QSI, Inc. DBA TIMES SUPER MARKET

(ACTIVES)

Times Super Market Enhanced Medical, Prescription Drug, and Vision Plan

Effective January 1, 2022

This is the plan document and summary plan description (SPD) for the Times Super Market Enhanced Medical, Prescription Drug, and Vision Plan ("Plan"). The Plan is a self-insured medical option which is made available by QSI, Inc. dba Times Super Market ("Company") to participants in the Times Super Market Health & Welfare Plan.

In accordance with all applicable policies of the Company, the Employees and any Dependents enrolled in the Plan are entitled to medical, surgical, hospital, prescription drug and vision benefits according to the terms, conditions and limitations set forth below.

SECTION 1
ELIGIBILITY AND ENROLLMENT

1.1 Participants. Coverage under the Plan is available to ILWU and non-bargaining employees working 20 hours or more per week for four (4) consecutive weeks. Coverage is effective the first of the month following four consecutive weeks of employment. Enrollment under the Plan shall terminate upon an employee's becoming a collectively bargained employee (excluding ILWU), failing to meet the work hours specified, or termination of the Plan. No other person is eligible to participate, including non-ILWU collectively bargaining employees, casual part-time employees working less than 20 hours per week, and any person not carried as an employee on the Company's payroll, regardless of whether such person's status is later re-determined to be that of an employee by the Internal Revenue Service or other Federal or State regulatory authority.

1.2 Dependents. The Spouse and Children under 26 years of age of an Eligible Employee are eligible for coverage under this Plan. Such individuals will be referred to as, "Dependents."

Coverage is available to a child under age 26 without regard to any other criterion, including marital status, dependency upon a parent (or anyone else) for financial support, disability, residency with a parent, or full-time student status. A Child's own spouse or children do not qualify for coverage. The Employee must enroll a Dependent within 30 days of the date of the Dependent's eligibility. If a Spouse or Dependent is not enrolled within 30 days of the date of eligibility, he or she may not be enrolled until the next open enrollment period, which is held once a year, generally during the month of October. If a Dependent is covered under a plan other than the Plan and he/she subsequently loses coverage, such Dependent may be enrolled within 30 days of the loss of coverage in this Plan. If the Dependent is not enrolled within the 30-days of this qualifying event, he/she may not be enrolled until the next open enrollment period.

(a) Non-Eligible Spouse or Dependent –
Eligible Dependents do not include:

- a spouse following legal separation or a final decree of dissolution of marriage or divorce (including any children of the spouse who were eligible only because of the marriage),
- any person who is on active duty in a military service, to the extent permitted by law,
- any person who is enrolled as an employee, or
- any person who is covered as a dependent of another employee (i.e., children may

not be covered by both parents if both parents are eligible for coverage under this Plan).

1.3 Coverage under this Plan shall terminate upon the earliest of the following events:

(a) For the Employee – Except as otherwise provided in the insurance certificate, your coverage under the Company sponsored insurance programs ends the last day of the month in which employment terminates. If an employee becomes disabled while covered under the Company sponsored insurance programs, his/her coverage will continue for a period of up to twelve (12) months. The Employer requires the disabled employee to provide proof of disability. If the employee does not return to work after 12 months of the approved disability leave, he/she will be given the option to continue coverage through COBRA.

(b) For the Employee's Spouse - upon the Employee's termination of coverage or upon the dissolution of the marriage.

(c) For the Employee's Child - upon the Employee's termination of coverage, or the Child attainment of 26 years of age, unless such Child meets the provisions of Section 1.4.

1.4 If a Child, upon reaching 26 years of age, is incapable of self-sustaining employment because of mental retardation or physical handicap, is chiefly dependent upon the Employee for support and maintenance, and is unmarried, the Child shall be allowed to continue coverage under this Plan so long as the Child continues to be incapacitated, dependent, and unmarried. The Employee must furnish written evidence of such incapacity, dependency, and marital status to the Employer within 30 days of the Child's reaching 26 years of age, and at any time thereafter as requested by the Employer. The Child's coverage shall terminate when the Employee's coverage terminates or when the Child marries or is no longer incapacitated and dependent.

(a) A child's status as a "Dependent" will continue after age 26 if he/she is:

- unmarried;
- primarily dependent on the Employee for support; and
- continues to meet the following conditions, as defined by Section 12102 of the Americans with Disabilities Act (ADAAA):
  - (i) a physical or mental impairment that substantially limits one or more major life activities of such individual,
  - (ii) a record of such an impairment or being regarded as having such an impairment.

  In accordance with ADAAA, the term disability shall not include transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments or other sexual behavior disorders, compulsive gambling, kleptomania or pyromania, or psychoactive substance use disorders resulting from current illegal use of drugs

1.5 The Employee shall inform the Employer in writing, if a Spouse or Dependent ceases to be eligible for benefits on or before the first day of the month following the month in which eligibility ceases. If the Employee fails to inform the Employer of the Spouse or Dependent's ineligibility, and the Plan makes payments for services to the ineligible Spouse or Dependent, the Employee 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 Employee shall notify the Employer within 21 days. Coverage for such Child shall terminate on the first day of the month following the date of notification or the date when notification should have been given.

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

1.7 **LIMITED ENROLLMENT EXCEPTIONS**

The following section outlines circumstances that may extend or limit the "normal" enrollment conditions.

(a) Qualified Medical Child Support Order (QMCSO)

Under certain circumstances, in compliance with federal law, QSI, Inc. dba Times Super Market provides immediate coverage for your children when you and your spouse divorce. The process begins when QSI, Inc. dba Times Super Market receives a QMCSO. A QMCSO is any valid judgment, decree or order, including approval of a settlement agreement, that:

- comes from a court of competent jurisdiction pursuant to a state's domestic relations law,
- requires you to provide group health coverage available under the plans for your children, even though you no longer have custody, and clearly specifies:
- your name and last known mailing address and the names and addresses of each child covered by the order,
- a reasonable description of the coverage to be provided,
- the length of time the order applies, and
- each plan affected by the order.

If the QMCSO meets the above requirements, the Plan will provide a written notification to you, and each child identified in the court order, of eligibility requirements under the plans. This notice will include any required enrollment material, a description of the procedures to be followed and a form for designating the child's custodial parent or legal guardian as his/her representative for all plan purposes. The child's custodial parent, legal guardian or a state agency can apply for coverage even if you do not. If you have any questions about any of these requirements or would like to obtain a copy of QMCSO procedures, contact your Human Resources Department.

(b) Reinstatement / Rehire

If you return to active employment and eligible status following an approved leave of absence in accordance with the company's guidelines and the Family and Medical Leave Act (FMLA), and during the leave you discontinued paying your share of the cost of coverage causing coverage to terminate, you may have coverage reinstated as if there had been no lapse (for yourself and any dependents who were covered at the point contributions ceased). The Plan will have the right to require that unpaid coverage contribution costs be repaid. In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain employees who return to active employment following active duty service as a member of the United States armed forces will be reinstated to coverage under the plan immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Plan.

- If you are laid off but rehired within the same Calendar month: Your participation will resume on the date of rehire with the same coverage elections you had prior to termination.
- If you are laid off but rehired in a subsequent Calendar month but less than six months after the date of termination: Your participation will resume on the first of the month in which you are rehired.
- Any terminated Employee who is rehired more than six months after termination will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

(c) Marriage –

Changing Coverage During the Year

Change In Status Events: As provided by the Internal Revenue Code **Enrollment Requirements**: You may change (enroll/drop) coverage **within 30 days** of the following **events:**

- Change in your legal marital status, including marriage, death of your spouse, divorce, legal separation or annulment.
- Change in the number of your dependents, including birth, adoption, placement for adoption or death of your dependent.
- Change in your employment status, including termination or commencement of employment of you, your spouse or your dependent.

- Change in work schedule for you or your spouse, including an increase or decrease in the number of hours of employment or commencement or return from an unpaid leave of absence.
- Your dependent satisfies or no longer meets the eligibility requirements (e.g., age) as described under *Sections 1.2 and 1.4.*
- A change in the place of residence or worksite of you or your spouse (***Note****: This move must affect your coverage options).*
- You, your spouse or your dependents lose COBRA coverage.
- You, your spouse or your dependents enroll for Medicare or Medicaid or lose coverage under Medicare or Medicaid.
- If the plan receives a decree, judgment or court order, including a QMCSO pertaining to your dependent, you may add the child to the plan (if the decree, judgment or court order requires coverage) or drop the child from the plan (if the ex-spouse is required to provide coverage).
- A significant change in benefit or cost of coverage for you or your spouse.
- Your spouse's employer provides the opportunity to enroll or change benefits during an open enrollment period.

Special Enrollment Rights: As provided by HIPAA	**Enrollment Requirements**: You must change (enroll/drop) coverage within:
You initially declined coverage under the plan because you had coverage under another plan, and subsequently incurred a loss of coverage under the other plan, including COBRA coverage	30 days of the event
Occurrence of certain events such as birth, adoption, placement for adoption or marriage	30 days of the event
Eligibility for state premium subsidies under the Children's Health Insurance Program or State Children's Health Insurance Program	60 days of the event
Loss of coverage under Medicaid, the Children's Health Insurance Program or State Children's Health Insurance Program	60 days of the event

SECTION 2
DEFINITIONS

2.1 "Beneficiary" means any Employee, Spouse or Dependent covered by this Plan.

2.2 "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.

2.3 "Certified IDR Entity" means an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasure.

2.4 "Child" means the Employee's
(a) natural child;

(b) adopted child or child placed in the home in anticipation of adoption or a child for whom the Employee acts as a court appointed guardian;
(c) stepchild; or
(d) any other child who is dependent upon the Employee for support as attested by income tax information and lives with the Employee in a parent-child relationship.

