

AFL HOTEL & RESTAURANT WORKERS HEALTH & WELFARE TRUST FUND

(RETIREES)

Comprehensive Medical Plan Document (Self-Funded)

Effective April 1, 1997

SECTION 1 DEFINITIONS

In accordance with all applicable policies of the AFL Hotel & Restaurant Workers Health & Welfare Trust Fund, the Participant and any Dependents listed on the enrollment card or added thereto, are entitled to medical, surgical, hospital and other benefits according to the terms, conditions and limitations set forth in this Plan.

When used in this Plan, in the Trust Fund's enrollment card and in any supplements to this Plan:

- 1.1 "Beneficiary" means any Participant or Dependent covered by this Plan.
- 1.2 "Calendar Year" means the period beginning January 1 and ending December 31 of any year. The first Calendar Year for a new Beneficiary shall begin on that Beneficiary's Effective Date and end December 31 of the same year.
- 1.3 "Child" means the Participant's:
 - (a) natural child;
 - (b) adopted child or child placed in the home in anticipation of adoption; or
 - (c) stepchild.
- 1.4 "Claims Administrator" means that entity contracted by the Trust Fund to process and pay claims as provided under this Plan.
- 1.5 "Clinical Laboratory" means a facility which:
 - (a) is certified or licensed as a Clinical Laboratory by the proper governmental authority;
 - (b) meets the requirements of the Federal Medicare program; and
 - (c) is approved by the Claims Administrator.
- 1.6 "Clinical Social Worker" means a person licensed in the practice of social worker and certified in clinical social work by a recognized national organization.
- 1.7 "Copayment" means a percentage of the Eligible Charge that is not paid as a benefit for covered services. The Beneficiary is solely responsible for paying this amount to the provider of services.
- 1.8 "Dentist" means a doctor of dentistry or dental surgery who is appropriately licensed to practice by the proper governmental authority and who renders services within the lawful scope of such license. A dentist is considered a "Physician" under this Plan, but only with respect to those Surgical Services which he or she is legally authorized to perform.
- 1.9 "Dependent" means the Participant's Spouse and each eligible Child under

[Affordable
Care Act](#)
Effective:
01/01/11
Adopted:
04/13/11

Effective:
03/01/01
Adopted:
01/31/01

- 26 years of age.
- 1.10 "Effective Date" means the date on which a person is accepted as a Beneficiary, as established and recorded by the Trust Fund, and is the date, subject to all applicable waiting periods provided under this Plan, on which such Beneficiary's eligibility for benefits under this Plan begins.
- 1.11 "Eligible Charge" means the charge used to calculate the benefit payment for a covered service as determined by the Trust Fund according to the criteria in Section 3.7.
- 1.12 "Home Health Agency" means an agency which:
- (a) is certified or licensed as such by the proper governmental authority;
 - (b) meets the requirements of the Federal Medicare Program; and
 - (c) is approved by the Claims Administrator.
- 1.13 "Hospital" means any inpatient acute care institution (but does not include any nursing or rest home, intermediate care facility, or Skilled Nursing Facility) which:
- (a) is primarily engaged in providing facilities for surgery and for medical diagnosis and treatment of injured or ill persons by or under the supervision of Physicians;
 - (b) has registered nurses on duty;
 - (c) is certified or licensed as a Hospital by the proper governmental authority; and
 - (d) is recognized as a Hospital by the American Hospital Association.
- 1.14 "Individually Identifiable Health Information" means information that either actually identifies the individual or creates a reasonable basis to believe that the information would identify the individual, as defined in 45 CFR §164.501.
- 1.15 "Injury" means an injury which results from an external force (such as a blow, collision, or impact) and which is of sufficient magnitude to require the services of a Physician within 48 hours. Subjective symptoms which occur spontaneously or from trivial movement or exercise such as localized pain of joints, pain from nerves, disturbances of circulation, muscle pains and aches, or headaches and which are of physiological, pathological, toxic, or infective origin are not to be considered the result of external force and therefore shall not be considered an injury.
- 1.16 "Marriage and Family Therapist" means an individual who is licensed in the practice of marriage and family therapy practice.
- 1.17 "Licensed Mental Health Counselor" means a person who engages in the practice of mental health counseling and certified for alcohol dependence, drug dependence or mental illness.
- 1.16 "Participant" means the person who executes the enrollment card which must be accepted by the Trust Fund.
- 1.17 "Participating Provider" means a provider of services who agrees with the Trust Fund that his or her fee to a Beneficiary for a service covered by this Plan shall not exceed the Eligible Charge for that service.
- 1.18 "Physician" means:
- (a) a doctor of medicine (M.D.); or
 - (b) a doctor of osteopathy (D.O.); or
 - (c) a doctor of podiatric medicine (D.P.M.); or
 - (d) a doctor of optometry (O.D.)

**Eligible
dependent
includes all
children
under 26**
Effective:
01/01/14
Adopted:
10/01/13

Effective:
04/14/03
Adopted:
03/12/03

Effective:
01/01/09
Adopted:
01/14/09

Effective:
01/01/09
Adopted:
09/24/08

Effective:
01/01/04
Adopted:
12/10/03

who is appropriately licensed to practice by the proper governmental authority, who is licensed to prescribe and administer prescription drugs and who renders services within the lawful scope of such license.

- 1.19 "Plan" means this document.
- 1.20 "Protected Health Information" means individually identifiable health information that is transmitted or maintained by electronic media or is transmitted in any other form or medium, as defined in 45 CFR §164.501.
- 1.21 "Psychiatrist" means a doctor of medicine (M.D.):
- (a) who is certified by or has at least three (3) years of psychiatric training acceptable to the American Board of Psychiatry and Neurology;
 - (b) who is appropriately licensed to practice by the proper governmental authority and who renders services within the lawful scope of such license; and
 - (c) whose practice is limited solely to psychiatry or psychiatry and neurology.
- 1.22 "Psychologist" means a person who is appropriately certified or licensed to provide psychodiagnostic or psychotherapeutic services by the proper governmental authority and who renders services within the lawful scope of such certificate or license.
- 1.23 "Registered Bed Patient" means a Beneficiary who has been admitted to a Hospital or Skilled Nursing Facility upon the recommendation of a Physician for any Injury or illness covered by this Plan and who is registered by the Hospital or Skilled Nursing Facility as an inpatient.
- 1.24 "Skilled Nursing Facility" means an inpatient care facility which:
- (a) is certified or licensed as such by the proper governmental authority;
 - (b) meets the requirements of the Federal Medicare Program; and
 - (c) is approved by the Claims Administrator.
- 1.25 "Spouse" means a person who is lawfully married to the Participant and is qualified as a Spouse in accordance with the Internal Revenue Code.
- 1.26 "Surgical Services" means professional services necessarily and directly performed by a Physician in the treatment of an Injury or illness requiring cutting; suturing; diagnostic and therapeutic endoscopic procedures; debridement of wounds including burns; surgical management or reduction of fractures and dislocations; orthopedic casting; manipulation of joints under general anesthesia; or destruction of localized surface lesions by chemotherapy (excluding silver nitrate), cryotherapy, or electrosurgery.
- 1.27 "Trust Fund" means the AFL Hotel & Restaurant Workers Health & Welfare Trust Fund or its designated representative.

Effective:
04/14/03
Adopted:
03/12/03

SECTION 2
ELIGIBILITY AND ENROLLMENT

- 2.1 Coverage under this Plan is available only to those individuals determined to be eligible by the Trust Fund. Enrollment hereunder shall cease upon termination of eligibility or termination of the Plan.
- 2.2 The Participant, Participant's Spouse and each of the Participant's Children under 26 years of age are eligible for coverage under this Plan. Coverage is available to a child without regard to marital status, dependency upon a parent (or anyone else) for financial support, residency with a parent, or full-time student status. A child's own spouse and child do not qualify for coverage. The Participant must enroll a Dependent with the Trust Fund within 30 days of the date of eligibility. If a Dependent is not enrolled within 30 days of the date of eligibility, he or she may be enrolled only at the next open enrollment period, which is held once a year. However, if a Dependent who is covered under a plan other than the Trust Fund subsequently loses coverage under that plan, such Dependent need not wait until the next open enrollment period but must enroll within 30 days of the loss of coverage under that plan. Failure to enroll within this 30-day period will result in the Dependent having to wait until the next open enrollment period.
- 2.3 Coverage under this Plan shall cease upon the earliest of the following events:
- (a) For the Participant - upon the Participant's termination of eligibility,
 - (b) For the Participant's Spouse - upon the Participant's termination of coverage or upon the dissolution of the marriage,
 - (c) For the Participant's Children - upon the Participant's termination of coverage, or when a Child reaches 26 years of age prior thereto, unless such Child meets the provisions of Section 2.4 below.
- 2.4 If a Child, upon reaching 26 years of age, is incapable of self-sustaining employment because of a mental or physical disability which was incurred prior to age 19, is primarily dependent upon the Participant for support and maintenance, and is unmarried, the Child shall be allowed continued coverage under this Plan so long as the Child continues to be so incapacitated, dependent, and unmarried. The Participant must furnish written evidence of such incapacity, dependency, and marital status to the Trust Fund within 31 days of the Child's reaching 26 years of age, and at any time thereafter upon request by the Trust Fund. The Child's coverage shall terminate when the Participant's coverage terminates or when the Child marries or is no longer incapacitated and dependent.
- 2.5 The Participant shall inform the Trust Fund, in writing, if a Dependent ceases to be eligible for benefits on or before the first day of the month following the month in which eligibility ceased. If the Participant fails to inform the Trust Fund of the Dependent's ineligibility, and the Plan makes payments for services to the ineligible Dependent, the Participant shall reimburse the Plan for the amount of such payments and any legal expenses to recover such payments. If proceedings to adopt a Child are not successful, the Participant shall notify the Trust Fund within 21 days. Coverage for such Child shall

**Affordable
Care Act**
Effective:
01/01/11
Adopted:
04/13/11

**Eligible
dependent
includes all
children
under 26**
Effective:
01/01/14
Adopted:
10/01/13

**Affordable
Care Act**
Effective:
01/01/11
Adopted:
04/13/11

**Affordable
Care Act**
Effective:
01/01/11
Adopted:
04/13/11

terminate as of the first day of the month following the date of notification or the date when notification should have been given.

- 2.6 Coverage for the Participant and any Dependents initially listed on the application card shall begin as of the Participant's Effective Date, provided that proper documentation is received, if the Trust Fund has accepted the Participant's application by giving written notice to the Participant of his or her Effective Date. By submitting the application card, the Participant also accepts and agrees to be bound by the provisions of the Plan as now in force and as hereafter amended.

