State of Hawaii Employer-Union Health Benefits Trust Fund

Supplemental Medical and Prescription Drug Reimbursement Plan

July 1, 2018

ARTICLE I. INTRODUCTION

1.1 Establishment of Plan

The Board of Trustees of the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) hereby establishes a self-funded Supplemental Medical and Prescription Drug Reimbursement Plan (the "Plan") to be effective as of the Effective Date specified in Section 2.1(e) below.

This Plan is intended to permit an Eligible Employee to obtain reimbursement of Eligible Medical Expenses on a nontaxable basis.

1.2 Legal Status

This Plan is intended to qualify as a medical reimbursement plan under Code Section 106 and regulations issued thereunder, and the eligible medical expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees' gross income under Code Section 105(b).

This Plan, as established will comply with all rules as contained within the EUTF Administrative Rules and all amendments thereto. In the event there is a conflict between this document and the EUTF Administrative Rules, the EUTF Administrative Rules will govern.

ARTICLE II. DEFINITIONS

2.1 Definitions

(a) **"Benefits"** means the reimbursement benefits for Eligible Medical Expenses set forth in Article V.

(b) **"Code"** means the Internal Revenue Code of 1986, as amended.

(c) **"Covered Individual"** means a Participant, Spouse or Dependent.

(d) **"Dependent"** means any individual who is a dependent of a Participant as defined the EUTF Administrative Rules as eligible.

(e) **"Effective Date"** means the Effective Date, July 1, 2018.

(f) **"Electronic Protected Health Information"** has the meaning described in 45 C.F.R. 160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic format. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment or disenrollment information and summary health information.

(g) **"Eligible Employee"** means an Employee eligible to participate in this Plan, as provided in Section 3.1.

(h) **"Eligible Medical Expenses"** means those expenses incurred by the Employee, or the Employee's Spouse or Dependents, that are eligible for reimbursement, as determined by the schedule of benefit and in accordance with Article V. For purposes of this Plan, an expense is "incurred" when the Participant or Covered Individual is furnished the medical care or services giving rise to the claimed expense. However, the following shall not be considered as being eligible

expenses:

- a medical expense incurred before the Employee first becomes enrolled in the Plan; or
- medical expenses incurred before the Plan is in existence.

(i) **"Employee"** means an individual who meets the requirements as described in Section 3.1 as being eligible to participate in this Plan.

(j) **"Health Insurance Plan"** means the individual or association group health insurance policies or plan(s) purchased by, and covering Eligible Employees, excluding those policies or plans that may be sponsored by the EUTF.

(k) **"Highly Compensated Individual"** means an individual defined under Code Section 105(h), as amended, as a "highly compensated individual" or "highly compensated employee."

(l) **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended.

(m) **"Participant"** means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III and in accordance with the EUTF Administrative Rules.

(n) **"Period of Coverage"** means the Plan Year, during which period the Benefits provided by this Plan shall be available to a Participant hereunder, with the following exceptions:

(a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.1; and

(b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.2.

(o) **"Plan"** means this instrument, including all amendments and attachments thereto.

(p) **"Plan Administrator"** means the EUTF or other third party appointed by the EUTF who has the authority and responsibility to manage and direct the operation and administration of the Plan.

(q) **"Plan Year"** means the annual accounting period of the Plan, July 1 through June 30 of each year.

(r) **"Protected Health Information"** shall have the meaning described in 45 C.F.R. 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

(s) **"QMCSO"** means a Qualified Medical Child Support Order, as defined in ERISA Section 609.

(t) **"Spouse"** shall have the meaning as contained in the EUTF Administrative Rules.

(u) **"Uniformed Services"** means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President of the United States in time of war or emergency.

(v) **"USERRA"** means the Uniformed Services Employment and Reemployment

Rights Act of 1994, as amended.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

Any individual who is defined as eligible within the EUTF Administrative Rules Section 3.01.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

- the termination of this Plan; or
- the date on which the Participant ceases to be eligible in accordance with the EUTF Administrative Rules.