2.5 "Claims Administrator" means such person or persons contracted by the Employer to process and pay claims as provided under this Plan.

2.6 "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.

2.7 “Clinical Social Worker” means a person licensed in the practice of social work and certified in clinical social work by a recognized national organization.

2.8 "Copayment" is the fixed amount the Beneficiary pays to the provider of services.

2.9 “Deductible” is the amount a Beneficiary has to pay out-of-pocket before the plan will cover the cost for medical services. See Section 4.

2.10 "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.

2.11 "Dependent" means the Employee’s Spouse and each Child eligible for coverage pursuant to Section 1.2 or 1.4.

2.12 "Effective Date" means the date on which a person is accepted as a Beneficiary, as established and recorded by the Employer, 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.

2.13 "Eligible Charge" means the charge determined by the Employer according to the criteria in Section 3.7 and is the charge used to calculate the benefit payment for a covered service.

2.14 “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

2.15 “Emergency Services” mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Beneficiary is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such

time as the Provider determines that the Beneficiary is able to travel using non-medical transportation or non-emergency medical transportation, and the Beneficiary is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

2.16 "Employee" means a non-collectively bargained employee who is carried as such on the Employer's payroll. A person is eligible for coverage as an Employee under this Plan only upon such person's execution of the enrollment card and its acceptance by the Employer.

2.17 "Employer" means QSI, Inc. dba Times Super Market or its Designated Representative

2.18 "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.

2.19 "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.

2.20 "Independent Freestanding Emergency Department is a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services

2.21 "Injury" means a physical damage 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.

2.22 "Maximum Allowable Charge" shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see Section 3.10 "No Surprises Act – Emergency Services and Surprise Bills") if no negotiated rate exists, the Maximum Allowable Charge will be the Qualifying Payment Amount (QPA), or an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

2.23 "Mid-Wife" is a health care professional who provides services such as pre and post natal care normal delivery services, routine gynecological services and any other services within the scope of his/her certification.

2.24 "Other Providers" are recognized as midwives, advanced practice registered nurses and physician assistants.

2.25 “Participating Health Care Facility” shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

2.26 "Participating Provider" means a provider of services who agrees with the Employer or Claims Administrator that his or her fee to a Beneficiary for a service covered by this Plan shall not exceed the Eligible Charge for that service.

2.27 "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.)

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

2.28 "Plan" means this document.

2.29 “Plan Administrator” means the Employer.

2.30 ”Plan Sponsor” means the Employer.

2.31 “Preventive Care” means certain Preventive Care Services to comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;

https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;

https://www.hrsa.gov/womensguidelines/.

For more information, Participants may contact the Plan Administrator / Employer.

2.32 "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.

2.33 "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.

2.34 “Qualifying Payment Amount” (QPA) means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan’s Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount

will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

2.35 “Recognized Amount” shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider’s billed charge or the Qualifying Payment Amount.

2.36 "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.

2.37 "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.

2.38 "Spouse" means a person who is lawfully married to the Employee and is qualified as a spouse in accordance with the Internal Revenue Code.

2.39 "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.

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, Licensed Mental Health and Substance Abuse Counselor, Marriage Family Therapist, Practice Registered Nurse, 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 license, and are approved by the Claims Administrator or Employer, will be covered. Benefits may be available for services rendered by other providers as shown in specific sections of this Plan. A list of participating providers is furnished automatically upon enrollment and without charge.

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 Employee is responsible for ensuring that the provider furnishes this report to the Claims Administrator, on the forms prescribed by the Claims Administrator, 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.

Effective January 1, 2010, payment of claims for services rendered by a Veterans Administration Medical Center and/or Uniformed Military Services Facility shall be adjudicated (processed) on a Participating Provider basis using the comparable Participating Provider Eligible Charge, but in no event shall the Plan pay the Veterans Administration Medical Center and/or Uniformed Military Services Facility any differently than the Plan’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) Non-Participating Provider. The Claims Administrator or Employer has no agreement with Non-Participating Providers, and they may charge the Plan's Beneficiaries more than the Eligible Charge for any service. The Plan's benefit payments for services rendered by Non-Participating Providers will be a specified portion or percentage of the Eligible Charge for the service. For services by a Non-Participating 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 Non-Participating Provider:

(i) are assignable;

(ii) shall be made by the Plan, in its sole discretion, directly to the Employee or to the Dependent or, in the case of the Employee'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 like services rendered.

(c) Effective January 1, 2022 - No Surprises Act - If a Beneficiary receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Beneficiary receives such item or service in reliance on that information, the Beneficiary's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

3.4 Reimbursement for Services. If a Beneficiary has paid for services covered by this Plan the Employee will be reimbursed in accordance with the terms of this Plan. To receive payment for such services, an Employee 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 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 Claims Administrator 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 Federal government health plans.

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 Claims Administrator 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 Non-Participating 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 Claims Administrator, or

b. the actual charge for the service.

(iii) The Eligible Charge for a covered service rendered by a Non-Participating 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 Claims Administrator, 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 Hawaii are based on the Eligible Charges for the same or comparable services rendered in Hawaii. If services are received from Non-Participating Providers, the member will be responsible for the co-payment and any amount that exceeds the reasonable and customary charges and taxes.

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 Employee 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 Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan member's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Beneficiary is entitled to them.

3.10 No Surprises Act – Emergency Services And Surprise Bills. For Non-Network claims subject to the No Surprises Act ("NSA"), Beneficiary cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Beneficiaries for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Beneficiary has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or Beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or Beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

3.11 Continuity Of Care**.** In the event a Beneficiary is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Beneficiary shall have the following rights to continuation of care.

The Plan shall notify the Beneficiary in a timely manner, but in no event later than 30 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that the Beneficiary has rights to elect continued transitional care from the Provider. If the Beneficiary elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Beneficiary ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Beneficiary if the Provider pursues a balance bill.

3.12 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 notify the Claims Administrator in the manner prescribed by 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 benefits, the Claims Administrator 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 24 hours of its receipt. The Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator must provide notice to the Beneficiary oral, 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 Claims Administrator may extend the time to respond to the Beneficiary by fifteen (15) days, if circumstances exist beyond the Claims Administrator's control that interfere with the timely determination of the claim, or if information necessary to complete the claim is missing. The Claims

Administrator 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 Claims Administrator expects to render a decision. The Claims Administrator 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 Claims Administrator may extend the time to respond to the Beneficiary by fifteen (15) days, if circumstances exist beyond the Claims Administrator's control that interfere with the timely determination of the claim, or if information necessary to complete the claim is missing. The Claims Administrator 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 Claims Administrator 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.

a.) Non-Urgent Care: If a Beneficiary is receiving ongoing treatment under the Plan, the Claims Administrator must provide advance notice of any determination to terminate or reduce the Beneficiary's treatment. The Claims Administrator 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.

b.) Urgent Care: Any claim a Beneficiary makes which involves both urgent care and a continuing course of treatment previously approved by the Claims Administrator, must be decided as soon as possible, given the urgency of the medical conditions involved. The Claims Administrator 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.

(c) Notice of Initial Benefit Determination. When the Claims Administrator makes an adverse benefit determination, the Claims Administrator 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 Claims Administrator 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;

(iii) 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 Employer or Claims Administrator. 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 Employer or Claims Administrator for review. A participant has 180 days from the date the Beneficiary's initial claim was processed to request this review. Any determination made by the Employer or Claims Administrator 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 Claims Administrator or Employer processed the Beneficiary's initial claim will be denied.

(e) Decision making on Appeals.

(i) Appeal of Urgent Care Claims. If the Beneficiary is appealing an urgent care claim, the Employer or Claims Administrator must allow the Beneficiary to submit either an oral or written request for appeal. The Employer or Claims Administrator 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 24 hours from the time the appeal is received.

(ii) Appeal of Pre-Service Claims. If the Beneficiary is appealing a pre-service claim, the Employer or Claims Administrator 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 Employer or Claims Administrator 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 Employer or Claims Administrator, with no preferential treatment given to the initial determination. The Employer or Claims Administrator 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 Employer or Claims Administrator 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 Employer or Claims Administrator 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.

(j) Requesting an Independent External Review

(i) Once the internal appeal process is exhausted, if not satisfied with the response of the Employer or Claims Administrator to the appeal, the Beneficiary has the right to an External Review of an adverse appeal decision. Generally such adverse appeal decisions are based on a determination that the services were experimental, investigational, or unproven health care or that there was a lack of medical necessity for the proposed or performed medical, surgical, or traumatic dental services involved, but may be related to other adverse appeal decisions.
(ii) The external review will be made by an independent review organization (IRO) with health care professionals who have no conflict of interest with respect to the benefit determination.
(iii) To request an external review, the Beneficiary must submit the request in writing within 4 months (120 days) after date of receipt of notice of an adverse determination.
(iv) Upon request, the Claims Administrator will provide a copy of the full independent external review policy and procedure, including information on how to initiate an appeal, and the contact information for any applicable health insurance consumer assistance or ombudsman established by law to assist individuals with the internal claim and appeal processes and external review processes.
(v) The external, independent reviewer's decision is legally binding on the Beneficiary and Claims Administrator even if there is disagreement with the decision.

3.13 Dialysis Benefit Preservation Program (the "Dialysis Program") – Outpatient Dialysis Treatment

1. Outpatient Dialysis Treatment. When used in this document, the term "Outpatient Dialysis Treatment" shall mean any and all products, services, and/or supplies provided to Plan members/participants/beneficiaries for purposes of, or related to, outpatient dialysis.