SECTION 3
CLAIM AND PAYMENT FOR SERVICES

- 3.1 Only services provided by Clinical Laboratories, Home Health Agencies, Hospitals, Physicians (M.D., D.O., or D.P.M.), Psychiatrists, Psychologists, and Skilled Nursing Facilities who qualify as such under the requirements of the Federal Medicare Program, are certified or licensed by the proper government authority, render services within the lawful scope of their respective licenses, and are approved by the Claims Administrator or Trust Fund will be covered. Benefits may be available for services rendered by other providers as shown in specific sections of this Plan.
- 3.2 Submission of Claim. No claim for services covered by this Plan will be paid unless it is supported by the provider's report regarding the services rendered. The Participant is responsible for ensuring that the provider furnishes this report to the Claims Administrator, on the forms prescribed by the Trust Fund, within one (1) year of the date the services are rendered.
- 3.3 Payment for Services.
- (a) Participating Provider. When covered services are rendered by a Participating Provider, the Plan will pay benefits directly to the Participating Provider. Participating Providers have agreed to limit their charges to Beneficiaries to not more than a specified amount. In addition, Participating Providers have agreed not to collect from any Beneficiary an amount exceeding the Beneficiary's Copayment specified in this Plan, except for non-covered services.
- All claims for services rendered by a Veterans Administration Medical Center and/or Uniformed Military Services Facility will be adjudicated (processed) on a participating provider basis using the comparable participating provider Eligible Charge, but in no event shall the Fund pay the Veterans Administration Medical Center and/or Uniformed Military Services Facility any differently than the Fund's participating provider Eligible Charges, and payments are to be made directly to the Veterans Administration Medical Center and/or Uniformed Military Services Facility.
- (b) Nonparticipating Provider. The Claims Administrator or Trust Fund has no agreement with nonparticipating providers and they may charge the Trust Fund's Beneficiaries more than the Eligible Charge for any service. The Plan's benefit payments for services rendered by nonparticipating providers will be a specified portion or percentage of the Eligible Charge for the service. For services by a nonparticipating provider, the benefit level may be a lower percentage of the Eligible Charge than the Plan would pay to a Participating Provider. The Beneficiary is responsible for paying the specified Copayment plus any amount of the provider's charge which exceeds the Eligible Charge. Payment of claims for services covered by this Plan and rendered by a nonparticipating provider:
- (i) are not assignable;
- (ii) shall be made by the Plan, in its sole discretion, directly to the

Effective:
01/01/05
Adopted:
09/20/07

Participant or to the Dependent or, in the case of the Participant's death, to his or her executor, administrator, provider, Spouse, or relative; and

- (iii) shall in no event exceed the amount which the Plan would pay to a comparable Participating Provider for the same services rendered.

3.4 Reimbursement for Services. If a Beneficiary has paid for services covered by this Plan, the Participant will be reimbursed in accordance with the terms of this Plan. To receive payment for such services, a Participant must submit a claim within one (1) year after the last day on which such services were rendered.

3.5 Late Claims. No payment will be made on any claim submitted to the Claims Administrator or Trust Fund more than one (1) year after the last day on which the services were rendered unless it shall be shown to the satisfaction of the Trust Fund that there was unusual and justifiable cause for such late submission.

3.6 Medical Necessity of Services. This Plan covers only medically necessary services; the Plan will not cover any unnecessary services nor will the unnecessary portion of any charge be paid. The fact that a Physician may prescribe, order, recommend, or approve a service does not in itself constitute medical necessity or make a charge an allowable expense under this Plan. A Beneficiary may ask a Physician to write to the Claims Administrator for a determination regarding the medical necessity of a service before it is performed. The Claims Administrator will determine the medical necessity of the test or treatment. To be considered medically necessary, a service must meet all of the following criteria:

- (a) The service or treatment must follow standard medical practice and be essential and appropriate for the diagnosis or treatment of an illness or Injury. Standard medical practice, with respect to a particular illness or Injury, means that the service was given in accordance with generally accepted principles of medical practice in the United States at the time furnished.
- (b) The service or treatment must not be "experimental" (e.g., used in research or on animals) or "investigative" (e.g., used only on a limited number of people or where the long-term effectiveness of the treatment has not been proven in scientific, controlled settings, and, where applicable, has not been approved by the appropriate government agency).
- (c) If there is more than one (1) medically appropriate method of treating a Beneficiary, the Plan's benefit will be based on the least expensive method, even if the health care provider elects to treat the Beneficiary by a more expensive method. Similarly, if the services could be provided in more than one (1) type of facility or setting (e.g., Hospital or Physician's office), the Plan's benefits will be based on the least expensive facility or setting.
- (d) The service or treatment is being covered by the U.S. Department of Health HCFA Medicare Coverage Issues Guidelines.

3.7 Eligible Charges. The Plan's benefit payments and the Beneficiary's

Copayments for services are based on the Eligible Charges for the services (i.e., the Beneficiary pays a specified percentage or portion of the Eligible Charge for each service). The Plan will not pay the portion of any charge that exceeds the Eligible Charge. General excise or other tax is not included in the Eligible Charge. A Beneficiary is responsible for paying all taxes.

(a) Definition.

(i) The charge for a covered service made by a Participating Provider will be considered eligible when it complies with the fee schedule established by the Trust Fund and the provisions contained in the agreement between the Claims Administrator and such Participating Provider.

(ii) The Eligible Charge for a covered service made by a nonparticipating provider who is a Physician, Psychiatrist, Psychologist, or Clinical Laboratory will be the lowest of the following two (2) charges:

- a. the charge established by the Trust Fund, or
- b. the actual charge for the service.

(iii) The Eligible Charge for a covered service rendered by a nonparticipating facility that is a Hospital, Skilled Nursing Facility, ambulatory surgical center, birthing center, Home Health Agency, or other similar facility will be the lowest of the following two (2) charges:

- a. the charge established by the Trust Fund, or
- b. the actual charge for the service.

(b) Claims for Services Provided by Out-of-State Providers. Benefit payments for covered services rendered outside [the State of Hawaii shall not exceed 150% of Eligible Charges](#) for the same or comparable services rendered in [the State of Hawaii](#). [Prior authorization is required prior to receiving non-emergency services outside the State of Hawaii as provided in Section 5, Managed Care Program.](#)

Effective:
03/01/11
Adopted:
7/13/11

3.8 Qualified Medical Child Support Orders. Any claim for benefits with respect to a Child covered by a Qualified Medical Child Support Order ("QMCSO") may be made by the Child or by the Child's custodial parent or court-appointed guardian. Any benefits otherwise payable to the Participant with respect to any such claim shall be payable to the Child's custodial parent or court-appointed guardian.

3.9 Review of Claims. The Trust Fund shall have discretionary authority to determine all questions of eligibility of Beneficiaries, to determine the amount and type of benefits payable to any Beneficiary or provider in accordance with the terms of this Plan, and [related regulations](#), and to interpret the provisions of this Plan, as is necessary to determine benefits.

Effective:
01/01/03
Adopted:
12/11/02

3.10 Claims and Appeals Procedures.

(a) Designation of an Authorized Representative. The Beneficiary may designate another person to act on the Beneficiary's behalf in the handling of benefits claims as the Beneficiary's authorized representative. In order for the Beneficiary to designate another individual to be an authorized representative, the Beneficiary must

complete and file a form with the Claims Administrator. If the Beneficiary designates an authorized representative to act on the Beneficiary's behalf, all correspondence and benefit determinations will be directed to the authorized representative, unless the Beneficiary directs otherwise. The Plan will also provide information to both the Beneficiary and the Beneficiary's authorized representative, if so requested. In the case of a claim for urgent care, where the Beneficiary is unable to act on his or her own behalf, the Plan will recognize a health care professional with knowledge of a Beneficiary's medical condition as the Beneficiary's authorized representative. A health care professional is a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with State law.

(b) Initial Claims. Upon the filing of a claim for reimbursement of benefits, the Plan must make a decision on the claim within the following time periods:

(i) Urgent Care Claims. Any claim for urgent care must be determined within 72 hours of its receipt. The Plan may orally notify the Beneficiary of the determination, but must provide a written notice within three (3) days following the oral notification. If the Beneficiary's claim is improperly filed or incomplete, the Plan must provide notice to the Beneficiary orally, or written if requested, within 24 hours of the date the claim was received. The notification will indicate what the proper claims filing procedures are or what information needs to be provided to complete the claim. Once the information has been provided, the determination should be made within 48 hours from the earlier of: 1) the time the Plan receives the necessary information from the Beneficiary; or 2) the expiration of the 48-hour period provided to the Beneficiary to submit the necessary information.

A claim will be regarded as an "urgent care" claim if any one of the following circumstances exist: 1) where failure to provide the service could seriously jeopardize the Beneficiary's life, health, or ability to regain maximum functions, or could subject the Beneficiary to serious pain that could not be managed without the requested care; or 2) where failure to provide the requested care, in a physician's opinion with knowledge of the Beneficiary's medical condition, would subject the Beneficiary to serious pain that could not be managed without the requested care; or 3) if the Beneficiary's treating physician deems it as urgent; or 4) if the Plan, in applying the judgment of a "prudent layperson who possesses an average knowledge of health and medicine," determines the claim to be one involving urgent care.

(ii) Pre-Service Claims. Any claim involving a requirement or request for approval prior to service being rendered must be processed within fifteen (15) days from the receipt of the claim.

This includes pre-authorizations and utilization reviews. If the claim is improperly filed, the Plan must provide notice to the Beneficiary orally, or written if requested, within five (5) days of the date the claim was received. The notification will indicate what the proper procedures are for filing claims. The Plan may extend the time to respond to the Beneficiary by fifteen (15) days, if circumstances exist beyond the Plan's control that interfere with the timely determination of the claim, or if information necessary to complete the claim is missing. The Plan must provide a notice of extension to the Beneficiary which must state the circumstances which provide the basis for the extension, and the date the Plan expects to render a decision. The Plan must provide notice prior to the extension period taking effect. The Beneficiary must be given at least forty-five (45) days from the date notification of the missing information is received to provide such information.

(iii) Post-Service Claims. Any claim submitted after services have been performed will be determined within 30 days of receipt. The Plan may extend the time to respond to the Beneficiary by fifteen (15) days, if circumstances exist beyond the Plan's control that interfere with the timely determination of the claim, or if information necessary to complete the claim is missing. The Plan must provide a notice of extension to the Beneficiary which must state the circumstances which provide the basis for the extension, and the date the Plan expects to render a decision. The Plan must provide notice prior to the extension period taking effect. The Beneficiary must be given at least forty-five (45) days from the date notification of the missing information is received to provide such information.

(iv) Concurrent Claims. If a Beneficiary is receiving ongoing treatment under the Plan, the Plan must provide advance notice of any determination to terminate or reduce the Beneficiary's treatment. The Plan must provide notice to the Beneficiary sufficiently in advance to allow the Beneficiary to appeal the determination and render a decision prior to any reduction or termination of the Beneficiary's treatment occurring. Any claim a Beneficiary makes which involves both urgent care and a continuing course of treatment previously approved by the Plan, must be decided as soon as possible, given the urgency of the medical conditions involved. The Plan must provide the Beneficiary with notice of the claim's determination within 24 hours of its receipt, if the claim was received at least 24 hours prior to the expiration of the Beneficiary's treatment. If the Beneficiary's claim was received less than 24 hours prior to the expiration of treatment, the Plan must provide notification of its decision to the Beneficiary within 72 hours of the receipt of the claim.

