HAWAII HEALTH
AND
WELFARE TRUST FUND
FOR
OPERATING ENGINEERS

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

Effective July 1, 2014

HAWAII HEALTH AND WELFARE TRUST FUND FOR OPERATING ENGINEERS

1075 Opakapaka Street
Kapolei, HI 96707
(808) 847-1289
(800) 660-9126

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FUND MANAGER
Associated Third Party Administrators
1640 South Loop Road
Alameda, CA 94502-7089
(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 • Life Insurance and Weekly Income and Disability claims questions • Burial Expense benefit questions and claims • Oxygen Benefit for air travel • Supplemental Anesthesia Benefit • HIPAA Certificate of Creditable Coverage • Medicare Part D Notice of Creditable Coverage	**Associated Third Party Administrators (ATPA)** 1640 South Loop Road Alameda, California 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 (Fully Insured) Claims Administrator and Medical PPO Network • Medical Network Provider Directory (free of charge) • Additions/Deletions of Network Providers • Claims information • Prior authorization for services • Case Management • Information About Coverage • Precertification of Admissions and Medical Services • Second and Third Opinions • Appeals of UM decisions • Prescription Drug Information • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Direct Member Reimbursement (for non-network retail pharmacy use)	**Hawaii Medical Service Association (HMSA)** 818 Keeaumoku Street Honolulu, HI 96808-0860 **Oahu** – 948-6111 **Hilo** – 935-5411 **Kona** – 329-5291 **Kauai** – 245-3393 **Maui** – 871-6295 **Prior Authorization:** (808) 948-6464 or (800) 344-6122 **Integrated Case Management** Oahu: 948-5711 Neighbor Islands and out-of-state: 800-365-7665 **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.

QUICK REFERENCE CHART

Information Needed	Whom to Contact
Chiropractic Care, Acupuncture and Massage Therapy (for HMSA enrollees) • Chiropractic Care, Acupuncture and Massage • Claims and prior authorization for chiropractic care, acupuncture and massage **This chiropractic, acupuncture and massage benefit is <u>not</u> available to Kaiser Enrollees.**	**HMSA has contracted with American Specialty Health Group, Inc. (ASH Group) to administer these benefits** For eligibility, benefits or claim questions, call Customer Service at 1-800-678-9133 between the hours of 8 a.m. and 5 pm., Monday through Friday, Hawaii Standard Time. To find a provider, see: http://www.ashcompanies.com/?hp=HMSA 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	**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)
Dental Plan (Fully Insured) • Dental Network Provider Directory • 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 and Provider Directory • 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

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Assistance in finding Chemical Dependency Treatment options • 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 A.R.P. (Assistance Recovery Program).	**Assistance Recovery Program (ARP)** 1620 South Loop Road Alameda, CA 94502 In Hawaii: 842-4624 Out of Hawaii: 800-562-3277 **Ask for the Local 3 A.R.P. 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 self-funded benefits</u> • HIPAA Notice of Privacy Practice	**Privacy & Security Officer** Associated Third Party Administrators (ATPA) 1640 South Loop Road Alameda, California 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, 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.

Failure to provide the SSN or complete the CMS model form (form is available from the Claims Administrator or https://www.cms.gov/MandatoryInsRep/Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals cannot be processed.

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Introduction

WHAT THIS DOCUMENT TELLS YOU

This Summary Plan Description (SPD) Wrap document 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 July 1, 2014, and replaces all other plan documents, summary plan descriptions and applicable amendments to those documents previously provided to Plan participants.

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 in this chapter.

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. All of the medical Plan 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. However, the full descriptions of the insured benefits are in the documents created by the various insurance companies.

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, 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.

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 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 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.

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, for example the birth of a child or Your marriage. However, once 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 which is explained later in this Chapter).

The following is only a summary of the HMSA benefits (and the amounts that You are responsible for). For a complete explanation, please refer to HMSA's Guide to Benefits for the Preferred Provider Plan.