A. The Plan has established a specialized procedure for determining the amount of Plan benefits to be provided for Outpatient Dialysis Treatment, regardless of the condition causing the need for such treatment; this procedure is called the "Dialysis Program." The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

B. The Dialysis Program shall consist of the following components:

i. Application. All claims filed by, or on behalf of, Plan members/participants/beneficiaries for coverage of Outpatient Dialysis Treatment ("Dialysis Claims") shall be subject to the provisions of this section, regardless of the treating healthcare provider's participation in the Preferred Provider Organization (PPO).

ii. Mandated Cost Review. All claims for Outpatient Dialysis Treatment shall be subject to cost containment review, negotiation and settlement, application of the maximum benefit payable analysis (as set forth below), and/or other related administrative services, which the Plan Administrator may elect to apply in the exercise of the Plan Administrator's discretion. The Plan Administrator reserves the right, in the exercise of its discretion, to engage relevant and qualified third party entities for the purpose of determining the Usual, Customary, and Reasonable Outpatient Dialysis Charge.

iii. Maximum Benefit. The maximum benefit payable for any and all Dialysis Claims shall be 100% of the lesser of (x) the Usual, Customary, and Reasonable Outpatient Dialysis Charge (as defined below), (y) the maximum allowable charge after all applicable deductibles and cost-sharing, and (z) such charge as is negotiated between the Plan Administrator and the provider of Outpatient Dialysis Treatment.

a. Usual, Customary, and Reasonable Outpatient Dialysis Charge. For the purposes of Outpatient Dialysis Treatment and the Dialysis Program, "Usual, Customary, and Reasonable Outpatient Dialysis Charge" means that portion of a claim for Outpatient Dialysis Treatment that is, (i) consistent with the common level of charges made by other medical professionals with similar credentials, or other medical facilities, pharmacies, or equipment suppliers of similar standing, in the geographic region in which the charge was incurred; (ii) based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation; (iii) for reasonably comparable services performed or provided in accordance with generally accepted standards of medical practice applicable to a similarly-situated individual receiving similar services in the same geographic region; (iv) otherwise in compliance with generally accepted billing practices for unbundling and/or multiple procedures; and (v) necessary and appropriate for the care and treatment of illness or injury presented, taking into consideration relevant data including, without limitation, industry practices and standards as they apply to

similar scenarios, and various forms of normative data and price indexes. The Usual, Customary, and Reasonable Outpatient Dialysis Charge does not necessarily mean the actual charge made, submitted, or accepted. The Plan Administrator reserves the right, in the exercise of its discretion, to engage relevant and qualified third-party entities for the purpose of determining the Usual, Customary, and Reasonable Outpatient Dialysis Charge.

iv. Secondary Coverage. Plan members/participants/beneficiaries eligible for other health coverage under any other health plan are strongly encouraged to enroll in such coverage. Plan members who do not enroll in other coverage for which they are eligible may incur costs not covered by the Plan that would have been covered by the other coverage. The Plan will only pay for costs payable pursuant to the terms of the Plan, which may not include any costs that would have been payable by such other coverage.

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. To the extent permitted by law, the Plan Administrator shall have the discretionary authority to rely conclusively upon all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Plan Administrator.

Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider. Such agreement is intended to supersede Section 3.13.

Description of Benefits

PLAN PROVISIONS	Participating Providers	Non-Participating Providers
Annual Deductible	$100 Per Person/$300 per Family	$100 Per Person
	For Other Services*	$300 Per Family
Annual Co-payment Maximum	$2,500 Per Person, Maximum $7,500 Per Family	
Lifetime Maximum	None	
Dependent Coverage	To age 26	
MEDICAL SERVICES	**Member Pays**	
PHYSICIAN SERVICES		
Office Visits (including Specialist)	$10 copayment	30% after annual deductible
Hospital Visits	10%	30% after annual deductible
Emergency Room Visits	10%	10%

PLAN PROVISIONS	Participating Providers	Non-Participating Providers
Urgent Care	10%	30% after annual deductible
Immunizations	No co-pay	30% after annual deductible
HOSPITAL SERVICES	-	-
Room & Care – semi-private room rate; unlimited number of days	10%	30% after annual deductible
Intensive Care Unit, Coronary Care Unit, Ancillary Services, Inpatient Laboratory and X-ray	10%	30% after annual deductible
Emergency Room Facility	20%	20%
Ambulatory Surgical Center	$50 copayment	30% after annual deductible
Maternity Services; semi-private room rate	10%	30% after annual deductible
INPATIENT SURGICAL SERVICES		
Surgery	10% for cutting 20% for non-cutting	30% after annual deductible
Anesthesiologist	10%	30% after annual deductible
OUTPATIENT SURGICAL SERVICES		
Surgery	10% for cutting 20% for non-cutting	30% after annual deductible
Anesthesiologist	10%	30% after annual deductible
OUTPATIENT LABORATORY & X-RAY SERVICES		
X-ray films, diagnostic services	20%	30% after annual deductible
Radiotherapy for malignancies and non-malignancies	20%	30% after annual deductible
MENTAL HEALTH SERVICES Member Pays		
INPATIENT	-	-
Hospital & Facility Services; semi-private room rate	10%	30% after annual deductible
Psychiatrist & Psychologist Services	10%	30% after annual deductible
Psychological Testing	10%	30% after annual deductible
OUTPATIENT	-	-
Psychiatrist & Psychologist Services	10%	30% after annual deductible
Psychological Testing	20%	20% after annual deductible
OTHER SERVICES Member Pays		

PLAN PROVISIONS	Participating Providers	Non-Participating Providers
OTHER SERVICES*	* All benefits payable after application of annual deductible	
Ambulance	20%	30%
Air Ambulance (Limited to State of Hawaii)	20%	30%
Allergy Testing	20%	30%
Appliances & Equipment	20%	30%
Applied Behavior Analysis Therapy of Autism Spectrum Disorder	10% No Deductible Applied	30%
Blood and Blood Products	20%	30%
Chemotherapy	20%	30%
Contraceptives (Contraceptive IUD, Implants and Injectables)	No co-pay	30%
Dialysis and Supplies	20%	30%
Evaluations for the Use of Hearing Aids	20%	30%
Gender Identity Services	20%	30%
Habilitative Services	20%	30%
Inhalation Therapy	20%	30%
Nutritional Counseling	10%	30%
Orthodontic Treatment of Orofacial Anomalies	20%	30%
Organ Donor Services	20%	30%
Outpatient Injections	20%	30%
Physical/Occupational/Speech Therapy	20% Outpatient / 10% Inpatient No Deductible Applied	30%
Preventive Care Services	No co-pay	30%
Pulmonary Rehabilitation - Outpatient	20%	30%
Supportive Care	No co-pay	Not Covered
BENEFITS FOR CHILDREN Member Pays		
Newborn Circumcision	10%	30% after annual deductible
Well Child Care Office Visits (Up until age 5)	No co-pay	30%
Well Child Care Office Visits (Ages 6 through 18)	No co-pay	30%
Well Child Care Immunization	No co-pay	No co-pay
Well Child Care Lab Tests	No co-pay	30%
Student Physical Exam: Beneficiaries six (6) through eighteen (18) years of age are entitled to one (1) Student Physical Exam per calendar year as required by school. Student Physical Exams are not subject to the Annual Deductible. 90% Participating Providers / 70% Non-Participating Providers		
DIAGNOSTIC TESTING Member Pays		

PLAN PROVISIONS	Participating Providers	Non-Participating Providers
Pap Smears (Screenings - One every 3 calendar years [CY] ages 21 through 65)	No co-pay	30%
Mammography (1 per CY age ≥ 40)	No co-pay	30%
Prostate Specific Antigen (Men, one per CY, age ≥ 50)	No co-pay	30%
ACUPUNCTURE / CHIROPRACTIC SERVICES Member Pays		
	There is a combined calendar year benefit maximum of $400.00 paid by the Plan for Acupuncture and Chiropractic Services.	
Acupuncture	$15 Co-pay per visit	$25 Co-pay per visit
Chiropractic: Spinal Manipulation	$15 Co-pay per visit	$25 Co-pay per visit
Chiropractic: Physical Therapy	$10 Co-pay per visit	$15 Co-pay per visit
Chiropractic: Office Visit (Examination)	$10 Co-pay per visit	$15 Co-pay per visit
Chiropractic: Radiology (Imaging)	$10 Co-pay per visit	$15 Co-pay per visit
VISION CARE SERVICES – Plan Pays		
VISION EXAM – One per calendar year	100% of eligible charge after $10 annual deductible	Up to $40
LENSES	Only one of the following per calendar year	
Single	100% of eligible charge after $10 annual deductible	Up to $16
Multifocal	100% of eligible charge after $10 annual deductible	Up to $25
Contact Lenses	Up to $130 of eligible charge after $25 annual deductible	Up to $50
FRAMES – One frame every other calendar year	100% of eligible charge after $15 annual deductible (1)	Up to $12

(1) Frames must be chosen from a group selected by the provider. If the member chooses a frame outside of the group, the member will have to pay any difference between the plan's allowance and the provider's charge for the frames. If the member replaces only the lenses of his/her glasses, the allowance for frames cannot be applied to the cost of the lenses.