3.3 Termination of Participation for an Eligible Spouse or Dependent

A participant dependent spouse or child shall terminate coverage according to the EUTF Administrative Rules Section 4.12.

ARTICLE IV. BENEFITS OFFERED AND METHOD OF FUNDING

4.1 Description of Benefits Offered

Benefits contained within this plan are as described in Appendix A.

4.2 Funding of the Plan

All of the amounts payable under this Plan shall be paid from the general assets of the EUTF. Nothing herein will be construed to require the EUTF Board of Trustees or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the EUTF from which any payment under this Plan may be made.

ARTICLE V. BENEFITS

5.1 Benefits

The Plan will reimburse Participants for Eligible Medical Expenses up to the schedule of benefits, contained in Appendix A.

Each Participant in the Plan shall be entitled to Benefits hereunder for all Eligible Medical Expenses incurred by the Participant on or after the effective date of his or her participation (and after the Effective Date of the Plan), subject to the limitations contained in this Appendix A, regardless of whether the mental or physical condition for which the Participant makes application for Benefits under this Plan was detected, diagnosed or treated before the Participant became covered by the Plan.

5.2 Eligible Medical Expenses

Under the Plan, a Participant may receive reimbursement for Eligible Medical Expenses incurred during a Period of Coverage according to the schedule of benefits contained in Appendix A.

Eligible Medical Expenses can only be reimbursed to the extent that the Covered Individual incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Health Insurance Plan, other insurance, or any other accident or health plan. If only a portion of Eligible Medical Expenses has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes co-payment or deductible limitations), this Plan can reimburse the remaining portion of such Eligible Medical Expenses if it otherwise meets the requirements of this Article V.

5.3 Nondiscrimination Requirements

To the extent that the Plan is considered a self-insured medical expense plan under Treasury Regulation Section 1.105-11, the Plan must comply with the nondiscrimination requirements as set forth under Code Section 105(h). Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code Section 105(h), as may be determined by the Plan Administrator in its sole discretion.

5.4 Reimbursement Procedure

(a) General Requirements. No Benefit shall be paid hereunder unless a Participant has first submitted a written Claim for Benefits to the Plan Administrator on a form specified by the Plan Administrator and pursuant to the procedures set forth below. Upon receipt of a properly documented claim, the Plan Administrator shall pay the Participant the Benefits provided under this Plan as soon as is administratively feasible. A Participant may submit a claim for reimbursement for an Eligible Medical Expense arising during the Period of Coverage at any time during the period that begins when the expense is incurred.

A Participant may not submit a claim that is attributable to a deduction under Code Section 213 for any prior taxable year or any claim that was incurred before the individual became eligible for coverage under this Plan, or which has already been paid through any other Health Insurance Plan, Section 125 "cafeteria" plan or other similar medical expense reimbursement arrangement.

All reimbursement claims must be submitted to the Plan Administrator within 180 days of the close of the Plan Year during which any such expense was incurred in order to be eligible for reimbursement.

(b) Timing. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Plan will reimburse the Participant for the Covered Individual's Eligible Medical Expense (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied (see Article VII regarding procedures for claim denials and appeals procedures). This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the

Participant 45 days in which to complete an incomplete reimbursement claim.

(c) Claims Substantiation. A Participant who seeks Benefits may apply for reimbursement by submitting required forms to the Plan Administrator in such form as the Plan Administrator may prescribe, setting forth:

- the nature and date of the expenses so incurred;
- the amount of the requested reimbursement; and
- the person for whom the reimbursement is being sought.

The application shall be accompanied by bills, invoices, Explanation of Benefits (EOB) or other statements from an independent third party showing that the Eligible Medical Expenses have been incurred and the amounts of such Eligible Medical Expenses, together with any additional documentation that the Plan Administrator may request.