Effective:
01/01/03
Adopted:
12/11/02

- (c) Notice of Initial Benefit Determination. When the Plan makes an adverse benefit determination, the Plan must give the Beneficiary written notice of the determination. The Claims Administrator must take appropriate measures to ensure actual receipt of the notice by the Beneficiary, and inform the Beneficiary of the significance of the notice and the right to receive the notice free of charge. The Plan must also provide the Beneficiary with the notice, free of charge, upon the Beneficiary's request. The notice must be in plain language and include the following information:
- (i) the specific reason(s) for the adverse benefit determination;
 - (ii) references to specific plan provisions on which the determination was based;
 - (ii) a description of any additional information or information that is needed for the Beneficiary to perfect the claim, and an explanation of why the information is necessary;
 - (iv) a description of the plan's review procedures and the time limits that apply to such procedures as well as a statement about the Beneficiary's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
 - (v) a statement that an explanation of the scientific or clinical judgment for the determination, which specifically applies the terms of the plan to the Beneficiary's medical circumstances, will be provided free of charge upon the Beneficiary's request, for determinations involving medical necessity or exclusions for experimental treatment, or other similar exclusion or limit;
 - (vi) the identification of any specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided to the Beneficiary free of charge, upon the Beneficiary's request; and
 - (vii) a description of the expedited review process if the claim is an urgent care claim.
- (d) Appeal of Claims. Any determination that a benefit is unnecessary or otherwise not payable shall be reviewed at the Beneficiary's request by the Benefits and Appeals Committee that is appointed and approved by the Trust Fund. The Beneficiary must submit a written request for review unless the claim is one involving urgent care, in which case the Beneficiary may make an oral request to the Plan for review. A participant has 180 days from the date the Trust Fund processed the Beneficiary's initial claim to request this review. Any determination made by the Benefits and Appeals Committee shall be a full and fair determination that will be conclusive upon all parties. Any request for review after 180 days from the date the Plan Administrator processed the Beneficiary's initial claim will be denied.
- (e) Decision making of Appeals.
- (i) Appeal of Urgent Care Claims. If the Beneficiary is appealing an urgent care claim, the Plan must allow the Beneficiary to

Effective:
01/01/03
Adopted:
12/11/02

- submit either an oral or written request for appeal. The Plan will communicate all necessary information to the Beneficiary through the most expedient means available (e.g., telephone or fax). The decision must be made no later than 72 hours from the time the appeal is received.
- (ii) Appeal of Pre-Service Claims. If the Beneficiary is appealing a pre-service claim, the Benefits and Appeals Committee must issue its decision no later than 30 days from the time the appeal is received.
 - (iii) Appeal of Post-Service Claims. If the Beneficiary is appealing a post-service claim, the Benefits and Appeals Committee must issue its decision no later than 60 days from the time the appeal is received.
- (f) Required Procedures for Appeals.
- (i) A full and fair review will be conducted on all appeals by the Benefits and Appeals Committee, with no preferential treatment given to the initial determination. The Benefits and Appeals Committee shall consider all evidence submitted by the Beneficiary or the Beneficiary's authorized representative, regardless of whether such evidence was previously submitted or considered at the initial benefit determination.
 - (ii) The determination on appeal will be made by individuals who were not involved in the determination of the initial claim, and who are not subordinates of anyone that was involved in the determination of the initial claim.
 - (iii) The Benefits and Appeals Committee must consult with healthcare professionals who have the appropriate training and experience in the field of medicine if the initial determination under review involved medical judgment (e.g., whether the drug is medically necessary or appropriate, investigational, or experimental). If a healthcare professional is required to be consulted in the appeal, the professional must not be the same individual that was involved in the initial determination of the claim, nor a subordinate of that individual.
- (g) Right to Submit Information. In appealing a denied claim, the Beneficiary has the right to submit written comments, documents, records, and other information relating to the claim under review whether or not such document, record, or other information was previously submitted at the initial benefit determination.
- (h) Beneficiary's Right to Access Information. Upon the Beneficiary's request, the Plan shall provide, at no cost to the Beneficiary, the following:
- (i) The identity of any medical or vocational experts that were hired on behalf of the Plan to provide advice in connection with the initial benefit determination, regardless of whether the advice was relied upon or not in making the initial determination; and
 - (ii) Reasonable access to, and copies of, all documents, records

and other information relevant to the claim, without regard to whether that information was submitted or considered part of the initial adverse benefit determination, free of charge. A document, record or other information will be considered relevant if it: 1) was relied upon in the initial adverse benefit determination; 2) was submitted, considered, or generated in the course of making the benefit determination, regardless of whether it was relied upon or not; or 3) demonstrates compliance with administrative processes and safeguards required for purposes of making a benefit determination.

- (i) Notification of Determination on Appeal. The Plan will provide written notification to the Beneficiary of the determination of the appeal. The notification will be written in understandable language and contain the following:
- (i) the specific reason(s) for the adverse benefit determination;
 - (ii) references to specific plan provisions on which the determination was based;
 - (iii) a statement that the Beneficiary is entitled to receive free, upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Beneficiary's claim for benefits;
 - (iv) a statement of the Beneficiary's right to bring a civil action under section 502(a) of ERISA;
 - (v) a statement that an explanation of the scientific or clinical judgment for the determination which specifically applies the terms of the plan to the Beneficiary's medical circumstances, will be provided free of charge, upon the Beneficiary's request, for determinations involving medical necessity or exclusions for experimental treatment, or other similar exclusion or limit;
 - (vi) the identification of any specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided to the Beneficiary, free of charge, upon the Beneficiary's request; and
 - (vii) a statement that reads: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

SECTION 4
DEDUCTIBLES AND LIMITATIONS

~~4.1 Benefits of this Plan will be provided to each eligible Beneficiary only after the Beneficiary has paid amounts equal to the deductibles described below. Payments used to satisfy one (1) deductible may not be used to satisfy another deductible. Payments necessitated by any benefit reduction resulting from any failure to satisfy a Managed Care Program review or notice requirement described in Section 5 may not be counted toward meeting any deductible. Deductibles can be satisfied by paying Eligible Charges or by incurring liability to pay them. The deductibles are as follows:~~

Annual
Deductible
eliminated
Effective:
01/01/06
Adopted:
12/07/05

~~(a) Annual Deductible. The Annual Deductible is the first \$100 in Eligible Charges incurred by a Beneficiary for those services or supplies received during a Calendar Year which are covered under Section 16, Other Medical Benefits, of this Plan. The Beneficiary is solely responsible for payment of the Annual Deductible. Beneficiary Eligible Charges or Copayments for services listed in Sections 6 through 15, as not being subject to the Annual Deductible, may not be counted toward satisfying the Annual Deductible.~~

Effective:
01/01/02
Adopted:
03/26/02

~~If the Beneficiary did not meet the Annual Deductible for the previous Calendar Year, any portion of the Annual Deductible paid during the last three (3) months of the previous Calendar Year (i.e., October, November, and December) may be carried over to the current Calendar Year's Annual Deductible as long as those deductible amounts were not used to meet the previous Calendar Year's Annual Deductible. This carry-over provision does not apply if a Beneficiary had met the Annual Deductible and received benefits for services or supplies that were subject to the Annual Deductible during the previous Calendar Year.~~

**Annual
Deductible
Eliminated**
Effective:
01/01/06
Adopted:
12/09/05

~~4.1 Maximum Annual Copayment. Whenever a Beneficiary makes Copayments for services covered under Sections 6 through 16 of this Plan that equal \$2,800 in any Calendar Year, the Beneficiary owes no Copayment for such services for the remainder of the Calendar Year. The Annual Deductible as described in Section 4.1(a) shall count toward satisfying the Maximum Annual Copayment. If services are rendered by a nonparticipating provider, the Beneficiary owes any difference between actual and Eligible Charges. In the case of a family, the Maximum Annual Copayment for a family or three or more shall not exceed \$8,400 for a Calendar Year. A Beneficiary's Copayments or additional expenses incurred by any benefit reduction resulting from any failure to satisfy a Managed Care Program review or notice requirement described in Section 5 will not be counted as Copayments toward meeting the Maximum Annual Copayment.~~

**Maximum
Annual
Copay
Increase**
Effective:
01/01/14
Adopted:
10/01/13

~~4.2 Annual Maximum per Calendar Year.~~

~~(a) Retirees under 65 years of age. The total benefits paid to or on behalf of a Beneficiary for essential health benefit services as defined in the Patient Protection and Affordable Care Act incurred in a Calendar Year shall not exceed a maximum of \$2,000,000.~~

**Annual
Deductible
eliminated**
Effective:
01/01/06
Adopted:
12/07/05

Effective:
01/01/02
Adopted:
03/26/02

**Affordable
Care Act**
Effective:
01/01/14
Adopted:
10/01/13

**Affordable
Care Act**
Effective:
01/01/14
Adopted:
10/01/13

~~(b) — Retirees 65 years of age and over. The total benefits paid to or on behalf of a Beneficiary for essential health benefit services as defined in the Patient Protection and Affordable Care Act incurred in a Calendar Year shall not exceed a maximum of \$2,000,000.~~

~~4.4 — Maximum Lifetime Benefits.~~

**Deleted
Lifetime
Maximum**
Effective:
01/01/11
Adopted:
04/13/11

~~(a) — Retirees under 65 years of age. The total benefits paid to or on behalf of a Beneficiary under this Plan shall not exceed \$1,000,000. After the \$1,000,000 in benefits is paid to or on behalf of a Beneficiary, then, beginning January 1 of the next year, an additional sum not to exceed \$25,000 annually will be paid for Eligible Charges incurred by such Beneficiary during each subsequent Calendar Year. The \$1,000,000 maximum shall apply to any and all benefits paid to or on behalf of a Beneficiary in the aggregate during his or her lifetime under this Plan, whether such Beneficiary derives such benefits as a Participant or as a Dependent or whether there is any interruption in the continuity of his or her coverage under this Plan. Similarly, the \$25,000 annual renewal, when applicable, shall be the maximum benefits which the Plan will provide in any Calendar Year to or on behalf of any Beneficiary after the \$1,000,000 maximum has been exhausted. The \$25,000 annual renewal is not cumulative and any portion of it which is not paid in a Calendar Year shall not carry forward to subsequent Calendar Years.~~