HMSA Plan Provision	HMSA Participating Provider	Non-Participating Provider
Lifetime Maximum	Unlimited	
Annual Copayment Maximum	$1,500/individual $4,500/family	
Annual Deductible *Asterisk indicates deductible applies	None	$100/individual $300/family
Physician Services ➢ Office Visits	None (for first office visit per illness or injury for Employee and Spouse) 10% for all other visits	30% *
➢ Hospital Visits	10%	30% *

HMSA Plan Provision	HMSA Participating Provider	Non-Participating Provider
Hospital and Facility Services		
➢ Hospital Room and Board	None	30% *
➢ Hospital Ancillary	None	30% *
➢ Intensive Care Unit, Coronary Care Unit	None	30% *
➢ Emergency Room	None	None
Surgical Services		
➢ Surgical Procedures	None	30% *
➢ Anesthesia	10%	30% *
Laboratory and Radiology		
➢ Diagnostic Testing	None (inpatient) 10% (outpatient)	30% *
➢ Laboratory and Pathology	None (inpatient) 10% (outpatient)	30% *
➢ X-Ray and other Radiology	None (inpatient) 10% (outpatient)	30% *
➢ Radiation Therapy (Malignancies and Non-Malignancies)	None (inpatient malignancy) None (outpatient malignancy) None (inpatient non-malignancy) 10% (Outpatient non-malignancy)	30% *
Mental Health Treatment		
➢ Inpatient	None	30%
➢ Outpatient	None	30%
Substance Abuse Treatment		
➢ Inpatient	None	30%
➢ Outpatient	None	30%
Other Medical Services		
➢ Allergy Testing	10%	30% *
➢ Ambulance (air and ground)	10%	30% *
➢ Blood and Blood products	10%	30% *
➢ Chemotherapy	10%	30% *

HMSA Plan Provision	HMSA Participating Provider	Non-Participating Provider
➢ Dialysis and Supplies	10%	30% *
➢ Durable Medical Equipment and Supplies	10%	30% *
➢ Hospice	None	Not Covered
➢ Injections	10%	30% *
➢ Organ and Tissue Donor Services	10%	30% *
➢ Organ and Tissue Transplant	None	Not Covered
➢ Orthotics & External Prosthetics	10%	30% *
➢ Physical & Occupational Therapy	None (inpatient) 10% (outpatient)	30% *
➢ Speech Therapy Services	None (inpatient) 10% (outpatient)	30% *
➢ Vision and Hearing Appliances (certain limitations apply)	10%	30% *
Benefits for Children		
➢ Newborn Circumcision	None	30% *
➢ Well Child Immunizations through age 6	None	30%*
➢ Well Child Care Lab through age 21	None	30% *
➢ Well Child Care Physician Office visits through age 21	None	30% *
Benefits for Men		30% *
➢ Prostate Specific Antigen (PSA) Test (Screening)	None	30% *
➢ Vasectomy	None	30% *
Benefits for Women		
➢ Contraceptives (including implants, IUD and Injectables)	None	50%
➢ Mammography	None	30%
➢ Maternity Care	Regular Plan Benefits for delivery. Prenatal and postnatal visits no charge.	Regular Plan Benefits
➢ Pap Smears (screening)	None	30% *
➢ Well Woman Exam	None	30% *

HMSA Plan Provision	HMSA Participating Provider	Non-Participating Provider
Retail Prescription Drugs (30-day supply)		
➢ Generic and Insulin (includes oral contraceptives and other contraceptive methods)	$1 (no copay for generic contraceptive drug)	$5
➢ Brand Name (includes oral contraceptives and other contraceptive methods)	$5 (no copay for brand prescription contraceptive drug only if a generic contraceptive is unavailable or medically inappropriate)	$7 plus 20% of remaining eligible charge
➢ Oral Chemotherapy Drugs	None	None
➢ Diabetic Supplies	$1	$5
➢ Contraceptive Diaphragms (per device)	None	$10
➢ Smoking Cessation Drugs	None	Regular Plan Benefits
➢ Formulary Spacers and Peak Flow Meters for inhaled drugs	None	None
Mail Service Prescription Drugs (90 day supply)		
➢ Generic	$2	Not Covered
➢ Brand Name	$2	Not Covered
➢ Oral Chemotherapy drugs	None	Not Covered

Following is only a summary of the Chiropractic/Acupuncture/Massage Benefits. These benefits are not available to Kaiser Participants.

CHIROPRACTIC / ACUPUNCTURE / MASSAGE BENEFITS		
	Participating Provider	**Non-Participating Provider**
Office Visits (up to 24 per calendar year)	You pay a $20 copayment per visit.	Plan pays 50% of allowable charges up to a maximum of $30 per visit.
X-ray, Radiological Consultations, and Clinical Laboratory Studies	No copay; maximum of $300 per member per calendar year	Plan pays 50% of allowable charges up to a maximum of $100 per member per calendar year
Supports and Appliances (up to a	No copay	50% up to a maximum of $20 per member per item

CHIROPRACTIC / ACUPUNCTURE / MASSAGE BENEFITS		
	Participating Provider	**Non-Participating Provider**
maximum benefit of $50 per member per calendar year)		
Maximum Number of Visits	24 visits per calendar year combined for all chiropractic acupuncture and massage services. Non-Participating providers are limited to no more than 12 visits in a calendar year.	