(d) Claims Denied. For reimbursement claims that are denied, see the appeals procedure in Article VII.

5.5 Reimbursements After Termination of Employment or Failure to Satisfy the Plan's Eligibility Requirements

Coverage under this Plan shall cease immediately upon any one of the following events:

(a) A Participant no longer meets the eligibility requirements of the Plan

(b) According to the terms in EUTF Administrative Rules Section 4.12.

Such Participant shall have the right to submit a claim for reimbursement and receive Benefits hereunder for any Eligible Medical Expense incurred during the Period of Coverage while the Participant was covered under the Plan at any time prior to the expiration of the 180 days following the date the Participant ceased to meet the eligibility requirements of the Plan.

5.6 USERRA

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, and, in accordance with the EUTF Administrative rules, coverage will be reinstated in the Plan.

ARTICLE VI. HIPAA PRIVACY AND SECURITY

6.1 EUTF's Certification of Compliance

The Plan shall not disclose Protected Health Information to the EUTF unless the EUTF certifies that the Plan document incorporates the provisions of 45 CFR 164.504(f)(2)(4), and that the EUTF agrees to conditions of disclosure set forth in this Article VI.

6.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the EUTF information on whether an individual is participating in the Plan.

6.3 Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to the EUTF, provided that the EUTF requests Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

"Summary Health Information" means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Insurance Plan; and (2) from which the information described at 42 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a 5-digit ZIP code.

6.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes

Unless otherwise prohibited by law, the Plan may disclose a Covered Individual's Protected Health Information to the EUTF, provided that the EUTF will use or disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the EUTF on behalf of the Plan such as quality assurance, claims processing (including appeals), auditing, and monitoring. Plan administrative functions do not include functions performed by the EUTF in connection with any other benefit or benefit plan of the EUTF, and they do not include any employment-related functions. Any disclosure to, and use by the EUTF of a Covered Individual's Protected Health Information will be subject to, and consistent with the provisions of this Article VI (including, but not limited to, the restrictions on the EUTF's use and disclosure described in 6.5) and the specifications and requirements of the Administrative Simplification provisions of Title II, Subtitle F of HIPAA and its implementing regulations at 45 C.F.R. Parts 160-64.

6.5 Restrictions on Use and Disclosure of Protected Health Information

(a) The EUTF will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by the Plan document, or as required by law.

(b) The EUTF will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply with respect to the Protected Health Information or Electronic Protected Health Information, respectively.

(c) The EUTF will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the EUTF.

(d) The EUTF will make Protected Health Information available to the Plan or to the Covered Individual who is the subject of the information in accordance with 45 C.F.R. 164.524.

(e) The EUTF will make a Covered Individual's Protected Health Information available for amendment and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 C.F.R. 164.526.

(f) The EUTF will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 C.F.R. 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528.

(g) The EUTF will make its internal practices, books and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the Plan available to the United States Department of Health and Human Services to determine compliance with the HIPAA as set forth in 45 C.F.R. Part 164, Subpart E.

6.6 Security Measures for Electronic Protected Health Information

The EUTF will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of a Covered Individual's Electronic Protected Health Information that the EUTF creates, receives, maintains or transmits on the Plan's behalf.

ARTICLE VII. APPEALS PROCEDURE

7.1 Procedure If Benefits Are Denied Under This Plan

Any claim for Benefits shall be made to the Plan Administrator. Appeals for denied benefits shall follow the EUTF Administrative Rules, Section 2.06 of the Hawaii Employer-Union Health Benefits Trust Fund.