~~(b) — Retirees 65 years of age and over. The total benefits paid to or on behalf of a Beneficiary under this Plan shall not exceed \$500,000. After the \$500,000 in benefits is paid to or on behalf of a Beneficiary, then, beginning January 1 of the next year, an additional sum not to exceed \$10,000 annually will be paid for Eligible Charges incurred by such Beneficiary during each subsequent Calendar Year. The \$500,000 maximum shall apply to any and all benefits paid to or on behalf of a Beneficiary in the aggregate during his or her lifetime under this Plan, whether such Beneficiary derives such benefits as a Participant or as a Dependent or whether there is any interruption in the continuity of his or her coverage under this Plan. Similarly, the \$10,000 annual renewal, when applicable, shall be the maximum benefits which the Plan will pay in any Calendar Year to or on behalf of any Beneficiary after the \$500,000 maximum has been exhausted. The \$10,000 annual renewal is not cumulative and any portion of it which is not paid in a Calendar Year shall not carry forward to subsequent Calendar Years.~~

SECTION 5
MANAGED CARE PROGRAM

5.1 **Managed Care Program Reviews.** A prior review must be obtained from the Claims Administrator for certain types of medical services. A prior review is required before admission to a Hospital, before receiving certain Surgical Services, and before receiving all services relating to mental illness and alcohol or drug dependence, as described in Sections 5.3, 5.4, and 5.5 in this document. A prior review is required for outpatient services to include Imaging scans (MRI, MRA, or PET scans), Gamma knife or X-knife procedures, Greater than two (2) OB ultrasounds per pregnancy as described in Section 11 in this document, In-vitro fertilization as described in Section 12.3 in this document, plastic and/or reconstructive surgery as described in Section 7.2 in this document, and outpatient rehabilitation to include Physical therapy, Speech therapy and Occupational therapy as described in Section 16.2 and 16.3 in this document. In addition, a prior review must also be obtained for other medical services to include Durable Medical Equipment as described in Section 16.7 in this document, Hospice Care as described in Section 10.1 in this document, Home Health Services as described in Section 6.3 in this document, Infusion therapy, and Human Growth Hormone Therapy as described in Section 18 in this document. The Plan may pay reduced benefits in cases where prior review of covered services is required, but not obtained.

Effective:
01/01/04
Adopted:
09/20/07

5.2 **Benefit Reductions.** Any benefits that would have been paid in connection with a Hospital admission, surgical procedure, or mental illness and alcohol or drug dependence services will be reduced by 10% if a required review is not requested and obtained. This 10% benefit reduction will also be applied if the Claims Administrator is not notified of an emergency or maternity admission within 48 hours of the event or by the next working day, whichever is later.

Additional expenses incurred by a Beneficiary because of any reduction of benefits made by the Plan pursuant to this Section 5 shall not count toward the Maximum Annual Copayment. Furthermore, if the Beneficiary is required to pay for any services because of a reduction of benefits, those services will not be eligible for increased benefits even if the Beneficiary has met the Maximum Annual Copayment.

**Annual
Deductible
eliminated**
Effective:
01/01/06
Adopted:
12/07/05

(a) **Participating Providers.** When services are recommended or provided by a Participating Provider, that provider is responsible for obtaining any required Managed Care Reviews on the Beneficiary's behalf. That Participating Provider will also be responsible for any benefit reduction required because of failure to obtain a review.

(b) **Nonparticipating Providers.** When the services are recommended or provided by a nonparticipating provider, the Beneficiary must assume responsibility for requesting any required review and for any reduction in benefits resulting from failure to do so.

5.3 **Preadmission Review.**

(a) Before admission to a Hospital, for any treatment that can be

Effective: April 1, 1997
Adopted: July 24, 1998
Updated: April 17, 2014

scheduled in advance, the Beneficiary or the Beneficiary's Physician shall notify the Claims Administrator and request a Preadmission Review. If a Preadmission Review is not obtained, the Beneficiary may have additional expenses as indicated in Section 5.2 above.

Where the admission cannot be scheduled in advance, e.g., in cases of emergency or maternity, the Beneficiary or the Beneficiary's Physician shall notify the Claims Administrator as soon as practical after admission, but in no event later than 48 hours or one (1) working day after the admission, whichever is later.

- (b) Approval of benefits for a Hospital admission will be based on whether the Hospital admission recommended by the Physician is medically necessary and whether the care can be provided safely and effectively out of the Hospital.
- (c) The Claims Administrator will notify the Beneficiary's Physician in writing if the payment of benefits for the admission is approved. The Beneficiary's Physician will also be notified if payment of benefits for the admission is not approved. The Beneficiary shall be responsible for all charges related to any Hospital admission for which the Plan has indicated it will not pay benefits.

5.4 Surgical Review.

- (a) The Plan has identified certain kinds of Surgical Services which are sometimes performed even though nonsurgical treatment may be equally effective. A list of these Surgical Services has been provided to Participating Providers and is available from the Claims Administrator. Before scheduling any of the listed Surgical Services, the Beneficiary or the Beneficiary's Physician shall notify the Claims Administrator and request a Surgical Review. Where the admission cannot be scheduled in advance, e.g., in cases of emergency or maternity, the Beneficiary shall notify the Claims Administrator as soon as practical after the surgery, but in no event later than 48 hours or one (1) working day after the surgery, whichever is later.
- (b) The Claims Administrator will notify the Beneficiary and the Beneficiary's Physician of the results of its Surgical Review. The Claims Administrator may approve or deny payment of benefits on the Beneficiary's receiving a second opinion on the necessity of the surgery. A Beneficiary may receive a second opinion at no cost to the Beneficiary if the second opinion is arranged by the Claims Administrator for the following surgeries: [Inpatient Cholecystectomy \(gall bladder surgery\)](#), [Varicose Vein surgery](#), [Blepharoplasty \(eyelid surgery\)](#), [Septoplasty/Rhinoplasty \(nose surgery\)](#), and [Scar Revision surgery](#). After receiving a second opinion, the Beneficiary and the Beneficiary's Physician may decide whether to proceed with the surgery. The second opinion does not need to confirm the recommended surgery. The Beneficiary shall be responsible for all charges related to any listed Surgical Services for which the Plan has indicated it will not pay benefits. If a Surgical Review is not obtained, the Beneficiary may have additional expenses as indicated in Section 5.2 above.

Effective:
01/01/04
Adopted:
09/20/07

Original Section 5.5 deleted and following sections renumbered

Effective:
01/01/10
Adopted:
10/29/09

5.5 Inpatient Review.

- (a) The Claims Administrator will review each Beneficiary's Hospital admission for the appropriateness of the inpatient care provided to the Beneficiary and the appropriateness of continuing hospitalization. This review will occur within 48 hours after admission and at set intervals, until the Beneficiary is discharged from the Hospital. The Claims Administrator will also review discharge plans for the appropriateness of after-Hospital care.
- (b) This review of the appropriateness of inpatient care and after-Hospital care is for benefit payment purposes. If the Claims Administrator has a question regarding the appropriateness of continuing hospitalization or after-Hospital care, or if the Claims Administrator determines that benefits are not payable, the Beneficiary and the Beneficiary's Physician will be notified. If the Claims Administrator decides that the continuation of any service or care is not medically necessary or appropriate, the Beneficiary and the Beneficiary's Physician may still decide to continue with the service or care, but benefits under this Plan will not be payable for that continued service or care.

5.6 Benefits Management Program. The Plan may assist a Beneficiary by providing benefits for alternative services that are medically appropriate, but may not otherwise be covered under this Plan. Benefits for any alternative services for a Beneficiary's illness or Injury will be paid in lieu of benefits for regularly covered services and will not exceed the total benefits otherwise payable for regularly covered services.

These alternative services will be paid in the Plan's sole discretion as long as the Beneficiary and the Beneficiary's Physician agree that the recommended alternative services are medically appropriate for the illness or Injury. Payment for alternative services in one (1) instance does not obligate the Plan to provide the same or similar benefits for the same or any other Beneficiary in any other instance. Payment of these alternative benefits is made as an exception and in no way changes or voids the Plan benefits, or terms and conditions.

5.7 If a Beneficiary does not agree with a benefit determination made under the Preadmission Review, Surgical Review, or Inpatient Review provisions above, the Beneficiary may ask for a second review by the Trust Fund. The Trust Fund will notify the Beneficiary of the results of such second review.

SECTION 6
MEDICAL BENEFITS

Subject to the provisions of this Plan, including the Exclusions in Section 18, a Beneficiary is entitled to the following medical benefits:

6.1 **Medical Services.** Medical benefits include visits to or by a Physician for medical services that the Beneficiary requires for the diagnosis or treatment of an illness or Injury. Medical services do not include Surgical Services or services required for the diagnosis or treatment of mental illness and alcohol or drug dependence. Except where otherwise stated below, the Plan will pay 90% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider.

(a) **Home, Office, Hospital Emergency Room, or Office Consultation Visit.** Separate charges for injections will not be covered under this section, but may be covered under other sections of this Plan.

(b) **Second Opinion.** The Plan will pay 100% of Eligible Charges for a Participating Provider or 80% of Eligible Charges for a nonparticipating provider for an office visit regarding a second opinion that is required by the Plan on the necessity of surgery if the second opinion is arranged by the Claims Administrator. Office visit benefits will be paid for all other second opinions on the necessity of surgery.

(c) **Hospital or Skilled Nursing Facility Visit.** One (1) Hospital or Skilled Nursing Facility visit per day to a Beneficiary who is a Registered Bed Patient.

(d) **Consultation Visit.** One (1) consultation visit by a Physician within one (1) specialty during each confinement. The Plan will pay its benefits hereunder as long as each of the following requirements are met:

- (i) The attending Physician must require the consultation;
- (ii) The Beneficiary must be confined as a Registered Bed Patient;
- (iii) The consultant's report must be acceptable to the Claims Administrator and included as a part of the record kept by the Hospital or Skilled Nursing Facility; and
- (iv) The consultation must be for reasons other than compliance with requirements imposed by the Hospital or Skilled Nursing Facility.

(e) **Well-Baby Care Visits.** Eight (8) routine well-baby visits during the first two (2) years of a Child's life, and one (1) visit each during ages two (2), three (3), four (4), and five (5). When a well-baby visit cannot be scheduled within an above designated benefit period, the visit may be covered if rendered within thirty (30) days of the benefit period, as long as the total number of well-baby visits allowed by the Plan is not exceeded. Well-baby immunizations are covered under Section 6.2 Immunizations; well-baby routine laboratory tests are covered under **Outpatient Diagnostic and Therapy Benefits.**

6.2 **Immunizations.** The Plan will pay 90% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider for well-baby immunizations and immunizations in

Effective:
01/01/00
Adopted:
12/15/99

Effective:
01/01/01
Adopted:
01/31/01

connection with the following: cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus, and chicken pox, and streptococcus pneumoniae.