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.

KAISER PERMANENTE HMO	
Description of Service	**Copay**
Annual Deductible	None
Annual Out-of-Pocket Max	$2,500 Individual/$7,500 Family
Primary Care Office visit	$15 copay/visit
Specialty Care Office Visit	$15 copay/visit
Preventive Care [1]	No Charge
Scheduled Prenatal Visits and first Postpartum visit	No Charge
Well-Baby Care (18 months or Younger) [2]	No Charge
Outpatient Ambulatory Surgery	$25 copay
Laboratory	No charge inpatient/50% outpatient
X-ray	No charge inpatient/50% outpatient
MRI/CT/PET/Nuclear Medicine	No charge inpatient/50% outpatient
Ambulance (Ground or Air)	20% of applicable charges
Emergency Room (worldwide)	$100 copay/visit
Urgent Care	$25 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	$150 copay per day
Outpatient Mental Health	$15 per visit
Inpatient Mental Health	20%
Outpatient Chemical Dependency Treatment	$15 per visit

KAISER PERMANENTE HMO	
Inpatient Chemical Dependency Treatment	20%
Prescription Drug Retail (30 consecutive day supply) • Generic [3]	$15 copay per prescription (no copay for generic contraceptives)
• Brand [3]	$15 copay per prescription (no copay for brand prescription contraceptive drug only if a generic contraceptive is unavailable or medically inappropriate)
Prescription Drug Mail Order (90 consecutive day supply) • Generic [4]	$30 per prescription
• Brand [4]	$30 per prescription
Skilled Nursing Facility (SNF)	No charge, limited to 60 days per benefit period
Infertility Services	$15 copay per visit
Hospice Care	No charge
Gym/Home exercise Program	$100 Gym/$10 Home
Home Health Care	No charge
Durable Medical Equipment (DME)	20%

1. Preventive screenings covered at no charge include anemia and lead screening for children, colorectal cancer screening, chlamydia detection, fecal occult blood test, lipid profile, newborn metabolic screening, cervical cancer screening, screening mammography, and osteoporosis screening.
2. At birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months.
3. Up to a 30-consecutive day supply or an amount determined by the health plan formulary. Excludes contraceptive drugs and devices.
4. 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 Insurance Company listed on the Quick Reference Chart at the front of this document.
- Certain supplemental benefits that are funded directly by the Trust Fund.
- Life Insurance, AD&D and Weekly Disability Income Benefits provided by the Life Insurance Company listed on the Quick Reference Chart at the front of this document.
- A burial expense benefit provided by the Insurance Company listed on the Quick Reference Chart at the front of this document.

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

DENTAL BENEFITS (For All Participants)		
	Participating Provider	**Non-Participating Provider**
Diagnostic & Preventive Services	100% of reasonable and customary charges	Reimbursed in accordance with a table of allowances
Other Dental Services	90% of reasonable and customary charges	Reimbursed in accordance with a table of allowances
Orthodontics	100% of reasonable and customary charges, to a lifetime maximum of $2,500	

Following is only a summary of the Vision benefits. For a complete description of Your coverage, please see the Vision Chapter beginning on page 41 of this SPD.

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
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 for single visions lenses $40 for bifocal lenses $50 for trifocal lenses $100 for Lenticular lenses $5 for tints
Elective Contact Lenses	Reimbursed up to $200	Reimbursed up to $200

VISION BENEFITS (For All Participants)		
	Participating Provider	**Non-Participating Provider**
(For vision correction only. One pair every 12 months, combined with eyeglasses)		
Medically Necessary Contact Lenses	Paid in full	Reimbursed up to $250
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
Laser Vision Correction Surgery	$500 allowance per eye (once per lifetime)	

Following is only a summary of the Supplemental benefits provided by the Fund. For an explanation of these self-funded benefits, please see page 37 regarding the Oxygen benefit, page 38 for the Supplemental Anesthesiologist benefit.