PHARMACY BENEFITS – Member Pays	
Annual Co-payment Maximum (1)	$4,850 Per Person, Maximum $7,200 Per Family

PLAN PROVISIONS	Participating Providers	Non-Participating Providers
Times and Preferred Network Pharmacies Prescription Drugs (2) (30 day supply)	$7 co-pay per Generic Prescription $20 co-pay per Preferred Brand Prescription $50 co-pay per Non-Preferred Brand Prescription	$60 co-pay per Generic Prescription $90 co-pay per Preferred Brand Prescription $125 co-pay per Non-Preferred Brand Prescription
Times, Preferred Network Pharmacies and Mail Order (2) (31-90 day supply)	$10 co-pay per Generic Prescription $25 co-pay per Preferred Brand Prescription $60 co-pay per Non-Preferred Brand Prescription	Member pays 100% of charges Member pays 100% of charges Member pays 100% of charges
All Other Non-Preferred Pharmacies in the Synergy MedSolutions Network (2) (30 day supply ONLY)	$60 co-pay per Generic Prescription $90 co-pay per Preferred Brand Prescription $125 co-pay per Non-Preferred Brand Prescription	Member pays 100% of charges Member pays 100% of charges Member pays 100% of charges
Specialty Drugs (3) (4) – Must be dispensed through Pharmacare	$100 co-pay for a 30 day supply If the cost of the covered Specialty drug exceeds $10,000, the co-pay is 20%, based on approved prior authorization.	Member pays 100% of charges

(1) You will not pay more than the annual co-payment maximum in a calendar year.

(2) If the cost of the drug exceeds $5,000, the co-pay is 20%, based on approved prior authorization.

(3) All Specialty Drugs must be dispensed through Pharmacare. Step Therapy Program applies.

(4) There will be a once per lifetime limitation on Hepatitis C treatment.

All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician.

All plan benefits shown as a percentage of Eligible Charge

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:

(a) Annual Deductible. The Annual Deductible is the first $100 per person or $300 for family in Eligible Charges that a Beneficiary incurs for those services or supplies received from a nonparticipating provider during a Calendar Year or for those services or supplies received from participating provider which are covered under Section 16, Other Medical Benefits, of this Plan and that are subject to the Annual Deductible. Beneficiary Copayments for services listed in Sections 6 through 16 as not being subject to the Annual Deductible may not be counted toward satisfying the Annual Deductible. The Beneficiary is solely responsible for payment of the Annual Deductible.

Maximum Annual Copayment. Whenever a Beneficiary makes Copayments for services covered under Sections 6 through 16 of this Plan that equal $2,500 per person 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 of three or more shall not exceed $7,500 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.

4.2 Maximum Lifetime Benefits. Unlimited.

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 certain services relating to mental illness and alcohol or drug dependence, as described in Sections 5.3, 5.4, and 5.5 below. Effective January 1, 2011, additional services have been added to the prior authorization list; Outpatient Services, Physical and Occupational Therapy, Transplants and Other Medical Benefits as indicated on the revised Prior Authorization list. The Plan may pay reduced benefits in cases where prior review of covered services is required, but is not obtained.

5.2 Benefit Reductions. Any benefits that would have been paid in connection with a Hospital admission will be subject to a penalty of at least 70% benefit with a maximum penalty of $300 per incident not to exceed $1,000 per calendar year per beneficiary. This 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. Certain Surgical Procedures, Outpatient Services, Other Medical Benefits and services related to Mental Illness and Alcohol or Drug Dependence will be subject to a 10% benefit reduction for failure to obtain prior review.

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 Annual Deductible, or 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.

(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 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 for the surgery, or may condition the payment of such benefits on the Beneficiary's receiving a second opinion on the necessity of surgery. A Beneficiary may receive a second opinion at no cost to the Beneficiary if the second opinion is arranged by the Claims Administrator. 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.

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 continue with the service or care, benefits under this Plan will not be payable for the 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 paid in lieu of benefits for regularly covered services, will not exceed the total benefits otherwise payable for regularly covered services.

These alternative services will be paid at the Plan's discretion as long as 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 Employer. The Employer will notify the Beneficiary of the results of such second review.

5.8 Prior Authorization Requirements for Times Super Market Members
The member must call the HMA Health Services Department for hospital admissions, services or procedures before the services are provided.

PHONE: (808) 951-4621
TOLL FREE: (866) 377-3977
FAX: (808) 206-5655

Prior Authorization: The following services require prior authorization through the Health Services Department. Failure to obtain prior authorization may result in a benefit reduction. Emergency and maternity admissions do not require prior authorization but HMA Health Services Department must be notified within 48 hours or by the next business day.

INPATIENT ADMISSION	All inpatient admissions including acute, skilled and observation stays.
OUTPATIENT SERVICES	○ Gamma Knife or X-knife Procedure ○ Greater than two (2) OB Ultrasounds ○ Imaging Scans (MRI, MRA & PET) ○ In Vitro Fertilization (1 per lifetime) ○ Reconstructive Surgery ○ Weight Loss Services
OUTPATIENT REHABILITATION SERVICES	○ Occupational Therapy – after initial 10 visits ○ Physical Therapy – after initial 10 visits ○ Pulmonary Rehabilitation ○ Speech Therapy – after initial 10 visits
OTHER MEDICAL BENEFITS	○ All Transplants ○ Applied Behavior Analysis Therapy of Autism Spectrum Disorder ○ Chemotherapy ○ Dialysis ○ Durable Medical Equipment & Prosthetics – over $500; rentals over $100 ○ Gender Identity Services

	○ Genetic Testing and Counseling ○ Habilitative Services ○ Home Health Services – after initial 12 visits ○ Home Infusion Therapy ○ Hospice ○ Human Growth Hormone Therapy ○ Inhalation Therapy ○ Injectables ○ Inpatient/Outpatient surgical services ○ Autologous chondrocyte implantation ○ Bariatric surgery ○ Blepharoplasty ○ Panniculectomy ○ Thoracic sympathectomy for hyperhidrosis ○ Treatment of varicose veins ○ Hyperbaric oxygen treatment ○ Nutritional Counseling – initial six visits/treatment plan ○ Orthodontic Services for the Treatment of Orofacial Anomalies ○ Radiotherapy ○ Routine Care Associated with Clinical Trials ○ Supportive Care Services
MENTAL HEALTH SUBSTANCE ABUSE SERVICES	○ Mental Health Services – Neuropsychological Testing (NPT)

SECTION 6
MEDICAL BENEFITS

Subject to the provisions of this Plan, 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 70% of Eligible Charges after the Annual Deductible for services of a Non-Participating Provider. Physician Office Visits, including Specialist Physician Office Visits, are subject to a $10 copayment at a Participating Provider; the Plan will pay 70% of Eligible Charges after the Annual Deductible for services of a Non-Participating Provider.

(a) Home, Office, Hospital Emergency Room, or Office Consultation Visit. The Plan will pay 90% of Eligible Charges 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. Separate charges for injections will not be covered under this section, but may be covered under other sections of this Plan. The Plan will pay 90% of Eligible Charges for Participating and Non-Participating Providers for emergency room physicians.

(b) 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.

(c) Consultation Visit. One (1) consultation visit by a Physician 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.

(d) Well-Child Care Visits. Seven (7) routine well-baby visits during the first 12 months of a Child's life, three (3) visits during the next 12 months, two (2) visits during age two (2) and one (1) visit each during ages three (3) to twenty-one (21). Well-Child Care Visits to include routine vision and hearing tests. The Plan will pay 100% of Eligible Charges for a Participating Provider and 70% of Eligible Charges for a Non-Participating Provider. Well-Child immunizations are covered under Immunizations; well-baby routine laboratory tests are covered under Outpatient Diagnostic and Therapy Benefits. Well-Child care visits, immunizations and routine laboratory tests are not subject to the Annual Deductible. Childhood preventive services, as required by The Affordable Care Act of 2010, are covered at 100% of Eligible Charges for Participating Providers.

(e) Student Physical Exam. For ages six (6) thru eighteen (18) years of age, one (1) per calendar year as required by school. Beneficiary entitled to one (1) Student Physical Exam per calendar year. The Plan will pay 90% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges for services of a Non-Participating Provider. Student Physical Exams are not subject to the Annual Deductible.

(f) Annual Preventive Health Evaluation – One annual preventive health evaluation for Beneficiaries who are 22 and older when received from their primary care provider. Services are limited to the following:

- Assessment of any added preventive screenings you might need. See other sections of this chapter including Section 11: Outpatient Lab Services.
- Performing certain preventive screenings that can be done at an office visit. See other sections of this chapter including Well Women Visits.

The Plan will pay 100% of Eligible Charges for a Participating Provider and 70% of Eligible Charges for a Non-Participating Provider. Annual Deductible does not apply.

(g) Temporomandibular Joint (TMJ) Disorder. The initial visit to diagnose TMJ is covered.

(h) Preventive Care Services.

The Plan shall provide coverage for evidence-based items or services, such as:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
2. Immunizations currently recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention;
3. Infants, children, and adolescents: Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
4. Women: Additional preventive care and screenings not described above in number one (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
5. Current recommendations of the United States Preventive Service Task Force (USPSTF) regarding breast cancer screening, mammography, and prevention.

For the most current list of U.S. Preventative Services Task Force A & B, the Advisory Committee on Immunization Practices, and the Health Resources and Services Administration recommendations that are relevant to the Affordable Care Act, please see the following websites for more details:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;

https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
https://www.hrsa.gov/womensguidelines/.

NOTE: The USPSTF recommendations can change, and those changes are generally applied at the beginning of each Calendar Year.