(a) **Human Papilloma Virus Quadrivalent Vaccine.**

Effective:
05/01/07
Adopted:
09/20/07

(i) The Human Papilloma Virus (HPV) quadrivalent vaccine is covered when the first dose is administered to an 11 to 12 year old male or female with the second and third dose administered prior to 13 years of age. Should the third dose be administered at 13 years of age or later, the third dose will be covered at 50% of Eligible Charges.

Effective:
01/01/08
Adopted:
04/09/09

(ii) For males or females ages 13 through 18 years of age, the Human Papilloma Virus (HPV) quadrivalent vaccine is covered at 50% of Eligible Charges for services of a Participating or Non-Participating Provider when the first dose is administered to a 13 through 18 year old male or female with the second and third dose administered prior to 19 years of age.

Effective:
01/01/08
Adopted:
01/14/09

**HPV vaccine
for all
beneficiaries**

Effective:
07/01/14
Adopted:
04/15/14

(iii) Under all other circumstances, this immunization will not be eligible for coverage.

(b) The Meningococcal vaccine is covered for individuals from the age of 11 years old. Those younger than 11 years old, who are at increased risk due to immune compromise or other disorders, will require prior authorization.

Effective:
10/01/07
Adopted:
09/20/07

(c) The Rotavirus vaccines is covered under the Plan when the first dose is administered to an infant 12 weeks of age and the remaining two (2) doses of the vaccine is administered by 32 weeks of age.

Effective:
10/01/07
Adopted:
09/20/07

6.3 Home Health Care. Subject to the limitations listed below, this Plan pays benefits for up to a maximum of 150 home health care visits per Calendar Year. The Plan will pay 100% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider.

(a) The attending Physician must certify in writing that a Beneficiary:

- (i) is homebound due to an Injury or illness,
- (ii) requires part-time skilled health services, and
- (iii) would require inpatient Hospital or Skilled Nursing Facility care if there were no home health care visits.

The Federal Medicare definition of homebound shall apply.

(b) If a Beneficiary requires home health care visits for more than 30 days, the Physician must recertify that additional visits are required and must provide a continuing plan of treatment at the end of each such 30-day period of care.

(c) Visits must be provided by a qualified Home Health Agency.

(d) No payment will be made for home health care services furnished primarily to assist the Beneficiary with personal, family, or domestic needs, such as general household services, meal preparations, shopping, bathing, or dressing.

SECTION 7 SURGICAL BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following surgical benefits:

- 7.1 Surgical Services. Except where otherwise stated below, the Plan will pay 100% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider for Surgical Services required for the diagnosis or treatment of a Beneficiary's Injury or illness.
- 7.2 Limiting Conditions for Surgical Benefits.
- (a) The Plan has payment restrictions and rules that apply to multiple Surgical Services, services of an assistant surgeon, and payment for preoperative and postoperative care for major and minor Surgical Services. A Beneficiary may contact the Claims Administrator for additional information regarding these restrictions and rules.
 - (b) Transplants.
 - (i) Subject to compliance with each of the conditions set forth in Section 7.2(b)(iii) below, the following transplants are eligible for benefits: kidney; cornea; bone marrow, excluding high dose chemotherapy with bone marrow transplants or peripheral stem cell infusion for epithelial ovarian cancer, multiple myeloma, primary intrinsic tumors of the brain; liver, excluding liver transplants for metastatic malignancies to the liver, and Hepatitis B e antigen or core antibody positive; heart; heart-lung; and lung. All other transplants, including artificial or animal organ transplants, are not eligible for benefits under this Plan.
 - (ii) Transplant Evaluation. No benefits will be paid in connection with bone marrow, liver, heart, heart-lung, and lung transplant evaluations without the prior approval from the Claims Administrator. Transplant evaluation means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations, which a Hospital or facility uses in evaluating a potential transplant candidate.
 - (iii) No benefits will be paid in connection with bone marrow, liver, heart, heart-lung, and lung transplants without the prior approval from the Claims Administrator. No transplant benefits will be approved unless each of the following conditions is met:
 - a. Both the Beneficiary and the specific transplant must meet the "medical necessity" criteria set forth in Sections 3.6(a) and (c).
 - b. The transplant must be performed at a transplant facility that is approved by the Claims Administrator or Trust Fund for that type of transplant and the contracted transplant facility has accepted the Beneficiary as a transplant candidate;

c. Any transplant that is classified as "experimental" or "investigative" in the circumstances presented, or as not proven to be safe and effective, will not be covered.

(c) Reconstructive Surgery. The Plan will pay benefits for reconstructive surgery only when it is required to restore, reconstruct and correct any bodily function that was lost, impaired, or damaged as a result of an illness or Injury. Reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications in all stages of mastectomy, including lymphedemas, are covered when medically necessary.

Effective:
01/01/99
Adopted:
03/17/99

7.3 Anesthesiology. The Plan will pay 90% of Eligible Charges for a Participating Provider or 80% of Eligible Charges for a nonparticipating provider for anesthesiology services when required by the attending Physician and used instead of the Hospital anesthesia services for a hospitalized patient.

SECTION 8 HOSPITAL BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following Hospital benefits:

8.1 Inpatient Hospital Benefits. This Plan pays benefits for a maximum of 365 days per Calendar Year for Hospital services received by a Beneficiary confined as a Registered Bed Patient.

Except where otherwise stated below, the Plan will pay 100% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider. The following Hospital inpatient services are covered:

- (a) Room and care based on semiprivate room rate.
- (b) Intermediate care unit.
- (c) Isolation unit.
- (d) Intensive care or coronary care unit. Such unit must be equipped and operated according to generally recognized Hospital standards acceptable to the Claims Administrator or Trust Fund.
- (e) Operating room, surgical supplies, Hospital anesthesia services and supplies, drugs, dressings, oxygen, antibiotics, and Hospital blood transfusion services.
- (f) If a Hospital charges for its ancillary services, as set forth in Section 8.1 (e) immediately above and Section 8.2 below, on an all-inclusive daily rate basis, the Plan will pay 90% of Eligible Charges for a Participating Provider or 80% of Eligible Charges for a nonparticipating provider for such ancillary services. In no event will the Plan pay more than it would have paid if the Hospital had charged separately for such services.
- (g) Inpatient Hospital services for a Beneficiary being treated for mental illness are covered under Section 13, Mental Illness and Alcohol or Drug Dependence Benefits, and are subject to the limitations specified in that Section 13.
- (h) **“Life Bed”.** Benefits for Life Bed services will be covered at an Eligible Charge of \$18.00 per day when available, subject to prior authorization. Failure to obtain prior authorization will result in no benefit payment.
- (i) Transplants. See Section 7.2(b) for limitations on benefits for transplants.

Effective:
01/01/08
Adopted:
12/13/07

8.2 Diagnostic and Therapy Benefits. The Plan will pay 100% of Eligible Charges for services of a Participating Provider and 80% of Eligible Charges for services of a nonparticipating provider.

- (a) Laboratory Services and Diagnostic Tests.
- (b) X-ray Films.
 - (i) X-ray films ordered within 48 hours following an Injury.
 - (ii) Other x-ray films.
- (c) Radiotherapy.

- (i) Radiotherapy used in the treatment of a malignant condition.
- (ii) For radiotherapy used in the treatment of a nonmalignant condition, the Plan will pay 90% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider.

8.3 Emergency Room Benefits. The Plan will pay 100% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider for use of a Hospital's emergency room facilities in connection with an Injury or illness requiring emergency or urgent surgical or medical attention as substantiated by the Physician's claim or a written Hospital report. The Plan will not pay charges incurred for use of the Hospital's emergency room facilities, outpatient operating room, supplies, and equipment in connection with nonemergency surgical or medical services.

8.4 Outpatient Surgical Center Benefits. The Plan will pay 100% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider. Outpatient surgical center services include routine laboratory and x-ray services normally associated with the surgery. Benefits for other laboratory services and diagnostic tests, x-ray films and radiotherapy, will be payable as provided under Section 11. Such center must be equipped and operated according to generally recognized standards that meet State of Hawaii licensing requirements.

SECTION 9
SKILLED NURSING FACILITY BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following Skilled Nursing Facility benefits:

- 9.1 Skilled Nursing Facility Benefits. Up to a maximum of 120 days of confinement per Calendar Year. The Plan will pay 90% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider.
- (a) Participating Providers. Benefits are based on a single, all-inclusive amount per day. Covered inpatient services include room and care based on semiprivate room rate, routine surgical supplies, drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy services. If a Participating Provider's diagnostic and therapy services are not included in the single, all-inclusive amount per day, the Plan will pay the diagnostic and therapy services in accordance with Section 11, Outpatient Diagnostic and Therapy Benefits.
 - (b) Nonparticipating Providers. Covered inpatient services include room and care based on semiprivate room rate, routine surgical supplies, drugs, dressings, oxygen, antibiotics, and blood transfusion services. For diagnostic and therapy services, see Section 11, Outpatient Diagnostic and Therapy Benefits.
- 9.2 The Plan will pay its benefits under this Section 9 as long as all of the following requirements are met:
- (a) The Beneficiary must be admitted upon the authorization of a Physician, be attended by a Physician, and be confined as a Registered Bed Patient;
 - (b) Confinement in the facility must not be primarily for comfort, convenience, rest cure, or domiciliary care; and
 - (c) If a Beneficiary remains in such facility more than 30 days, the attending Physician must submit to the Claims Administrator an evaluation report concerning the Beneficiary at the end of each such 30-day period of confinement.

SECTION 10
HOSPICE BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following hospice benefits:

- 10.1 Hospice Benefits. Up to a maximum of 150 days of hospice services for a terminal illness, with payment based on an all-inclusive daily rate. The Plan will pay 100% of Eligible Charges for services of a Participating Provider. Services rendered by a nonparticipating provider are not a benefit of this Plan.
- 10.2 Limitations.
- (a) All hospice services must be received from a hospice agency that is currently under contract with the Claims Administrator or Trust Fund to provide hospice benefits and is operated under generally accepted standards for hospices.
 - (b) The hospice agency and attending Physician must certify in writing that the Beneficiary is terminally ill and has a life expectancy of six (6) months or less.
 - (c) A Beneficiary who elects hospice benefits shall not be eligible for any other benefits for the treatment of the terminal illness, except medical services benefits from a Physician. A Beneficiary may continue to receive benefits for all other illnesses or Injuries.
 - (d) A Beneficiary may decide to discontinue hospice care and receive other covered services at any time before the end of the 150-day hospice benefit period. However, if the Beneficiary decides to do so, any remaining days of the 150 days of hospice benefits will be lost and will not be available for future use.
-

SECTION 11
OUTPATIENT DIAGNOSTIC AND THERAPY BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following outpatient diagnostic and therapy benefits provided that these services are ordered by a Physician in the diagnosis or treatment of an Injury or illness. Except where otherwise stated, the Plan will pay 100% of Eligible Charges for outpatient services of a Participating Provider or 80% of Eligible Charges for outpatient services of a nonparticipating provider.