SUPPLEMENTAL BENEFITS PROVIDED DIRECTLY BY THE TRUST FUND	
Medically Necessary Oxygen during Air Travel (for all Participants)	80% of the airline's applicable charges, up to a maximum of $400 per round-trip travel
Supplemental Anesthesiologist Benefit (for HMSA Participants who receive anesthesia benefits from a Non-Participating Provider) • Surgeon who performed the surgery must be a Participating Provider; and • The surgical procedure must be a covered benefit under the HMSA Plan.	Fund will pay: • 20% of the Allowed Charge from a Non-Participating anesthesiologist; and • 100% of any deductible amount applied to such charge under the HMSA Plan.

Following is only a 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.

LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT, WEEKLY DISABILITY INCOME BENEFIT	
Life Insurance	
Engineer	$30,000
Spouse	$2,000

LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT, WEEKLY DISABILITY INCOME BENEFIT	
Children (according to age) ➢ 14 days but less than 6 months ➢ 6 months but less than 2 years ➢ 2 years but less than 3 years ➢ 3 years but less than 19 years	 $100 $200 $400 $500
Accidental Death & Dismemberment (Engineer Only)	$20,000
Weekly Disability Income Benefit (Engineer Only)	Up to $460/week for 1st 26 weeks; $200/week for 2nd 26 weeks.

Following is only a summary of the Burial Expense Benefit. For a complete explanation, please contact the Trust Fund Office.

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.

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 at 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. 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.

NO RESCISSION OF COVERAGE

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except 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 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 eligibility by working 360 hours in three (3) consecutive months or less.

DISABLED EMPLOYEES

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.

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 the You have been called to active duty, the Plan will offer the right to elect USERRA coverage for the 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.

EXTENSION OF ACTIVE HOUR BANK UPON RETIREMENT

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

You 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.

ELIGIBLE DEPENDENTS

Your lawfully married spouse and Your children, under age 26, are eligible for medical, prescription drugs, dental and vision benefits coverage. Eligible children are 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.

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. To secure Dependent coverage, You must provide the Trust Fund Office with the name and age of each Dependent.

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.

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.

SPECIAL ENROLLMENT FOR NEW DEPENDENTS

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 31 days after the date of marriage, birth, adoption or placement for adoption.

If You do not enroll Your Spouse for coverage within 31 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 31 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 a benefit package option under the other plan, unless substitute coverage offered.

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 properly enrolled within 31 days after birth will become effective as of the date of the child's birth.
- **Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption** who is properly enrolled more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

New Dependents 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.

Keeping the Trust Fund Office Informed of Any Changes

You must notify the Trust Fund Office when ANY change occurs in the information provided on the enrollment form – for example, marriage, birth of a child, death, divorce, or any other change in Your family status. You must also notify the Trust Fund Office if You change Your address.

It is very important that You notify the Trust Fund Office if You and Your spouse divorce. Any claims paid for expenses incurred by ineligible Dependents after the date of the divorce will become the responsibility of the participant. Also, if the Trust Fund Office is not notified of a divorce within 60 days, the former spouse will lose rights to COBRA continuation coverage.

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;
- When 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.

CERTIFICATE OF CREDITABLE COVERAGE WHEN ELIGIBILITY TERMINATES

When Your coverage ends, the Fund will automatically provide You and/or Your eligible dependents with a Certificate of Coverage that indicates the period of time You were covered under the Plan. The certificate will be provided to You shortly after the Fund knows or has reason to know that coverage for You and/or Your dependent has ended. In addition, a certificate of coverage will be provided to You upon request if the Trust Fund Office receives Your request within two (2) years after the date Your coverage ended. You may use the certificate to prove to a new health plan the length of time You were covered under this Plan in order to reduce the period of any pre-existing condition limitations of the new plan.

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 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**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. 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 the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

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

Qualifying Event

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

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

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	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.

FAILURE TO ELECT COBRA CONTINUATION COVERAGE

In considering whether to elect COBRA, You should take into account that failure to continue Your group health coverage will affect Your future rights under federal law, as noted below:

- You can lose the right to avoid having pre-existing condition exclusions applied to You by other group health plans if You have more than a 63-day gap in health coverage; and electing COBRA may help You not have such a gap; and
- You will also lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if You do not get COBRA Continuation Coverage for the maximum time available to You.

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.
- If Your active coverage included supplemental anesthesia and the oxygen benefit for air travel, these benefits will be included with Your COBRA coverage (if You elect to continue Your medical benefits).

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.

Question for Legal Counsel. Do you agree we can remove the following provision? The HCTC expires on January 1, 2014. Beginning January 1, 2014, every eligible TAA recipient will be responsible for paying their full health coverage premiums without HCTC. .