Covered Preventative Service for:	
Adults	▪ **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked ▪ **Alcohol Misuse** screening and counseling ▪ **Aspirin** use for men and women 50 to 59 years (covered under prescription drug plan) ▪ **Blood Pressure** screening for all adults ▪ **Cholesterol** screening for adults of certain ages or at higher risk ▪ **Colorectal Cancer** screening for adults 45 to 74 years ▪ **Depression** screening for adults ▪ **Type 2 Diabetes** screening for adults 35 to 69 years who are over weight or obese ▪ **Diet** counseling for adults at higher risk for chronic disease ▪ **Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting** ▪ **Hepatitis B screening for people at high risk** ▪ **Hepatitis C screening for adults age 18 to 79 years** ▪ **HIV** screening for everyone age 15 to 64, and other ages at increased risk ▪ **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary: • Hepatitis A • Hepatitis B • Herpes Zoster • Human Papillomavirus (HPV) • Influenza (Flu Shot) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Shingles • Tetanus, Diphtheria, Pertussis • Varicella (Chickenpox) ▪ **Lung** cancer screening for adults 50 to 79 at high risk, they're heavy smokers or have quit in the past 15 years ▪ **Obesity** screening and counseling for all adults ▪ **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk ▪ **Syphilis** screening for all adults at higher risk ▪ **Tobacco Use** screening for all adults and cessation interventions for tobacco users ▪ **Tuberculosis screening for certain adults without symptoms at high risk**
Women, Including Pregnant Women	• **Anemia** screening on a routine basis for pregnant women • **Bacteriuria** urinary tract or other infection screening for pregnant women • Bone **density screening for all women over age 65 and younger that have gone through menopause** • **BRCA** counseling about genetic testing for women at higher risk

Covered Preventative Service for:	
	• **Breast Cancer Mammography** screenings one (1) baseline for ages 35 to 39 then one (1) annual mammogram for 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 are eligible for a mammogram upon the recommendation of a Physician. • **Breast Cancer Chemoprevention** counseling for women at higher risk • **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women • **Cervical Cancer** screening Pap test (Pap smear) for women age 21-65 • **Chlamydia Infection** screening for younger women and other women at higher risk • **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs • **Domestic and interpersonal violence** screening and counseling for all women • **Folic Acid** supplements for women who may become pregnant (covered under prescription drug plan) • **Gestational diabetes** screening for women 24 weeks pregnant and those at high risk of developing gestational diabetes • **Gonorrhea** screening for all women at higher risk • **Hepatitis B** screening for pregnant women at their first prenatal visit • **Human Immunodeficiency Virus (HIV)** screening and counseling for everyone age 15 to 65, and other ages at increased risk • **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing for women of certain ages • Maternal **depression screening for mothers at well-**baby visits • **Osteoporosis screening for postmenop**ausal women • Preeclampsia **prevention and screening for pregnant women with high blood pressure** • **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk • **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users • **Sexually Transmitted Infections (STI)** counseling for sexually active women • **Syphilis** screening for all pregnant women or other women at increased risk • **Urinary incontinence screening for women yearly** • Urinary **track or other infection screening** • **Well-woman visits** to obtain recommended preventive services for all women
Children	▪ **Alcohol, tobacco, and Drug Use** assessments for adolescents ▪ **Autism** screening for children of certain ages ▪ **Behavioral** assessments for children ▪ **Bilirubin concentration screening for newborns** ▪ **Blood Pressure** screening for children ▪ **Blood screening for newborns** ▪ **Cervical Dysplasia** screening for sexually active females

Covered Preventative Service for:	
	▪ **Congenital Hypothyroidism** screening for newborns ▪ **Depression** screening for adolescents ▪ **Developmental** screening for children at certain ages ▪ **Dyslipidemia** screening for children at higher risk of lipid disorders ▪ **Fluoride** supplements for children without fluoride in their water source (covered under prescription drug plan) ▪ **Gonorrhea** preventive medication for the eyes of all newborns ▪ **Hearing** screening for all newborns and regular screenings for children and adolescents as recommended by their provider ▪ **Height, Weight and Body Mass Index** measurements for all children ▪ **Hematocrit or Hemoglobin** screening for all children ▪ **Hemoglobinopathies** or sickle cell screening for newborns ▪ **Hepatitis B screening for adolescents at higher risk** ▪ **HIV** screening for adolescents at higher risk ▪ **Hypothyroidism screening for newborns** ▪ **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary: • Diphtheria, Tetanus, Pertussis • Haemophilus influenzae type b • Hepatitis A • Hepatitis B • Human Papillomavirus (HPV) • Inactivated Poliovirus • Influenza (Flu Shot) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Rotavirus • Varicella (Chickenpox) ▪ **Lead** screening for children at risk of exposure ▪ **Medical History** for all children throughout development ▪ **Obesity** screening and counseling ▪ **Oral Health** risk assessment for young children ▪ **Phenylketonuria (PKU)** screening for this genetic disorder in newborns ▪ **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk ▪ **Turberculin Screening Test** ▪ **Tuberculin** testing for children at higher risk of tuberculosis ▪ **Vision** screening for all children ▪ **Well-baby and well-child visits**

6.2 Immunizations. The Plan will pay 100% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges for a Non-Participating Provider for immunizations in connection with the following:

- o Cholera
- o Diphtheria
- o Hepatitis
- o Influenza
- o Measles
- o Mumps
- o Rubella

- Whooping cough
- Polio
- Smallpox
- Tetanus
- Typhoid
- Typhus
- Rotavirus
- Meningococcal
- Chicken pox
- Human Papillomavirus Vaccine (HPV) for males and females ages 9-26
- Zostavax Vaccine (aka Shingles) for employee and dependents 60 years of age and older.

For well-child immunizations, the Plan will pay 100% of Eligible Charges for services of a Participating Provider or a Non-Participating Provider. Annual Deductible does not apply.

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 70% of Eligible Charges after the Annual Deductible for services of a Non-Participating 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.

6.4 Urgent Care Services. The Plan will pay 90% of Eligible Charges for Urgent Care Services, of a Participating Provider. The Plan will pay 70% of Eligible Charges after the Annual Deductible for a Non-Participating Provider.

6.5 Well-Woman Visits. Preventive services for women of any age, the Plan will pay 100% of Eligible Charges for a Participating Provider or 70% of Eligible Charges for a Non-Participating Provider up to a maximum benefit of $500.00 for breast feeding support only, see section (c). Annual Deductible does not apply.

(a) Annual well-women exam

(b) Testing for sexually transmitted infection (STI) and human immunodeficiency virus (HIV)

(c) Breast feeding support

(i) The purchase of a breast pump, breast feeding support and counseling by a trained provider either during pregnancy and/or after giving birth will be covered at no charge. Your plan will cover one device per pregnancy when purchased from Times Super Market. Neighbor island members must purchase the device through mail order from Times on Oahu. If the device or services are received from a non-participating provider out-of-network benefits will apply. Breast pumps will be restricted to the Ameda and Medela brands. Both manual and electric models will be covered up to a maximum benefit of $500.00. A prescription from a physician is not required.

The rental of a hospital-grade breast pump will be covered if prescribed by a physician for a mother whose baby is unable to be breastfed directly because of a medical condition or because the infant is hospitalized.

(d) Domestic violence screening and counseling
(e) Contraception

SECTION 7
SURGICAL BENEFITS

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

7.1 Surgical Services.

(a) Cutting. The Plan will pay 90% of Eligible Charges for cutting surgical services of a Participating Provider or 70% of Eligible Charges after the annual deductible for services of a Non-Participating Provider for Surgical Services required for the diagnosis or treatment of a Beneficiary's Injury or illness.

(b) Non-Cutting: The Plan will pay 80% of Eligible Charges for non-cutting surgical services, of a Participating Provider 70% of Eligible Charges after the annual deductible for services of a Non-Participating Provider for Surgical Services required for the diagnosis or treatment of a Beneficiary's Injury or illness.

(c) Small bowel and multivisceral transplants are covered at 100% of Eligible Charges for services of a Participating Provider. Services rendered by a Non-Participating Provider are not a benefit of this Plan.

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)(iv) below, the following transplants are eligible for benefits:

- Pancreas
- Simultaneous Kidney/Pancreas
- Kidney
- Small bowel and multivisceral
- Corneal
- Bone marrow limited to autologous and allogeneic bone marrow transplants for specified diseases or conditions as described in this section, 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
- Lung

All other transplants, including artificial or animal organ transplants, are not eligible for benefits under this Plan.

(ii) Bone Marrow Transplant. Benefits for bone marrow transplants are limited to autologous and allogeneic bone marrow transplants for the specified diseases or conditions described in this section. Benefits are not available for autologous and allogeneic bone marrow transplants for any other diseases or conditions.

The limited benefits specified below for allogeneic and autologous bone marrow transplants are an exception to the exclusion for experimental or investigative procedures. This limited exception is not intended to, and does not operate as, a waiver of the exclusion for experimental or investigative procedures. The limited benefit is subject to all other conditions and provisions of this plan.

Allogeneic and Autologous Bone Marrow Transplants mean medical and/or surgical procedures composed of several steps or stages including, without limitation:

- The harvest of stem cells from the blood or bone marrow of a third-party donor ("allogeneic") or from the patient ("autologous")
- Processing and/or storage of harvested stem cells.
- The administration of high dose chemotherapy and/or high dose radiation therapy. High Dose Chemotherapy and High Dose Radiation Therapy are forms of therapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a bone marrow transplant is required or warranted.
- The infusion of harvested stem cells.
- Hospitalization, observation, and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities, and low blood counts.

This definition specifically includes transplants when the transplant component is derived from circulating blood instead of, or in addition to harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, high dose chemotherapy and/or high dose radiation therapy.

Allogeneic Bone Marrow Transplants.