- 11.1 Laboratory Services and Diagnostic Tests. Including the following:
- (a) Laboratory tests in connection with well-baby care visits are limited to the following tests through age five (5): two (2) tuberculin tests, two (2) blood tests (hemoglobin or hematocrit), and one (1) urinalysis.
 - (b) Routine Pap Smear. Limited to one (1) per Calendar Year.
 - (c) Prostate Specific Antigen Test. Limited to one (1) per Calendar Year for men ages 50 and above.
 - (d) Tuberculin Tine Test. Limited to one (1) per Calendar Year.
- 11.2 X-ray Films.
- (a) X-ray films ordered within 48 hours following an Injury.
 - (b) Other x-ray films.
- 11.3 Radiotherapy.
- (a) Radiotherapy used in the treatment of a malignant condition.
 - (b) For radiotherapy used in the treatment of a nonmalignant condition, the Plan will pay 90% of Eligible Charges for outpatient services of a Participating Provider or 80% of Eligible Charges for outpatient services of a nonparticipating provider.
- 11.4 Screening by Low-Dose Mammography. Screening by low-dose mammography is limited to one (1) baseline mammogram during ages 35 through 39, **and one (1) mammogram every twelve (12) months for women ages 40 and above**. Women of any age with a history of breast cancer or whose mother or sister has had a history of breast cancer **or women with an increased risk of breast cancer**, or who have had an abnormal mammogram requiring breast biopsy are eligible for a mammogram upon the recommendation of a Physician. **When a mammography test cannot be scheduled within the above designated benefit periods, the mammography test may be covered if rendered within ten (10) days of the benefit period, as long as the total number of mammography tests allowed by the Plan is not exceeded.**

Effective:
07/01/08
Adopted:
06/18/08

Effective
01/01/04
Adopted:
06/10/04

SECTION 12
MATERNITY BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following maternity benefits:

- 12.1 Pregnancy, Childbirth, and Related Medical Conditions. Medical, surgical, Hospital, and other benefits as provided elsewhere in this Plan are available to a Beneficiary for pregnancy, childbirth or other termination of pregnancy, and related medical conditions with the following clarifications and limitations:
- (a) Nurse-Midwife Services. Services must be rendered by a certified nurse-midwife who is properly licensed, is certified by the American College of Nurse-Midwives, and is formally associated with a Physician for purposes of supervision and consultation. For normal pregnancy and childbirth, the Plan will pay 100% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider.
 - (b) The Eligible Charge for delivery includes prenatal and postnatal care. If payments for prenatal care are made separately prior to delivery, these payments will be considered an advance payment and will be deducted from the maximum allowance for delivery.
 - (c) Birthing Center Services. Hospital benefits described in Section 8 are also available for services of a properly licensed birthing center approved by the Claims Administrator or Trust Fund when such birthing center is used instead of regular Hospital facilities for childbirth. Benefits for birthing center services are in lieu of payment for inpatient Hospital services. The Plan will pay 100% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider.
 - (d) Diagnostic tests for an unborn Child are eligible for payment under Section 11 only when medically necessary.
- 12.2 Newborn Child. Benefits as provided elsewhere in this Plan are available to a Child from the date of birth for routine nursery care, circumcision, premature birth care, illness, Injury, or birth defect if the Child is enrolled as a Beneficiary with the Trust Fund within 30 days after birth.
- 12.3 In Vitro Fertilization.
- (a) Coverage is limited to one (1) procedure per lifetime, whether successful or not.
 - (b) Requirements and criteria for in vitro fertilization include, but are not limited to, the following:
 - (i) The Beneficiary's oocytes are to be fertilized with the Beneficiary's Spouse's sperm;
 - (ii) The Beneficiary and the Beneficiary's Spouse have a history of infertility of at least five (5) years' duration; or infertility is associated with one (1) or more of the following medical conditions:
 - a. Endometriosis;
 - b. Exposure in utero to diethylstilbestrol, commonly known

Deleted 12-month waiting period for in vitro procedure
Effective: 01/01/14
Adopted: 10/01/13

- as DES;
- c. Blockage of, or surgical removal of, one (1) or both fallopian tubes (lateral or bilateral salpingectomy); or
- d. Abnormal male factors contributing to the infertility.
- (iii) The Beneficiary has been unable to attain a successful pregnancy through other applicable infertility treatments for which coverage is available under this Plan.
- (iv) The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.
- (v) The term "Spouse" means a person who is lawfully married to the patient and is qualified as a Spouse in accordance with the Internal Revenue Code.
- (c) Physician Services for in vitro fertilization are covered as described in Section 6, Medical Benefits. Diagnostic laboratory and x-ray services are covered as described in Section 11, Outpatient Diagnostic and Therapy Benefits. Prescription drugs are covered as described in the Prescription Drug Plan.
- (d) The following exclusions are applicable:
 - (i) The cost of equipment and of collection, storage and processing of sperm.
 - (ii) In vitro fertilization requiring the use of either donor sperm or donor eggs.
 - (iii) Artificial insemination requiring the use of donor sperm.
 - (iv) Services related to conception by artificial means, other than artificial insemination and in vitro fertilization as specified above.

Deleted
\$5,000
limit
Effective:
01/01/11
Adopted:
07/11/13

SECTION 13
MENTAL ILLNESS AND ALCOHOL OR DRUG DEPENDENCE BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to only the following benefits in connection with mental illness treatment and alcohol or drug dependence treatment:

13.1 Mental Illness Benefits.

(a) Inpatient Benefits.

(i) Benefit Maximums. Inpatient Hospital facility services received by a Beneficiary confined as a Registered Bed Patient shall count against the 365 days per Calendar Year maximum inpatient Hospital benefits allowed under Section 8.

MH Parity
Effective:
01/01/10
Adopted:
10/29/09

(ii) Inpatient Hospital or Facility Services. Benefits for room and care, inpatient services, and diagnostic x-rays and laboratory testing are in accordance with Section 8, Hospital Benefits, for services in a Hospital or Qualified Treatment Facility.

Prior Section
Amendments
(no longer in
red) include:

A Qualified Treatment Facility means an inpatient or outpatient facility for the treatment of mental illness that has been accredited as such by the Joint Commission on Accreditation of Health Care Organizations or the Commission on Accreditation of Rehabilitation Facilities and, if the facility is residential, has been licensed as a special treatment facility by the proper government authority.

Clinical Social
Worker
Effective:
03/01/01
Adopted:
01/31/01

(iii) Inpatient Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapy Services. The Plan will pay 90% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a nonparticipating provider for Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist visits to a Beneficiary being treated for mental illness in a Hospital or Qualified Treatment Facility, up to one (1) visit per day while hospitalized in the Hospital or Qualified Treatment Facility.

Licensed
Mental Health
Counselor
Effective:
01/01/09
Adopted:
09/24/08

Marriage and
Family
Therapist
Effective:
01/01/09
Adopted:
01/14/09

(b) Outpatient Benefits.

(i) Outpatient Facility, Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist Services. The Plan will pay 90% of Eligible Charges for a Participating Provider or 80% of Eligible Charges for a nonparticipating provider for covered outpatient mental illness services provided by a Qualified Treatment Facility, Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist.

(c) Psychological Testing. Benefits for inpatient services in a Hospital or Qualified Treatment Facility are in accordance with Section 8, Hospital Benefits. The Plan will pay 90% of Eligible Charges for outpatient services of a Participating Provider or 80% of Eligible Charges for

MH Parity
Effective:
01/01/10
Adopted:
01/10/13

outpatient services of a nonparticipating provider for psychological testing sessions.

13.2 Alcohol and Drug Dependence Treatment Benefits. Mental illness benefits, Sections 13.1(a) and (b) above, are available to a Beneficiary for alcohol and drug dependence treatment services including detoxification. Benefits for alcohol and drug dependence treatment services shall count against the inpatient and outpatient benefit maximums under Section 13.1 above, and shall be subject to the clarifications and limitations in Section 13.3 below.

13.3 Limiting Conditions. Benefits for mental illness and alcohol or drug dependence services shall be payable only if the following conditions are satisfied:

(a) General Limitations.

The Beneficiary or the Beneficiary's Physician must notify the Claims Administrator and obtain a Preadmission Review by the Claims Administrator as required under Section 5.

(b) Mental Illness Limitations. No mental illness services shall be eligible for reimbursement hereunder unless (i) the Beneficiary has a nervous or mental disorder classified as such in the current version of the Diagnostic and Statistical Manual of the American Psychiatric Association and (ii) the services are provided under an individualized treatment plan approved by a Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist. Epilepsy, senility, mental retardation, or other developmental disabilities and addiction to or abuse of intoxicating substances do not in and of themselves constitute a mental disorder.

(c) Alcohol or Drug Dependence Services Limitations.

(i) Program Providers. The Claims Administrator or Trust Fund has contracted with a limited number of providers to become Program Providers of alcohol and drug dependence services. Participating Provider benefits shall be paid only for services rendered by such Program Providers. Nonparticipating provider benefits shall be paid for services rendered by other providers.

(ii) Outpatient alcohol or drug dependence services must be provided under an individualized treatment plan approved and performed by a Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist who is a certified substance abuse counselor.

(iii) In the case of alcohol or drug dependence treatment episodes, if the Hospital or Qualified Treatment Facility charges on an all-inclusive daily rate basis, the Plan shall pay benefits in accordance with Section 8, Hospital Benefits.

(iv) The cost of educational programs to which drinking or drugged drivers are referred by the judicial system and any and all services performed by mutual self-help groups shall not be eligible for reimbursement hereunder.

MH Parity – Deleted section 13.3(a)(i)
Effective: 01/01/10
Adopted: 01/10/13

SECTION 14
ORAL SURGICAL BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to limited benefits as listed below. For the purposes of this Section 14, a Dentist means a doctor of dentistry (D.M.D.) or dental surgery (D.D.S.) who is appropriately licensed to practice by the proper government authority and who renders services within the lawful scope of such license.

- 14.1 Surgical Benefits. Benefits as provided in Section 7 for oral Surgical Services performed by a Dentist shall be payable only when the Dentist is performing emergency or Surgical Services that could also be performed by a Physician (M.D. or D.O.).
 - 14.2 Hospital Inpatient Benefits as provided in Section 8 are available for dental services only when a Physician certifies in writing that the Beneficiary has a separate medical condition, such as hemophilia, that makes hospitalization necessary for the Beneficiary to safely receive dental services or that the oral surgery itself requires hospitalization.
-

SECTION 15
AMBULANCE BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following ambulance benefits:

The Plan will pay 90% of Eligible Charges for a Participating Provider or 80% of Eligible Charges for a nonparticipating Provider for services of a properly licensed automobile ambulance **to the nearest, adequate hospital or skilled nursing facility for treatment** if benefits under Sections 8.1 or 8.4 are allowed for such Injury or illness – **and all of the following apply.**

Effective:
09/01/02
Adopted:
12/11/02

15.1 Transportation begins at:

(a) the place where an Injury or illness occurred or first required emergency care; or

(b) a hospital or nursing facility of which the beneficiary is an inpatient and services to treat the Injury or illness are not available.