~~THE TRADE ACT~~

~~The Trade Adjustment Assistance Reform Act of 2002 (also called the Trade Act or TAA Program) creates a variety of benefits and services including a health coverage tax credit (HCTC) for certain individuals who have become eligible for Trade Adjustment Assistance (TAA) or Alternative Trade Adjustment Assistance (ATAA), and for certain retired employees receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (called eligible individuals).~~

~~The health coverage tax credit is designed to help reduce the out-of-pocket cost of COBRA coverage for individuals who have become unemployed as a result of increased imports from, or shifts in production to, foreign countries. Because the HCTC is authorized under federal law, the rules for program eligibility are subject to change. If this provisions conflicts with current federal law, then that law will apply.~~

- ~~HCTC eligible individuals can either take a tax credit or get help paying their premiums as they become due.~~
- ~~If You have questions about these rules contact: the United States Department of Labor Employment and Training Administration, the Division of Trade Adjustment Assistance at phone: 1-888-365-6822 or website: http://www.doleta.gov/tradeact or the HCTC website: http://www.irs.gov/individuals/article/0,,id=187948,00.html.~~

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.

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.

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 31 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

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of Your termination of employment or reduction in hours, You die, become divorced or legally separated, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or child is extended to 36 months measured from the date of Your termination of employment or reduction in hours (or the date You first became entitled to Medicare, if that is earlier, as described below).

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 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 and that plan does not contain any legally

applicable exclusion or limitation with respect to a Pre-Existing Condition the Qualified Beneficiary may have; **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.

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.

HIPAA CERTIFICATION OF CREDITABLE COVERAGE WHEN COVERAGE ENDS

When Your COBRA coverage ends, the Trust Fund Office will automatically provide You and/or Your covered Dependents (free of charge) with a HIPAA Certificate of Coverage that indicates the period of time You and/or they were covered under the Plan. If Your coverage under this Plan ends, and You and/or Your covered Dependents become eligible for coverage under another group health plan, or if You buy, for Yourself and/or Your covered Dependents, a health insurance policy, You may need this certificate (to prove that You did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to You and/or Your covered Dependents in that new group health plan or health insurance policy. The certificate will indicate the period of time You and/or they were covered under this Plan, and certain additional information that is required by law.

The requirement on the Plan to provide a HIPAA certificate of creditable coverage will be eliminated effective December 31, 2014 because Health Reform prohibits medical plans from applying a pre-existing condition limitation starting with a plan year beginning on or after January 1, 2014.

The certificate will be sent to You (or to any of Your covered Dependents) by first class mail shortly after Your (or their) coverage under this Plan ends. This certificate will be in addition to

any certificate provided to You after Your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to You and/or any covered Dependent upon receipt of a written request for such a certificate if that request is received by the Trust Fund Office within two years after the later of the date Your coverage under this Plan ended or the date COBRA coverage ended.

HMSA 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 an HMSA Conversion Plan or another individual plan for which You qualify. You should request an application for coverage under the HMSA Conversion Plan from HMSA.

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 HMSA 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 insurance Plan's 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 insurance 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 insurance Plan. That is because prescription drug coverage is part of the entire medical plan. Generally, You may only drop medical plan coverage at this Plan's next Open Enrollment period.

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 HMSA 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 prior authorization from Kaiser or HMSA 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 prior authorization 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

If You or Your Dependents have insurance with another plan in addition to this Plan, 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.

COVERAGE FOR EMPLOYEES ELIGIBLE FOR MEDICARE

In most cases, the Trust Fund plan is primary over Medicare for active Employees and their eligible Spouses who are eligible for Medicare unless they elect Medicare as their primary coverage. The Plan will comply with federal regulations regarding Medicare as Secondary Payer, including coordination of benefits for those who are eligible for Medicare due to Disability or End Stage Renal Disease.

THIRD PARTY LIABILITY AND PLAN'S RIGHT TO REIMBURSEMENT

What Third Party Liability Means

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

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

Note that the third party liability rules apply regardless of which medical plan You have elected. Please contact the Insurance Company listed on the Quick Reference Chart for a full description of the third party liability rules that apply to You coverage.