Allogeneic bone marrow transplants are available only for treatment prescribed for the following conditions:

- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia.
- Advanced stage Hodgkin's disease.
- Advanced stage, intermediate-grade, or high-grade non-Hodgkin's lymphoma.
- Advanced stage neuroblastoma.
- Chronic myelogenous leukemia that is in blast crisis or chronic phase.
- Gonadal germ cell tumors.
- Homozygous beta-thalassemia.
- Infantile malignant osteopetrosis.
- Lysomal storage diseases.
- Myelodysplastic syndrome.
- Severe aplastic anemia.
- Severe combined immunodeficiency syndrome.
- Wilm's tumor.
- Wiskott-Aldrich syndrome.

Autologous Bone Marrow Transplants

Benefits for autologous bone marrow transplants are limited to treatment prescribed for the following conditions:

- Acute lymphocytic and non-lymphocytic (i.e., myelogenous) leukemia.
- Advanced stage intermediate-grade or high-grade non-Hodgkin's lymphoma.
- Advanced stage Hodgkin's disease.
- Advanced stage neuroblastoma.
- Breast cancer.
- Gonadal germ cell tumors.
- Multiple myeloma if in accord with our criteria, the disease is newly diagnosed or responsive to previous treatment for multiple myeloma.
- Wilms' tumor.

(c) (iii) Transplant Evaluation. No benefits will be paid in connection with bone marrow, liver, heart, heart-lung, kidney, pancreas, simultaneous Kidney/pancreas, small bowel and multivisceral transplant, 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.

(iv) 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 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

(v) Wait list fees for one transplant/facility is covered.

(c) Services which are not covered include the following:

i. Organ donor services if you are the organ donor;

ii. Expenses of transporting a living donor;

iii. Mechanical or non-human organs, except for artificial hearts when used as a bridge to a permanent heart transplant;

iv. The purchase of any organ;

v. Transplant services or supplies or related services or supplies other than those described in Chapter 7: Surgical Benefits. Related Transplant Supplies are those that would not meet payment determination criteria but for your receipt of the transplant, including, and without limit, all forms of bone marrow or peripheral stem cell transplants;

vi. Transportation for organ or tissue transplant services or transportation of organs or tissues.

vii. Out of Country transplants.

(d) 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. Reconstructive surgery of congenital anomalies (i.e., defects present from birth) is covered only when the defect severely impairs or impedes normal, essential bodily functions and is medically necessary.

(e) Vasectomy. The Plan will pay 90% of Eligible Charges for a Participating Provider or 70% of Eligible Charges after the Annual Deductible for a Non-Participating Provider for only the initial surgery for a vasectomy. Benefits do not include the reversal of a vasectomy.

7.3 Anesthesiology. The Plan will pay 90% of Eligible Charges for a Participating Provider or 70% of Eligible Charges after the Annual Deductible for a Non-Participating 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 90% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges after the Annual deductible for services of a Non-Participating 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. Must be equipped and operated according to generally recognized Hospital standards acceptable to the Claims Administrator.
(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, (e) immediately above and 8.2 below, on an all-inclusive daily rate basis, the Plan will pay 90% of Eligible Charges for a Participating Provider or 70% of Eligible Charges after the Annual deductible for a Non-Participating 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.
(h) Transplants. See Section 7.2(b) for limitations on benefits for transplants.

8.2 Laboratory Services, Diagnostic Tests, X-rays, and Radiotherapy Benefits.

(a) Laboratory Services, Diagnostic Tests, X-Rays, and Radiotherapy. The Plan will pay 90% of Eligible Charges for inpatient services of a Participating Provider and 70% of Eligible Charges after Annual deductible for inpatient services of a Non-Participating Provider.
(b) X-ray Films.
(c) Radiotherapy.

8.3 Emergency Room Benefits. The Plan will pay 80% of Eligible Charges for services of a Participating or Non-Participating Provider for the 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 non-emergency surgical or medical services. The deductible will not apply.

8.4 Outpatient Surgical Center Benefits. Surgery and procedures performed in an Ambulatory Surgery Center are provided upon payment of a $50.00 copayment per admission for services of a Participating Provider. The Plan will pay 70% of Eligible Charges after the Annual Deductible for services of a Non-Participating 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 70% of Eligible Charges after the Annual deductible for services of a Non-Participating 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) Non-Participating 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. Plan payment for hospice services and hospice referral visits for a terminal illness, will be 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 Non-Participating 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 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.

SECTION 11
OUTPATIENT LABORATORY SERVICES, DIAGNOSTIC TESTS, X-RAYS, AND RADIOTHERAPY BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the above 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 80% of Eligible Charges for outpatient services of a Participating Provider or 70% of Eligible Charges after the Annual Deductible of a Non-Participating Provider.

11.1 Laboratory Services and Diagnostic Tests. Including the following:

(a) Laboratory tests in connection with well-child care visits are limited to the following tests through age five (5): two (2) tuberculin tests (blood, tine or skin sensitivity test), two (2) blood tests (hemoglobin or hematocrit), and one (1) urinalysis, or as required by the Affordable Care Act of 2010.

(b) Tuberculin Tine Test. Limited to one (1) per Calendar Year. To include for other testing methods.

(c) Chlamydia screenings.

(d) Genetic Testing and Counseling

11.2 X-ray Films.

11.3 Radiotherapy.

11.4 Preventive Care Services. The Plan will pay 100% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges for services of a Non-Participating provider. Annual Deductible does not apply.

(a) Evidence-based screenings.

(b) Routine Pap Smear. Limited to one (1) every three (3) Calendar Years for women ages 21 though 65.

(c) Screening by Low-Dose Mammography. Limited to one (1) baseline for ages 35 to 39 then one (1) annual mammogram for 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 are eligible for a mammogram upon the recommendation of a Physician.

(d) Prostate Specific Antigen (PSA) Screening Test. Limited to one (1) per Calendar Year for men ages 50 and above.

(e) Colonoscopy Screening. Limited to one (1) screening every five (5) years. For ages 45 to 74; OR Sigmoidoscopy Screening. Limited to one (1) screening every five (5) years. For ages 50 and above.

(g) Fecal Occult Blood Test (FOBT) Screening – For ages 50 and above.

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 90% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges after the Annual Deductible for services of a Non-Participating 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 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 90% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges after Annual Deductible for services of a Non-Participating Provider.

(d) Diagnostic tests for an unborn Child are eligible for payment under Section 11 only when medically necessary.

(e) Pregnancy Termination. The Plan will pay 90% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges after Annual Deductible for services of a Non-Participating Provider.

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 Employer 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 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.
  (vi) Prior Authorization is required for physician, surgical and outpatient lab and x-ray services. A 10% penalty will be applied when prior authorization is not obtained.

(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. Injectable Drugs are covered as described in Section 16.8, Outpatient Injectables . Except as otherwise provided in this Plan, prescription drugs are not covered.

(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) Cryopreservation of oocytes, semen and embryos.
  (v) Services related to conception by artificial means, other than artificial insemination and in vitro fertilization as specified above.

12.4 Artificial Insemination. The Plan will pay 80% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges after the annual deductible for services of a Non-Participating Provider. Coverage for other related services such as office visits, labs and radiology are described in other sections of this document.

12.5 Tubal Ligation. The Plan will pay 100% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges after the annual deductible for services of a Non-Participating Provider for the surgery for a tubal ligation. Reversal of a tubal ligation is not covered.

12.6 Preventive Service. For certain preventive services, as required by The Affordable Care Act of 2010, the Plan will pay 100% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges for services of a Non-Participating Provider.

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.

(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.

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

(iii) Inpatient Psychiatrist or Psychologist Services. The Plan will pay 90% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges after the Annual Deductible of a Non-Participating Provider for Psychiatrist or Psychologist 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.

(iv) Psychological Testing. The Plan will pay 90% of Eligible Charges for a Participating Provider, and 70% of Eligible Charges after Annual and Hospital deductibles of a Non-Participating Provider for psychological testing sessions.

(b) Outpatient Benefits.

(i) Outpatient Facility, Licensed Physician, Psychiatrist, or Psychologist, Licensed Mental Health Counselor, Marriage/Family Therapist; Advanced Practice Registered Nurse or Clinical Social Worker Services. The Plan will pay 90% of Eligible Charges for a Participating Provider or 70% of Eligible Charges after Annual Deductible of a Non-Participating Provider for covered outpatient mental illness services provided by a Qualified Treatment Facility, Psychiatrist, Psychologist, or a clinical Social Worker. .

(ii) Psychological Testing. The Plan will pay 80% of Eligible Charges for services of a Participating Provider and 80% of Eligible Charges after the annual deductible for a Non-Participating 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 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.

(i) For inpatient Hospital or facility services, benefits will be limited to room and care charges and no additional benefits will be payable for intensive or special care psychiatric units.

(ii) 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 or Psychologist. 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 Employer 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. Non-Participating 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 or Psychologist 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.

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 80% of Eligible Charges after the Annual Deductible for a Participating Provider or 70% of Eligible Charges after the Annual Deductible for a Non-Participating Provider for services of a properly licensed automobile ambulance from the place where an Injury occurred or an illness first required care if benefits under Sections 8.1 or 8.4 are allowed for such Injury or illness. Does not apply to transportation to a skilled nursing facility. Air ambulance service benefits shall be limited to inter-island transportation within the state of Hawaii. Air ambulance services must be rendered by a properly licensed or certified air ambulance and ordered by a Physician from the place where Injury occurred or illness first required care to the nearest facility equipped to furnish immediate emergency treatment for such illness or Injury

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 after the Annual Deductible for services of a Participating Provider or 70% of Eligible Charges after the Annual Deductible for services of a Non-Participating Provider for the following medical services. Certain services require prior authorization. See Prior Authorization List.