15.2 Transportation ends at the nearest facility equipped to furnish emergency treatment.

15.3 Transportation is for the purpose of emergency treatment.

SECTION 16
OTHER MEDICAL BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following other medical benefits:

Except where otherwise stated, the Plan will pay 80% of Eligible Charges for services of a Participating Provider or a nonparticipating provider for the following medical services.

**Annual
Deductible
eliminated**
Effective:
01/01/06
Adopted:
12/07/05

16.1 Air Ambulance Services. Air ambulance services benefits shall be for transportation within the State of Hawaii and transportation within the United States of America when facilities within the State of Hawaii are not equipped to furnish treatment of a medically necessary illness or Injury. Services performed by medical transport personnel required during air ambulance transportation are also covered benefits under this Plan. Air ambulance services must be rendered by a properly licensed or certified air ambulance from the place where Injury occurred, or illness first required care or a referring treatment facility if all of the following apply:

Effective:
09/01/02
Adopted:
12/11/02

(a) Transportation begins at:

- (i) The place where an Injury or illness occurred or first required emergency care; or
- (ii) A hospital or nursing facility of which the beneficiary is an inpatient and services to treat the Injury or illness are not available.

(b) Transportation ends at the nearest facility equipped to furnish emergency treatment.

(c) Transportation is for the purpose of emergency treatment.

**Deleted
\$15,000
limit**
Effective:
01/01/11
Adopted:
07/11/13

16.2 Physical Therapy Services. Physical therapy services rendered by a registered physical therapist (R.P.T) or registered occupational therapist (O.T.R.). Services must be ordered by a Physician under an individual treatment plan, be medically necessary to restore a musculoskeletal function that the Beneficiary lost or had impaired by illness or Injury, and be reasonably expected to improve the patient's condition through short-term care. (Long-term maintenance and group exercise programs are not covered.)

16.3 Speech Therapy Services. Speech therapy services from a speech therapist holding a Certificate of Clinical Competence from the American Speech and Hearing Association when such services are ordered by a Physician under an individual treatment plan, are medically necessary to restore a Beneficiary's speech or hearing function which was lost or impaired by illness or Injury, and are reasonably expected to improve the patient's condition through short-term care. (Long-term maintenance programs are not covered). Speech therapy for Children with developmental learning disabilities (developmental delay) is not a covered benefit.

- 16.4 Allergy Testing. 100% of Eligible Charges for a Participating Provider or 80% of Eligible Charges for a nonparticipating provider. Not to exceed one (1) series of tests per Calendar Year.
- 16.5 Allergy Treatment Materials. When used in conjunction with allergy treatment services.
- 16.6 Blood. Blood and blood products (except when donated) and blood bank service charges. Any additional charges for autologous blood (reserved for the Beneficiary who donated the blood) are excluded as a benefit.
- 16.7 Appliances and Durable Medical Equipment. Benefits for the initial provision and replacement of the following appliances and durable medical equipment: hearing aids (one (1) device per ear every five (5) years); cardiac pacemakers; artificial limbs, eyes, and hips, and similar nonexperimental appliances; casts, splints, trusses, braces, and crutches; oxygen and rental of equipment for its administration; rent or purchase of wheelchair and hospital-type bed; and charges for use of an iron lung, artificial kidney machine, pulmonary resuscitator, and similar special medical equipment. The Plan will pay only for the appliances and durable medical equipment listed above. All appliances and durable medical equipment must be for services covered under this Plan and must be ordered by the attending Physician. However, the Plan must agree that the ordered item is medically necessary for the treatment of the Beneficiary's illness or Injury before the item will be considered a covered benefit. The Plan will not pay for any convenience items.
- 16.8 Chemotherapy for Malignancy. Chemical agents and their administration (other than oral) for treatment of malignancy.
- 16.9 Transplant Donor Services. Eligible medical and Hospital costs of the donor or services of an organ bank only when a Beneficiary is the recipient. Covered expenses for screening of donors shall be limited to expenses associated with the actual donor. If the donor is covered under another medical plan, that other plan shall be the primary plan and its benefits shall be applied before benefits under this Plan apply.
- 16.10 Outpatient Injections. Outpatient services and supplies for the injection or intravenous administration of either medication or nutrient solutions required for primary diet.
- 16.11 Evaluations for the Use of Hearing Aids.
- 16.12 Dialysis and Supplies. Acute or maintenance dialysis for kidney disorders, if not covered by Medicare.
-

SECTION 17
EXCLUSIONS DURING WAITING PERIODS

- 17.1 If a Beneficiary is confined in a Hospital or **other inpatient facility** at the time his or her coverage under this Plan begins and was not a Beneficiary under some other medical plan of the Trust Fund immediately prior to the Effective Date of such coverage, the Beneficiary shall be entitled to benefits for the Injury or illness which required such confinement **from the effective date of eligibility under this Plan. However, if Beneficiary had other insurance or coverage immediately prior to the effective date under this Plan, which extends coverage for any services related to the hospitalization or other inpatient facility, the Plan will provide coordination of benefits, in accordance with the National Association of Insurance Commissioners (NAIC) primary and secondary rule, with the beneficiary's existing coverage until the termination of Beneficiary's existing coverage. Thereafter, the Plan will provide coverage in accordance with the Plan documents and plan of benefits.**
- 17.2 A Participant's newborn Child, including an adopted newborn, is not subject to the above waiting period exclusion provided that the Child is enrolled as a Beneficiary within 30 days after the date of birth.
- 17.3 An adopted Child who is not a newborn Child described above, is not subject to the above waiting period exclusion provided that the Child is enrolled as a Beneficiary within 30 days after the date of placement for adoption in the home.
- 17.4 The exclusion provided under this Section 17 shall be in addition to any exclusions provided elsewhere in this Plan.

Effective:
07/01/08
Adopted:
01/14/09

SECTION 18
GENERAL PROVISIONS

18.1 General Limitations and Exclusions. The limitations and exclusions provided under this Section 18 shall be in addition to any limitations and exclusions provided elsewhere in this Plan.

- (a) The Plan will not pay benefits for any services when the Beneficiary is entitled to receive disability benefits or compensation under any Workers' Compensation or Employer's Liability Law for Injury or illness. In the event the Beneficiary formally appeals the denial of a claim for Workers' Compensation, the Beneficiary shall notify the Trust Fund of such appeal. Upon the execution and delivery to the Trust Fund of all documents it requires to secure the Trust Fund's rights of reimbursement, including without limitation, a Subrogation and/or Loan Agreement in the form attached hereto as Exhibit A, benefits will be provided under this Plan. However, such payment of benefits shall be considered only as an advance or loan to the Beneficiary. If the claim is declared eligible for benefits under Workers' Compensation or Employer's Liability Law or if the Beneficiary reaches a compromise settlement of the Workers' Compensation claim, the Beneficiary agrees to repay 100% of the advance or loan, without any deduction for legal fees incurred or paid by the Beneficiary, within 10 calendar days of receiving payment, **and the Plan shall have a lien on that portion of said recovery which is due for said advance or loan, even if the award or settlement does not make the Beneficiary whole or does not include medical expenses, whether held by the Beneficiary, or by any other person or party for the Beneficiary.** If reimbursement is not made as specified, the Plan, at its sole option, may:
- (i) take legal **and/or equitable** action to collect 100% of any payments made, including any legal fees incurred or paid by the Plan in pursuit of reimbursement, or
 - (ii) offset future benefit payments by the amount of such reimbursement, including any legal fees incurred or paid by the Plan in pursuit of reimbursement.
- (b) The Plan will not pay benefits for any services:
- (i) when services for an Injury or illness are provided without charge to the Beneficiary by any federal, state, territorial, municipal, or other government instrumentality or agency, or
 - (ii) when services for an Injury or illness would have been provided without charge or collection but for the fact that the person is a Beneficiary under this Plan.
- (c) The Plan will not pay any benefits, to the extent that such benefits are payable, by reason of any false statement or other misrepresentation made in an application for membership or in any claims for benefits. If the Plan pays such benefits before learning of any false statement, the Participant agrees to reimburse the Plan for 100% of such payment, without any deduction for legal fees incurred or paid by the

Effective:
03/09/05
Adopted:
12/20/06

Beneficiary, and the Plan shall have a lien on that portion of any recovery obtained by the Beneficiary, whether held by the Beneficiary or by any other person or party for the Beneficiary, for such injury or illness which is due for said benefits paid by the Plan, even if the award or settlement does not make the Beneficiary whole or does not include medical expenses. In addition, the Beneficiary agrees to reimburse the Plan for any legal fees incurred or paid by the Plan to secure reimbursement. If reimbursement is not made as specified, the Plan, at its sole option, may:

Effective:
03/09/05
Adopted:
12/20/06

- (i) take legal and/or equitable action to collect 100% of any payments made, including any legal fees incurred or paid by the Plan in pursuit of reimbursement, or
 - (ii) offset future benefit payments by the amount of such reimbursement, including any legal fees incurred or paid by the Plan in pursuit of reimbursement.
- (d) The Trust Fund is not an insurer against nor liable for the negligence or other wrongful act or omission of any provider, provider's employee, or other person or for any act or omission of any Beneficiary.
- (e) The Trust Fund does not guarantee the availability or quality of or undertake to provide any services of any third party including the availability of Participating Providers.
- (f) The Plan will not pay benefits for services required in the treatment of an Injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists, or that occurs during a period of active duty exceeding 30 days in the service of any armed force of any state or nation.
- (g) The Plan will not pay benefits in connection with:
- i. Services not described as covered in this Plan;
 - ii. Cosmetic services (services, supplies, or drugs that may improve the physical appearance, but do not restore or materially improve a bodily function, including related services such as laboratory tests, anesthesia, and hospitalization -this exclusion also applies to cosmetic services because of psychological or psychiatric reasons);
 - iii. Treatment of any complications as a result of previous cosmetic, experimental, investigative services or other services not covered under this Plan - regardless of how long ago such services were performed;
 - iv. Treatment of baldness, including hair transplants and topical medications;
 - v. Eye refractions or eye examinations except if done by a doctor of optometry for the diagnoses and management of diseases and disorders of the visual system as well as diagnoses of related systemic conditions;
 - vi. Eyeglasses or contact lenses;
 - vii. Refractive eye surgery to correct visual problems;
 - viii. Rest cures;
 - ix. Treatment with nonionizing radiation;

Effective:
03/09/05
Adopted:
12/20/06

Effective:
01/01/03
Adopted:
12/11/02

Effective:
01/01/04
Adopted:
12/10/03

Effective:
01/01/03
Adopted:
12/11/02

- x. Routine physical examinations or health appraisals and services related thereto except for well-baby care and the screening services provided under Section 11;
- xi. Dental services generally done only by Dentists and not by Physicians (including orthodontia; dental splints and other dental appliances; dental prostheses; osseointegration and all related services; removal of impacted teeth; and any other procedures involving the teeth, structures supporting the teeth, and gum tissues) except for Oral Surgical Benefits as provided in Section 14; any services in connection with the diagnosis or treatment of temporomandibular joint problems or malocclusion (misalignment of teeth or jaw), regardless of the symptoms or illnesses being treated;
- xii. Reversal of sterilization;
- xiii. Fertilization by artificial means and all drugs or services related to the diagnosis or treatment of infertility (except for one (1) in vitro fertilization program per qualified married couple per lifetime);
- xiv. All services and prosthetic devices related to sexual transformation or treatment of sexual dysfunction regardless of cause;
- xv. Biofeedback and other forms of self-care or self-help training and any related diagnostic testing;
- xvi. Human growth hormone therapy, except replacement therapy services to treat:
 - a. Hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy.
 - b. Short stature due to endogenous growth hormone deficiency.No benefit will be paid in connection with human growth hormone therapy without prior approval from the Claims Administrator;
- xvii. Weight loss or weight control programs;
- xviii. Services from a member of the Beneficiary's immediate family or household;
- xix. A Physician's waiting or stand-by time;
- xx. Outpatient prescription drugs;
- xxi. Private duty nursing; and
- xxii. Foot orthotics, except for specific diabetic conditions.