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

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

- **Workers Compensation Insurance.** If You have or may have coverage under worker's compensation insurance, such coverage will apply instead of the coverage under the Hawaii Health and Welfare Trust Fund for Operating Engineers. Medical expenses arising from injuries or illness covered under worker's compensation insurance are excluded from coverage under this Trust Fund.
- **Motor Vehicle Insurance.** If Your injuries or illness are due to a motor vehicle accident or other event for which motor vehicle insurance coverage reasonably appears to be available under Hawaii Revised Statutes Chapter 431, Article 10C, then You must exhaust the benefits available from that motor vehicle coverage before You are entitled to benefits from the Hawaii Health and Welfare Trust Fund for Operating Engineers. You are responsible for any cost sharing payment required under such motor vehicle coverage insurance. You must provide the Trust Fund, through the insurance company, with 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 motor vehicle insurance. Upon verification of exhaustion of motor vehicle insurance benefits, You will be entitled to benefits from this Trust Fund, subject to the Trust Fund's right to reimbursement of all amounts paid by the Trust Fund under its contracts with the insurance companies.

What You Need To Do

HMSA or Kaiser will provide benefits in connection with the injury or illness in accordance with the terms of their contracts with Hawaii Health and Welfare Trust Fund for Operating Engineers only if You cooperate by doing the following:

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

If You do not cooperate as described above, Your claims may be delayed or denied, and the Trust Fund 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 Fund's rights to recover payments.

CHIROPRACTIC / ACUPUNCTURE / MASSAGE BENEFITS

(These benefits are <u>not</u> available to Kaiser Enrollees)

YOUR OUT-OF-POCKET COST

These benefits are not subject to the Plan's annual deductible. When You use an American Specialty Health Group (ASH) provider, You pay only a $20 copayment each visit. When You use Non-Ash providers, the Plan pays 50% of Allowed Charges up to a maximum of $30 per visit. You also pay any amount that exceeds the Allowed Charges or the maximum benefit payable as shown in the Schedule of Benefits.

ANNUAL MAXIMUM VISITS

There is a combined maximum of 24 visits each calendar year for services of all providers for these complementary benefits. 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. Similarly, 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 visits per year from a Non-Participating provider.

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** performed by a Participating provider or referred by a Participating provider are payable in full up to a $300 maximum per member per calendar year. Services provided by and/or ordered by a Non-Participating provider are payable at 50% of billed charges up to a $100 maximum per member per calendar year.
- **Supports and appliances:** When provided by a participating provider, supports and appliances are payable in full up to the combined Participating and Non-Participating limit of $50 per member, per calendar year. When provided by a Non-Participating provider, supports and appliances are payable at 50% of billed charges up to a $20 maximum benefit per member per item and a combined participating and nonparticipating limit of $50 per member, per calendar year.

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 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 of application of massage therapy techniques to the musculoskeletal soft tissue.

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

PRIOR AUTHORIZATION REQUIRED

- For covered services you receive from a **Participating Provider**, utilization review requirements are the responsibility of your provider, not you.
- For services you receive from a **Nonparticipating Provider**, utilization review requirements are your responsibility and include a post-serve 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

- 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 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.
- Any services provided by a person who is a family member including a person who is related to the covered person in any of the following ways: spouse, domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (including stepparent), brother or sister (including stepbrother or stepsister), or child (including legally adopted, step, or foster child). A family member also includes individuals who normally live in the covered person's household
- 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.

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

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.
- 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

(a)

OXYGEN BENEFIT FOR AIR TRAVEL

(This benefit is provided directly by the Trust Fund and is available to both HMSA and Kaiser enrollees.)

If an eligible individual requires medically necessary oxygen during air travel, the Trust Fund will reimburse up to 80% of the airline's applicable charges, up to a maximum of $400 per round-trip travel, subject to the following limitations and conditions:

- Coverage is limited to required business travel for a Contributing Employer or for Operating Engineers Local 3, up to four times per calendar year.
- The Eligible Individual is required to provide his/her Physician's written statement of the diagnosis that necessitates continuous oxygen, the liter flow per minute, and any delivery method needed that is different than standard nasal prongs. The Physician's letter should include travel dates and be dated not more than 15 calendar days prior to the scheduled flight.

There is no coverage for supplemental oxygen for ground support. It is the Participant's responsibility to arrange for oxygen prior to boarding, during layovers for connecting flights and at the final destination after landing.

BENEFITS FOR ANESTHESIOLOGY SERVICES

(This benefit is available only for the Engineer and his or her covered Dependents enrolled in the HMSA medical Plan)

The benefits of this section are payable by the Trust Fund only if an Eligible Individual enrolled in the Hawaii Medical Service Association (HMSA) Plan incurs charges for the services of an anesthesiologist who does not participate in the HMSA preferred provider network.