16.1 Physical/Occupational 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 (generally not longer than 90 days). Physical Therapy and Occupational Therapy visits are limited to maximum visits for either therapy, not both combined. (Long-term maintenance, group therapy and exercise programs are not covered.)

(a) Outpatient: See above for applicable percentages.

(b) Inpatient: Inpatient physical therapy and occupational therapy services will be paid by the Plan at 90% of Eligible Charges, no deductible applied, for services of a Participating Provider and 70% of Eligible Charges after the Annual Deductible for a Non-Participating Provider.

16.2 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 benefit.

(a) Outpatient: See above for applicable percentages.

(b) Inpatient: Inpatient speech therapy services will be paid by the Plan at 90% of Eligible Charges, no deductible applied, for services of a Participating Provider and 70% of Eligible Charges after the Annual Deductible for services of a Non-Participating Provider.

16.3 Allergy Testing and Treatment Materials. Covered.

16.4 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.

16.5 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 sixty (60) months), payment for digital hearing aids are limited to no more than the amount that the Plan would pay for analog hearing aids; cardiac pacemakers; artificial limbs, eyes, and hips, and similar nonexperimental appliances; casts, splints, trusses, braces, and crutches; oxygen (inhalation therapy) 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; Orthotics and External Prosthetics and Vision and Hearing Appliances. 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. The Plan will not pay for any convenience items.

16.6 Chemotherapy Infusion and Injections for Malignancy. Chemical agents and their administration (other than oral) for treatment of malignancy. Oral chemotherapy drugs are covered under the prescription drug program.

16.7 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.

16.8 Outpatient Injectables. To include Outpatient/Home IV Therapy. Outpatient services and supplies for the injection or intravenous administration of medication, biological therapeutics, biopharmaceuticals or nutrient solutions required for primary diet. Injectable and intravenous covered drugs must be FDA approved.

16.9 Evaluations for the Use of Hearing Aids.

16.10 Dialysis and Supplies. Covered Benefits include Dialysis Services, whether rendered in a Facility setting or in the home (hemodialysis or peritoneal Dialysis), diagnostic testing, laboratory tests, equipment and supplies provided by a Dialysis provider and only to the extent they are Medically

Necessary..

Dialysis Services, diagnostic testing, lab expenses, equipment and supplies are those services and items used in the dialysis treatment for acute renal failure or chronic irreversible remain insufficiency (treatment of Anemia and other diagnoses related to renal failure). This also includes injectable and intravenous medication, including, but not limited to Heparin, Epogen, Procrit and other medications administered directly before, during or after a dialysis procedure. Dialysis procedures are for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis regardless of whether they are provided on an inpatient or outpatient basis.

16.11 Contraceptives - Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.

(a) Contraceptive IUD – Covered. The Plan will pay 100% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges after the Annual deductible for services of a Non-Participating Provider. Copayment for Contraceptives do not apply toward meeting the annual copayment maximum.

(b) Contraceptive Implants – Covered. The Plan will pay 100% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges after the Annual Deductible for services of a Non-Participating Provider. Copayment for Contraceptives do not apply toward meeting the annual copayment maximum.

(c) Contraceptive Injectables - Covered. The Plan will pay 100% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges after the Annual Deductible for services of a Non-Participating Provider. Copayment for Contraceptives do not apply toward meeting the annual copayment maximum.

16.12 Medical Foods. The Plan will pay 80% of Eligible Charges for services of a Participating Provider or 80% of Eligible Charges for services of a Non-Participating Provider. Annual Deductible does not apply. Copayments do not count toward the annual copayment maximum.

16.13 Human Growth Hormone Therapy. Pre-approved for replacement therapy services to treat hypothalamic-pituitary axis damage caused by primary brain tumors. The Plan will pay 80% of Eligible Charges for services of a Participating Provider or 70% of Eligible Charges for services of a Non-Participating Provider. Annual Deductible does not apply.

This Plan does not cover Growth Hormone Therapy unless the Plan's criteria is met and if growth hormone is for replacement therapy services to treat;

- Hypothalamic pituitary axis damage caused by primary brain tumors, trauma, infection or radiation therapy
- Turner's syndrome
- Growth failure secondary to chronic renal insufficiency awaiting renal transplant
- AIDS wasting or cachexia without evidence of suspected or overt malignancy and where other mores of nutritional supplements have been tried
- Short stature
- Neonatal hypoglycemia secondary to growth hormone deficiency
- Prader- Willi Syndrome
- Severe growth hormone deficiency in adults

These services must be pre-approved.

16.14 Gender Identity Services. The services listed below are covered, but only when deemed medically necessary to treat gender dysphoria. Your copayment may vary depending on the type of service or supply you receive. Additional benefit information about the service or supply can be found in the other sections:

- Gender reassignment surgery
- Hospital room and board
- Hormone injection therapy
- Laboratory monitoring

- Other gender reassignment surgery related services and supplies which are medically necessary and not excluded. These include but are not limited to sexual identification counseling, pre-surgery consultations and post-surgery follow-up visits
- Otherwise covered services deemed medically necessary to treat gender dysphoria

Please note: Certain services and supplies must be pre-certified. See 5.1 Managed Care Program Reviews.

Please note: Exclusions or limitations may apply. See Section 18.1: General Limitations and Exclusions.

16.15 Supportive Care. The Plan will pay 100% of Eligible Charges for services of a Participating Provider. Services rendered by a Non-Participating Provider are not a benefit of this Plan. A comprehensive approach to care for members with a serious or advanced illness including Stage 3 or 4 cancer, advanced Congestive Heart Failure (CHF), advanced Chronic Obstructive Pulmonary Disease (COPD), or any advanced illness that meets the Plans requirements. Benefits will be provided only for services received in the State of Hawaii and when a member is referred by his or her physician to a participating provider.

- Coverage is limited to 90 calendar days of service in a 12 month period and is provided with no copayment cost to members
- Member may suspend or decline supportive care services at any time
- Supportive care services are automatically suspended when a member is admitted to a hospital or SNF

16.16 Autism Spectrum Disorders – Diagnosis and Treatment. The following services, in accord with Hawaii law and the Plan's medical policies, are covered:
Behavioral health treatment. Benefits for Applied Behavior Analysis rendered by a Recognized Behavior Analyst as described in Section 16.17 Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by the Plan.
Psychiatric care
Psychological care
Therapeutic care
Certain services require prior authorization. There is no coverage for care that is custodial in nature or provided by family or household members.

16.17 Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by the Plan - The Plan will pay 90% of Eligible Charges for a Participating Provider or 70% of Eligible Charges after Annual Deductible of a Non-Participating Provider for Therapy for Treatment of Autism Spectrum Disorder. Only for autism spectrum disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, in accord with Hawaii law and the Plan's medical policy. Services must be provided in the state where member resides by a Behavior Analyst recognized by the Plan. Certain services require prior authorization.

16.18 Orthodontic Services for Treatment of Orofacial Anomalies. To treat orofacial anomalies resulting from birth defects or birth defect syndromes, in accord with Hawaii law and the Plan's medical policy. Benefits are limited to a maximum of $5,500 per treatment phase, Prior authorization is required.

16.19 Nutritional Counseling. The Plan will pay 90% of Eligible Charges for a Participating Provider or 70% of Eligible Charges after Annual Deductible of a Non-Participating Provider for nutritional counseling rendered by a recognized licensed dietitian for the treatment of eating disorders.

- Services are limited to nutritional interventions provided as part of an individualized treatment plan for an individual appropriately diagnosed with an eating disorder;
- Dieticians must be licensed to practice dietetics in the state in which they practice in order to provide dietetic services to individuals diagnosed with an eating disorder;
- Prior Authorization is required for the initial six visits;
- Requests for continuation of care for an additional six months must include a treatment plan.

16.20 Routine Care Associated with Clinical Trials. Covered in accord with the Affordable Care Act. Coverage is limited to services and supplies provided when you are enrolled in a qualified clinical trial if such services would be paid for by the Plan as routine care.

16.21 Habilitative Services. Covered, in accord with The Plan's medical policies, for health care services that Devices assist an individual in partially or fully acquiring skills and functions of daily

living. Habilitation is the process of evaluation, treatment and education for the purpose of developing, improving and maintaining skills and functions that the individual has not previously possessed. Prior Authorization is required.

16.22 Pulmonary Rehabilitation – Outpatient. Covered. An approach to reducing symptoms and improving quality of life in individuals with compromised lung function. Benefits are not provided for maintenance programs. Prior Authorization is required.

16.23 Inhalation Therapy. Covered.

SECTION 17
EXCLUSIONS DURING WAITING PERIODS

17.1 If a Beneficiary is confined in a Hospital or in a Skilled Nursing Facility at the time his or her coverage under this Plan begins and was not a beneficiary under some other medical plan of the Employer immediately prior to the Effective Date of such coverage, the Beneficiary shall not be entitled to benefits for the Injury or illness which required such confinement. However, the Plan will pay benefits for covered services for such Injury or illness that are rendered after the Beneficiary has been discharged from the Hospital or Skilled Nursing Facility.

17.2 A Employee'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.

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 Employer of such appeal. Upon the execution and delivery to the Employer of all papers it requires to secure its rights of reimbursement, 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. If reimbursement is not made as specified, the Plan, at its sole option, may:

(i) take legal action to collect 100% of any payments made plus 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 plus 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 Employer agrees to reimburse the Plan for 100% of such payment, without any deduction for legal fees incurred or paid by the Beneficiary. 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:

(i) take legal action to collect 100% of any payments made plus 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 plus any legal fees incurred or paid by the Plan in pursuit of reimbursement.

