometimes referred to as a specialty hospital or post acute care, or long term acute care (LTAC) facility.

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. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the Allowed Charge will be allowed as the Plan's benefit:

1. Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of the Allowed Charge
Secondary and additional procedures	50% of the Allowed Charge per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of the Allowed Charge
First site secondary and additional procedures	50% of the Allowed Charge per procedure
Second site primary and additional procedures	50% of the Allowed Charge per procedure

Telehealth: the remote diagnosis and treatment of patients by means of telecommunications technology. Telehealth services are professional health care services like office visits, consultations, screening, counseling and education that are provided using an interactive 2-way audio and video telecommunications system permitting real-time communication for purposes of diagnosis, consultation, or treatment by a Physician or other qualified Health Care Practitioner who is not at the location of the patient, and who is acting in accordance with the telemedicine laws of the state or jurisdiction where the services are rendered.

Trust Agreement means the Trust Agreement establishing the Hawaii Health and Welfare Trust Fund for Operating Engineers and any modification, amendment, extension or renewal.