You will receive a "Report to Member" from HMSA which will outline the services rendered. You may submit Your "Report to Member" to the Fund Office and the Fund will pay 20% of the reasonable and customary charge made by a non-preferred provider anesthesiologist and 100% of any deductible amount applied to such charge under the HMSA Plan, provided:

- The surgeon who performed the surgery for which the anesthesia services were provided is an HMSA PPO provider, and

- The surgical procedure for which the anesthesia services were provided is a covered benefit under the HMSA medical Plan.

VISION CARE BENEFITS

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

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 VSP.

VISION NETWORK

VSP contracts with an independent network of 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.)

Please note: If Your covered Dependent Children (up to age 19) receive treatment from a Network Doctor, the limitations on frequency of services do not apply (dollar maximums do apply). However, if Your covered Dependent Children receive treatment from a Non-Network Doctor, the 12 and 24 month limitations are maintained.

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 $35 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 $30
Lenses for Eyeglasses	• No coverage for special coatings • A single vision, lined bifocal, lined trifocal, lined lenticular and tints payable once every 12 months.	Covered in full for: *Single Vision (Standard*) *Lined Bifocal* *Lined Trifocals* *Lined Lenticular*	The Plan pays: *Single Vision:* 100%, up to $25. *Lined Bifocals*: 100%, up to $40. *Lined Trifocals:* 100%, up to $50. *Lenticular:* 100% up to $100 *Tints*: up to $5 If only one lens is needed, the allowance will be one-half the pair allowance.
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 *Elective Lenses (not Visually Necessary):* 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)

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**
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)	
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
    - Anti-reflective coating

- Color coating
- Mirror coating
- Scratch Coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses (covered from Network providers for children and handicapped Dependents)
- Polycarbonate lenses
- Progressive multifocal lenses
- 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.

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.

LASER VISION BENEFIT

The Vision Plan will provide You 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.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The **Plan's self-funded group health benefits** 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.

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 Plan Administrator, and

(2) The staff designated by the Plan Administrator

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

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 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:

- Chiropractic/Acupuncture/Massage
- Oxygen for Air Travel
- Supplemental Anesthesia
- Vision Plan

Types of Claims

There are four types of claims applicable to the self-funded benefits described in this booklet.

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 prior authorization 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 applicable urgent claim reviewer, 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.

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 prior authorization.

  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 prior authorization) does not guarantee payment of Plan benefits. For example, benefits would not be payable if Your eligibility for coverage ended before the services were rendered or the maximum benefit had already been paid.

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.

> **"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 prior authorization. See "Urgent Claims" under "Types of Claims" above for an explanation of when a request for prior authorization might need to be handled as an urgent claim.

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 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:

- **Pre-service claims**: If Your **pre-service** claim has been improperly filed, VSP will notify You and/or Your doctor as soon as possible but no later than 5 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.

  If Your pre-service claim has been properly filed, VSP will ordinarily notify You of its decision within **15 days** from the date Your claim is filed, unless additional time is needed (VSP will generally make a decision within 3 to 5 days). The time for response may be extended up to 15 days if necessary due to matters beyond the control of VSP. 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 VSP expects to make a decision.

  If an extension is needed because VSP needs additional information from You, VSP 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). VSP 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.

- **Post-service health care claims**: Ordinarily, You will be notified of the decision on Your post-service claim within 30 days of the date the VSP or the Trust Fund Office receives the claim. This period may be extended one time for up to 15 days if the extension is necessary due to matters beyond the control of VSP or the Trust Fund Office. 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 VSP or the Trust Fund Office expects to make a decision.

  If an extension is needed because the VSP or the Trust Fund Office, needs additional information from You, VSP or the Trust Fund Office 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). VSP or the Trust Fund Office 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.

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 prior authorization 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.

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
- 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 you do not understand English and have questions about a claim denial, contact the Administrative Office to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 800- 251-5014 or 808- 847-1289 or 800- 660-9126.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 800- 251-5014 or 808- 847-1289 or 800- 660-9126.
- CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 800- 251-5014 or 808- 847-1289 or 800- 660-9126.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800- 251-5014 or 808- 847-1289 or 800- 660-9126.

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.

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.

Appeals of decisions on **urgent** or **concurrent claims** should **not** be submitted via the US Postal Service. They should be made by telephone or fax to VSP. VSP 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.

Appeals of **pre-service claims** or **post-service claims** decisions must be in writing and sent by fax or mail sent to VSP.

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

Appeals of vision claims should be submitted in writing to VSP (at the address listed on the Quick Reference Chart). All other appeals should be sent to the Trust Fund Office.

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.

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.

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.