ARTICLE VIII. RECORDKEEPING AND PLAN ADMINISTRATION

8.1 Plan Administrator

Except as to the functions reserved within the Plan, the administration of this Plan shall be under the supervision of the EUTF Board of Trustees. It is the principal duty of the Plan Administrator to see that this Plan is carried out in accordance with its terms for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

8.2 Powers of the Plan Administrator

The Plan Administrator shall have such authority and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right (except as to matters reserved to the EUTF Board of Trustees or which the EUTF Board of Trustees may reserve to itself) to interpret the Plan and to decide all matters thereunder, including the right to remedy possible ambiguities, inconsistencies or omissions. All determinations made by the EUTF Board of Trustees with respect to any matter hereunder shall be conclusive and binding on all persons.

8.3 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the EUTF Board of Trustees, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan and in accordance with the contract between the Plan Administrator and the EUTF.

8.4 Disbursement Reports

The Plan Administrator shall issue directions to the EUTF concerning all Benefits which are to be paid from the general assets of the EUTF pursuant to the provisions of the Plan.

8.5 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of Benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code Section 106, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the reimbursements to which he or she is properly entitled under the Plan.

ARTICLE IX. GENERAL PROVISIONS

9.1 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the EUTF Board of Trustees may amend or terminate all or any part of this Plan at any time for any reason by resolution of the EUTF Board of Trustees or by any person or persons authorized by the EUTF Board of Trustees to take such action.

9.2 Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of Hawaii, to the extent not superseded by the Code or any other federal law.

9.3 Code Compliance

It is intended that this Plan meet all applicable requirements of the Code, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code and shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

9.4 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the EUTF makes any commitment or guarantee that any amounts paid to, or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is

excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

9.5 Source of Payments

The EUTF shall be the sole source of Benefits under the Plan. No Participant or Covered Individual shall have any right to, or interest in, any assets of the EUTF upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Participant or Covered Individual.

9.6 Mental or Physical Incompetence

If the Plan Administrator determines that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, the Plan Administrator may cause all payments thereafter becoming due to such person to be made to any other person for his benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section 9.7 shall completely discharge the Plan Administrator and the EUTF.

9.7 Payments to Beneficiary

Any Benefits otherwise payable to a Participant following the date of death of such Participant shall be paid to his or her Spouse, or, if there is no surviving Spouse, to his or her estate, but only to the extent such Benefits are related to Eligible Medical Expenses incurred by the Participant or his or her eligible Dependents prior to his or her date of death.

9.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

9.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and shall not be construed as defining or limiting the meaning or construction of any provision.

9.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

9.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

Adopted this date: JUL -1 2018

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND:

Administrator: _____

Chair: _____

APPROVED AS TO FORM:

_____
Deputy Attorney General

Appendix A

EUTF Supplemental Medical & Prescription Drug Plan

This EUTF supplemental plan provides reimbursement of eligible out-of-pocket medical and prescription drug expenses for active employee-participants who are primarily covered under a non-EUTF health plan. All covered services must first be paid by your primary medical and prescription drug plan prior to receiving any supplemental plan reimbursements for any copayment and/or coinsurance for eligible medical and drug expenses up to your plan year benefit maximums.

Schedule of Benefits	
Plan Year	July 1, 2018 through June 30, 2019.
Plan Type	Group supplemental medical and prescription drug plan is a secondary payer.
Plan Year Benefit Maximum	$2,750 per covered participant Prescription Drug Sublimit: $250
Prescription Drug Benefit	The maximum reimbursement for prescription drug copayment charges is $20 per 30-day supply, $40 per 60-day supply, and $60 per 90-day supply. Reimbursements for prescription drug copayment charges shall not exceed $250 per plan year per covered participant. Reimbursements for prescription drug copayments count towards the $2,750 Plan Year Maximum.
Eligible Medical Expenses	Those out-of-pocket medical, hospital and surgical expenses listed under Covered Expenses. Some exclusions apply (see plan exclusions list on next page).