Deleted
\$5,000
limit
Effective:
01/01/11
Adopted:
07/11/13

18.2 When a Beneficiary Has Other Health Coverage (Coordination of Benefits).

- (a) If a Beneficiary is covered by "this Plan" and any "other plan" that provides benefits for medical, surgical, Hospital or other services, the benefits of "this Plan" and those of the "other plan" will be coordinated so that the combined benefits are not more than the Eligible Charge for the covered service.
 - (i) "This Plan" shall mean this document.
 - (ii) "Other plan" shall mean the Federal Medicare Program, any "no-fault" or other type of motor vehicle insurance, or any

- group health plan including another group plan of the Trust Fund. It shall not include any other nongroup health plan.
- (b) Coordination of benefits rules are rules used by most group health plans to determine the order of payment of two (2) or more health plans and to determine the amount of payment. In coordinating the benefits of two (2) plans, one (1) plan (primary plan) pays its benefits in full and the other (secondary plan) normally pays reduced benefits. These rules help the plans to avoid unnecessary delay in deciding which plan is primary and also to avoid making costly duplicate payments.
 - (c) The Plan's determination of which health plan is primary is modeled according to the guidelines provided by the National Association of Insurance Commissioners (NAIC).
 - (d) Special Provisions Relating to Medicaid. In determining or making any payment for a Beneficiary hereunder, eligibility for State provided medical assistance shall not be taken into account.
 - (e) Special Provisions Regarding Medicare. For those Beneficiaries with Medicare, this Plan will be a supplement to the Federal Medicare Program. For those Beneficiaries who are at least 65 years of age and are eligible for Medicare but who have not obtained Medicare, this Plan will pay only up to those amounts which would have been paid had Medicare been obtained. Where a Spouse is actively employed and covered under an employer group health plan, applicable Federal statutes will determine which plan is primary for the Spouse and retiree.
 - (f) Special Provisions Regarding Motor Vehicle Insurance Coverage.
 - (i) Any motor vehicle insurance coverage will be considered the primary plan and its benefits will be applied first. Before the Plan pays benefits for an Injury covered by motor vehicle insurance, the Beneficiary must provide the Claims Administrator with a list of the medical expenses that the motor vehicle insurance covered according to the date on which the expenses were incurred. The Claims Administrator will review the list of expenses to verify that benefit maximums are depleted. Upon verification of depletion, covered services received by the Beneficiary will be eligible for benefits in accordance with this Plan.
 - (ii) If another person caused the motor vehicle accident and the Beneficiary may recover damages pursuant thereto, any benefits for which the Beneficiary may be eligible shall be subject to the provisions of Section 18.3, Injury or Illness Involving Third Parties. Under Section 18.3, the Plan is not liable to pay any benefits for injuries caused by another person. However, the Plan may assist the Beneficiary by making an interest-free loan in the form of benefit payments once motor vehicle insurance benefits have been depleted as described in subparagraph (e)(i) above.
 - (g) For the purposes of enforcing or determining the applicability of this

Effective:
04/01/97
Adopted:
10/02/12

Section 18.2, the Participant, on his or her own behalf or on behalf of his or her Dependents:

- (i) will disclose all coverage under any "other plan";
- (ii) consents to the Claims Administrator or Trust Fund's releasing to any party or obtaining from any party any information which the Claims Administrator or Trust Fund deems necessary for such purposes;
- (iii) authorizes direct reimbursement to or from the "other plan" when such direct payment is appropriate and necessary to facilitate the coordination and adjustments of this Plan's and "other plan's" payments under this section; and
- (iv) will, upon request, execute and deliver such instruments or documents as may be required to satisfy the intent of this section.

18.3 Injury or Illness Involving Third Parties. If an Injury or illness of a Beneficiary is or may have been caused by another person or party and the Beneficiary has or may have a right to recover damages pursuant thereto, the Plan shall not be liable to pay any benefits. However, upon the execution and delivery to the Trust Fund of all documents it requires to secure the Trust Fund's rights of reimbursement, including without limitation, a Loan Agreement in the form attached hereto as Exhibit B, the Plan may pay benefits in connection with such Injury or illness. Such payment shall be considered only as an advance or loan to the Beneficiary. The Plan shall be reimbursed for 100% of this advance or loan, without any deduction for legal fees incurred or paid by the Beneficiary from any recovery received **by the Beneficiary or by any other person or party for the Beneficiary**, pursuant to such Injury or illness, including recovery from any under-insured or uninsured motorist coverage, even if the award or settlement does not make the Beneficiary whole or does not specifically include medical expenses. The Beneficiary promises not to waive or impair any of the rights of the Trust Fund without written consent. In addition, the Plan shall be reimbursed for any legal fees incurred or paid by the Trust Fund to secure reimbursement of the advance or loan.

Effective:
03/09/05
Adopted:
12/20/06

If the Plan pays any benefits because of such Injury or illness, the Trust Fund shall have reimbursement rights and shall have a lien **on that portion of any recovery obtained by the Beneficiary or by any other person or party for the Beneficiary, for such injury or illness which is due for said benefits paid by the Plan, without any deduction for legal fees incurred or paid by the Beneficiary from any recovery received pursuant to such injury or illness, including recovery from any under-insured or uninsured motorist coverage, even if the award or settlement does not make the Beneficiary whole or does not specifically include medical expenses,** including any legal fees incurred or paid by the Plan to secure reimbursement. Such lien may be filed with **the Beneficiary** his or her agent or insurance company, **any other person or party holding said recovery for the Beneficiary**, or the court; and such lien shall be satisfied from any recovery received by the **Beneficiary or by any other person or party for the Beneficiary**, however classified or allocated **or held**. If reimbursement is not made as specified, the Plan, at its sole option, may take any legal **and/or equitable** action to recover the amount

Effective:
03/09/05
Adopted:
12/20/06

that was paid for the Beneficiary's Injury or illness (including any legal expenses incurred or paid by the Plan) and/or may offset future benefit payments by the amount of such reimbursement (including any legal fees incurred or paid by the Plan).

- 18.4 Release of Information. By accepting benefits described in this Plan, the Beneficiary agrees that the Claims Administrator, Trust Fund or its designated representative (i.e., consultants or attorneys) may examine and copy the Beneficiary's medical records, including records containing mental health, substance abuse, and AIDS related information, for the purposes of:
- (a) administering the Plan between the Trust Fund and the Beneficiary;
 - (b) complying with government requirements; and
 - (c) bona fide research or education.

- 18.5 Authority to Authorize Changes. The Board of Trustees expressly reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time. Benefits provided under this Plan are not vested.

The authority to make any such changes to the Plan rests solely with the Board of Trustees. No individual Trustee, Union representative, or Employer representative is authorized to interpret this Plan on behalf of the Board of Trustees, or to act as an agent of the Board of Trustees.

SECTION 19
PRIVACY RELATED PROVISIONS RELATING TO PROTECTED HEALTH
INFORMATION

Effective:
04/14/03
Adopted:
03/12/03

- 19.1 Permitted Uses of Protected Health Information.
The trustees of the Trust Fund and/or appropriate employees of the Trust Fund's designated representatives may use or disclose protected health information of a Beneficiary for the purposes of treatment, payment or health care operations of the Plan without the consent of the Beneficiary, or as otherwise permitted by the HIPAA Privacy Rule. Any use or disclosure of protected health information by the trustees of the Trust Fund and/or appropriate employees of the Trust Fund's designated representatives will be generally limited to the minimum amount necessary to accomplish the intended purpose of the use or disclosure.
- 19.2 Persons Authorized to Access Protected Health Information.
Only trustees of the Trust Fund and/or appropriate employees of the Trust Fund's designated representatives will have the authority to access protected health information for the purpose of administering the Plan or processing claims for benefits under the Plan.
- 19.3 Impermissible Uses or Disclosures.
Any impermissible use or disclosure of protected health information by the Trust Fund or its designated representatives shall be reported to the Trust Fund's designated Privacy Official for appropriate handling in accordance with the policies and procedures established by the Trust Fund and applicable law.
- 19.4 Disclosure of Protection Health Information to the Fund.
The Plan will disclose protected health information to the Trust Fund only upon receipt of a certification that the plan documents have been amended to incorporate the agreement of the Trust Fund in the form attached as Exhibit A.
-

SECTION 20
NON-EMERGENCY INTER-ISLAND TRAVEL BENEFITS

Effective:
09/01/12
Adopted:
10/02/12

Subject to the provisions of this Plan, travel expenses related to medically necessary care required by Beneficiaries who reside in the State of Hawaii, but do not reside on the island of Oahu may be reimbursed as follows:

- 20.1 Non-Emergency Inter-Island Travel Reimbursement. A Beneficiary who resides in the State of Hawaii, but who does not reside on the island of Oahu, and who requires non-emergency medical services (for the diagnosis or treatment of an illness or injury) which are not available on the island where the beneficiary resides, may be reimbursed for qualified travel expenses to the island of Oahu related to obtaining the medically necessary care. The following benefit will be provided, subject to prior review and authorization by the Claims Administrator.
- (a) Reimbursement for air travel of up to \$200.00, or the actual cost of the fare, whichever is less.
 - (b) Reimbursement for taxi fare to and from the airport of up to \$50.00, or the actual cost of the fare, whichever is less, on the island of Oahu.
 - (c) Reimbursement for qualified travel expenses for one accompanying parent or guardian up to the benefit limitation if the Beneficiary seeking inter-island travel benefits is a minor Child under 18 years of age.