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**: You will receive notice of a decision on review prior to the termination of the benefit.
- **Post-service health care claims**: You will receive a decision on review by VSP within **60 days** of receipt of Your appeal.
- Decisions on appeals of **Eligibility,** or claims denied by **VSP** 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 you do not understand English and have questions about a claim denial, contact the Administrative Office to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 800- 251-5014 or 808- 847-1289 or 800- 660-9126.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 800- 251-5014 or 808- 847-1289 or 800- 660-9126.
- CHINESE (中文): **如果需要中文的帮助**, 请拨打这个号码 800- 251-5014 or 808- 847-1289 or 800- 660-9126.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800- 251-5014 or 808- 847-1289 or 800- 660-9126.

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.

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.

Maximum Times for Processing of Vision and Claims for Supplemental Benefits (Times are suspended during waits for additional information requested of You)				
	Pre-Service Claims	**Urgent Claims**	**Concurrent Claims**	**Post-Service Claims**
Trust Fund Office or VSP 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)
VSP 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
Trust Fund Office or VSP 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
You respond to request for information	Within 45 days of request	Within 48 hours of request	Not applicable	Within 45 days of request
Trust Fund Office or VSP 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
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
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 than 30 days in advance, at subsequent meeting (may be delayed until third such meeting)

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
1640 South Loop Road
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:

Associated Third Party Administrators (ATPA)
1640 South Loop Road
Alameda, California 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 and PPO), drug and dental.
- **Self-Funded:** Vision, chiropractic/acupuncture/massage, oxygen during air travel and the supplemental anesthesia benefit.

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

The Privacy Department
Associated Third Party Administrators
1640 South Loop Road
Alameda, California 94502

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

Mr. Lance Inouye
Ralph S. Inouye Co., Ltd.
2831 Awaawaloa Street
Honolulu. Hawaii 96819

Mr. Rodney H. Nohara
Jayar Construction, Inc.
1176 Sand Island Parkway
Honolulu. Hawaii 96819

Ms. Kathleen Thurston
Thurston-Pacific, Inc.
1090 Mikole Street
Honolulu, Hawaii 96819

Mr. Randall Ching, Alternate
Highway Construction Co. Ltd.
720 Umi Street
Honolulu, Hawaii 96819

Mr. Corey Yamashita
Kiewit Infrastructure West Co.
1001 Kamokila Blvd., Suite 305
Kapolei, Hawaii 96707

Employee Trustees

Mr. Russell E. Burns
Operating Engineers Union Local 3
1620 South Loop Road
Alameda, California 94502

Mr. Pane Meatoga
Operating Engineers Local 3
1075 Opakapaka Street
Kapolei, HI 96707

Mr. Dan Reding
Operating Engineers Union Local 3
1620 South Loop Road
Alameda, California 94502

Mr. Carl Goff, Alternate
Operating Engineers Union Local 3
1620 South Loop Road
Alameda, California 94502

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 PROVIDED:

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 *Provides medical, prescription drug and vision benefits with guaranteed payment of these benefits for participants who select the Plan for medical coverage.*
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** *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 retional 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.

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
1075 Opakapaka Street
Kapolei, HI 96707
(808) 847-1289
(800) 660-9126

Hawaii

OPERATING ENGINEERS LOCAL #3
50 Waianuenue
Hilo, Hawaii 96720
(808) 935-8709
toll-free (877) 935-8709

Maui, Molokai and Lanai

OPERATING ENGINEERS LOCAL #3
95 Lono Avenue, Suite # 104
Kahului, Hawaii 96732
(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.

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 precertification. For information on precertification, 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.

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; and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

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.

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.*

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.

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:

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) 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.

∗ 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.

e) 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, precertification 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.

Fund means the Hawaii Health and Welfare Trust Fund for Operating Engineers.

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.

Local Union means the Operating Engineers Local Union No. 3 of the International Union of Operating Engineers, AFL-CIO.

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:

- Appropriate and necessary for the symptoms, diagnosis, and direct care or treatment of Your illness or injury;
- Consistent with professionally recognized standards of health care in the United States, and given at the right time and in the right setting;
- Not primarily for Your convenience or the convenience of Your provider; and
- The most appropriate supply or level of service that can be safely provided.

The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not in and of itself mean that it is Medically Necessary

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.

Spouse means the Employee's lawful Spouse who is neither divorced nor legally separated from the Employee.

Trust Agreement means the Trust Agreement establishing the Hawaii Health and Welfare Trust Fund for Operating Engineers and any modification, amendment, extension or renewal.

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