Covered Expenses

The following medical, hospital, surgical care, physician and ancillary expenses are eligible under this supplemental plan:

Preventive Services
- Colorectal Screening
- Immunizations
- Newborn and Well-Baby Care
- Prostate Screening
- Routine Mammogram
- Routine Office Visit/Exam (One Per Year)
- Routine Pap Smear
- Routine Well-Woman Exam

Testing
- Allergy Testing
- Diagnostic Laboratory and Pathology
- Radiology, CT Scans, Ultrasound and Nuclear Medicine

Chemotherapy and Radiation Therapy

Hospital and Facility Services
- Ambulatory Surgical Center
- Birthing Center
- Emergency Room
- Inpatient Anesthesia Services
- Inpatient Hospital Room and Board
- Outpatient Hospital Ancillary Services
- Skilled Nursing Facility

Physician Services
- Consultations
- Office, hospital and emergency room visits
- Physician Assistants and Nurse Midwives working under the direct supervision of a physician
- Routine Obstetrical Care
- Surgeon, assistant surgeon and anesthesia

Other Services
- Ambulance
- Appliances and Braces
- Behavioral Health Services (In and Outpatient)
- Cardiac Rehabilitation (Short-Term)
- Dialysis and Related Supplies
- Durable Medical Equipment
- Home Therapies and Home Health Care
- Hospice Care
- Inhalation (or Respiratory) Therapy
- Injections
- Physical Therapy
- Prosthetics
- Speech Therapy
- Tissue and Organ Transplants

Plan Exclusions List

This EUTF supplemental plan does not pay for taxes, your primary group health plan's deductible or enrollment fees, services not specified as Covered Expenses, and services or benefits not paid by your primary group health plan. Any charges after reaching the plan maximum in your primary group health plan are excluded from reimbursement. Plan exclusions include but are not limited to the following:

- Acupuncture
- Aromatherapy
- Behavior testing
- Benefits not covered by your primary group health plan
- Biofeedback
- Bionic devices
- Blood or blood products
- Charges for donor sperm or ova
- Charges in excess of the eligible/allowable rates negotiated between any group health/medical plan and the provider or entity providing the service to the employee-beneficiary
- Chiropractic
- Complications of a non-covered procedure
- Cosmetic surgery
- Cost of storing or processing sperm
- Counseling for Bereavement, Genetic, Sexual Identification
- Custodial care
- Dental Care Services
- Disposable take home supplies
- Expenses or care for cosmetic surgery performed mainly to change a person's appearance
- Expenses or care that are not medically necessary or not prescribed by a licensed physician
- Expenses exceeding the maximum benefit amount allowed under this plan or your primary group health plan
- Expenses incurred after your termination date of this plan
- Expenses incurred prior to your coverage effective date of this plan
- Expenses not listed (eligible) under Covered Expenses in this plan.
- Expenses paid or payable under any other source including insurance plan/policy
- Experimental or investigational services
- Eye exams, eye exercises
- Eyeglasses; corrective lenses
- Fertility/Infertility
- Gender reassignment
- Government covered services (Medicaid, Medicare, QUEST)
- Group health plan deductibles that you have to satisfy in your primary group health plan
- Hair loss
- Hearing aids
- Homemaker services
- Hypnotherapy
- Massage therapy
- Naturopathy
- Oral travel immunizations/medications
- Over the counter drugs
- Personal convenience items
- Photo-refractive keratectomy
- Physical Examinations Related to
  - Employment
  - Insurance
  - Licensing
  - Court-order such as parole or probation
- Prescription drug charges in excess of the benefit maximum or annual prescription drug benefit maximum
- Provider is an Immediate Family Member
- Radial keratotomy
- Rest cure
- Reversal of voluntary sterilization
- Routine foot care (unless medically necessary)
- Self-help or self-cure
- Services for which the patient has no responsibility to pay due to:
  - Military or service-related condition
  - Workers' Compensation liability
  - Automobile related condition
- Services not medically necessary
- Sleep therapy
- Stand-by time
- Transplants
  - Services for or transportation of a living donor
  - Mechanical or non-human organs
  - Organ purchase
- Travel and lodging cost
- Weight reduction programs
- Wigs