(d) The Employer 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 Employer 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 to the extent permitted by law 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) Specific Exclusions.

The Plan will not pay benefits in connection with services not described as covered in this Plan, including, but not limited to:

(i) Counseling services such as bereavement, genetic, marriage or family, nutrition and sexual identification.

(ii) Dental Care generally provided only by dentists and not Physicians, such as orthodontics, dental splints and other dental appliances, dental prostheses, maxillary and mandibular implants (osseointegration) and all related services, removal of impacted teeth, any other dental procedures involving the teeth, gums and structures supporting the teeth, and any services in connection with the diagnosis or treatment of TMJ (temporomandibular joint) problems or malocclusion of teeth or jaws.

(iii) Eyeglasses and contacts:
Sunglasses; prescription inserts for diving masks or other protective eyewear; nonprescription industrial safety goggles; nonstandard items for lenses including tinting and blending; oversized lenses, and invisible bifocals or trifocals; repair and replacement of frame parts and accessories; eyeglass lenses; contact lenses; exams for fitting or prescription (including vision exercises), and frames.

(iv) Vision Services:
Refractive eye surgery to correct visual acuity problems; replacement of lost, or stolen or broken lenses, contact lenses or frames; vision training; aniseikonic studies and prescriptions; and reading problem studies or other procedures determined to be special or unusual.

(v) Prescription drugs

(vi) Experimental or Investigative Treatment
Medical treatments, procedures, drugs, devices, or care and all related services or supplies that are experimental or investigational. A medical treatment, procedure, drug, device, or care is experimental or investigative if:

a. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval or marketing has not been given at the time the drug or devices is furnished; 2.) The drug, device, medical treatment, or procedure or the patient informed consent

document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or 3.) Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is for the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or 4.) Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated does, toxicity, safety, efficacy or its efficacy compared with a standard means of treatment or diagnosis.

b. "Reliable evidence" shall mean only published reports and articles in authoritative and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, Medicare treatment or procedure.

(vii) Fertility and Infertility:
Contraceptives (e.g., condoms, foams, or creams which do not require a prescription); service or supplies related to the diagnosis of infertility, or related to the treatment of infertility, including, but not limited to: collection, storage and processing of semen; ovum transplants; gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and services related to conception by artificial means; and reversal of vasectomy or tubal litigation.

(viii) Preventative and Routine
- Immunizations (except as otherwise provided in the Plan)
- Routine Foot Care
- Routine Circumcision (except as otherwise provided in the Plan)
- Physical Examinations (routine, periodic, physical or health examinations, or screening procedures including those related to school, employment, insurance and travel.), except as otherwise provided in the Plan.

(ix) Provider Type: You are not covered for services and/or supplies offered by:
- A non-participating hospice provider
- An Immediate Family Member Provider (i.e., parent, child or spouse)
- A Physician Assistant
- Private Duty Nursing
- Social Worker (except for covered mental health or substance abuse services)

(x) Transplants (living organ donor services, cost of transporting living donor, mechanical or non-human organs, organ purchases, transplant services or supplies other than as described as covered by this Plan.)

(xi) Replacement breast pumps, supplies that don't come with the breast pump or supplies to replace old supplies that came with the pump. Disposable supplies such as replacement milk storage bags, ties, breast shields, batteries, etc., other than as described as covered by this Plan.

(h) Miscellaneous Exclusions:
Except as otherwise provided by this Plan, the following are not covered: acupuncture; airline oxygen; biofeedback (and any other related diagnostic testing); bionic devices; blood; cardiac rehabilitation; chemotherapy (high-dose) except as

otherwise provided by this Plan for pre-approved bone marrow transplants specified in section 7.2(b)(ii); complications of a non-covered procedure; cosmetic services, surgery or supplies that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function; custodial care, sanitariums care or rest cures; supervising services by a physician or nurse for a person who is not under specific medical, surgical, or psychiatric treatment to improve that person's condition and to enable that person to live outside a facility providing this care; services and supplies (including prosthetic devices) related to erectile dysfunction except if due to an organic cause (e.g. penile implants); medication and drug therapies related to erectile dysfunction except certain injectibles approved by the Claims Administrator, and only to treat erectile dysfunction related to an organic cause; foot orthotics, except for specific diabetic conditions as defined by Medicare guidelines; genetic testing and screening; Hypnotherapy; Human Growth Hormone Therapy except as preapproved for replacement therapy services to treat hypothalamic-pituitary axis damage caused by primary brain tumors, Turner's syndrome, growth failure secondary to chronic renal insufficiency awaiting renal transplant, AIDS-waisting or cachexia without evidence of suspected or overt malignancy and where other modes of nutritional supplements (e.g., hyper -alimentation, enteral therapy) have been tried, short stature due to growth hormone deficiency, neonatal hypoglycemia secondary to growth hormone deficiency, and Prader-Willi Syndrome; baldness or hair loss; miscellaneous supplies billed separately by a provider; rental or purchase of a motor vehicle or any equipment or costs associated with covering a motor vehicle to accommodate a disability; personal convenience items; nonionizing radiation; high-dose radiation; self-help and self-cure programs or equipment; sexual transformation services, supplies, or surgery; provider's waiting or stand-by time; travel or lodging costs; weight reduction programs and supplies; and wigs or artificial hairpieces.

(i) The Plan shall not be required to pay any claim until it determines that the Beneficiary was provided services covered by this Plan. Payment will not be made for services not actually rendered.

(j) The Plan will not pay benefits when confinement in a Hospital or in a Skilled Nursing Facility is primarily for custodial or domiciliary care. Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services, and other forms of self-care or supervisory services by a Physician or nurse for a person who is not under specific medical, surgical, or psychiatric treatment to reduce such person's disability and to enable such person to live outside an institution providing such care. However, benefits for confinement in a Hospital or Skilled Nursing Facility will be paid if such confinement is required because of a concurrent Injury or illness (whether related or not) which requires medical or Surgical Services otherwise provided as benefits under this Plan.

18.2 <u>When a Beneficiary Has Other Health Coverage (Coordination of Benefits)</u>.

(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 Employer. It shall not include any other non-group health plan.

Plan members who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Plan member incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

A provider that accepts the payment from the Plan will be deemed to consent and agree

that (i) such payment shall be for the full amount due for the provision of services and supplies to a Plan member and (ii) it shall not "balance bill" a Plan member for any amount billed but not paid by the 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, or provision of, State provided medical assistance shall not be taken into account.

(e) Special Provisions Regarding Medicare. The Federal Medicare Program will be considered the primary plan unless the Beneficiary is an active employee covered under an employer's health plan. Where an employee or Dependent is covered by both Medicare and an employer health plan, applicable Federal statutes will determine which plan is primary.

(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 (f)(i) above.

(g) For the purposes of enforcing or determining the applicability of this Section 18.2, the Employee, 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 Plan releasing to any party or obtaining from any party any information which the Claims Administrator or Plan 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, or has or may have a right to recover damages or receive payment without regard to fault, the Plan shall not be liable to advance any benefits. However, the Plan may advance benefits in connection with such Injury or illness in the form of an interest-free loan if a Beneficiary complies with the following conditions and rules:

(a) The Beneficiary must notify the Plan of any actual or potential legal action (including any claim, demand or legal proceeding) which the Beneficiary anticipates bringing or has

brought against any third party or other source of recovery in connection with the illness or Injury, not later than 30 calendar days subsequent to submitting or filing a claim, demand or legal action against the third party or other source or recovery.

(b) The Beneficiary must promptly execute and deliver to the Plan all liens, assignments or other documents which the Plan determines are necessary to secure the Plan's rights of reimbursement (and the Beneficiary shall authorize and direct person making any payment on account of any such injury or illness to pay to the Plan so must of such payment as necessary to discharge the Beneficiary's obligation; and

(c) The Beneficiary must cooperate in protecting the Plan's interest under these rules. The interest free loan is made without waiver of the Plan's rights of reimbursement and the other rules described in section 18.4.

18.4 Right of Reimbursement.

(a) The Beneficiary must repay the interest free loan from any recovery received from or on behalf of the third party, including, but not limited to, proceeds from any:

(i) Motor vehicle insurance, including the Beneficiary's underinsured or uninsured motorist coverage;
(ii) Property and casualty insurance;
(iii) Medical malpractice coverage;
(iv) Settlement, judgment, or award;
(v) Workers' compensation insurance or other employer liability program; or other insurance.

(b) The Plan shall have a first lien on such proceeds, up to the amount of the total benefits the Plan paid related to such injury or illness. The Beneficiary must repay the interest free loan even if the proceeds obtained (by settlement, judgment, award, insurance proceeds, or other payment):

(i) Do not specifically include medical expenses,
(ii) Are stated to be for general damages only,
(iii) Are for less than the actual loss or alleged loss suffered by the Beneficiary due to the injury or illness,
(iv) Are obtained on the Beneficiary's behalf by the Beneficiary's estate, legal representative or parent,
(v) Are without any admission of liability, fault, or causation by the third party or payor.

The Plan will have the same rights of lien and reimbursement described above even if the Beneficiary does not sign any documents, to the extent of any payments made by the Plan on the Beneficiary's behalf for any charges related to the illness or injury.

The rights of reimbursement are in addition to any equitable subrogation rights and/or statutory lien rights the Plan may have for reimbursement of these payments.

The Plan's lien may be filed with any third party responsible for such illness or injury, their agent or insurance company, the Beneficiary's legal representative or the court.

Once the Beneficiary has: (1) complied with the requirements above; (2) received a recovery relating to the injury or illness; and (3) paid the Plan's lien as described above (or any lesser amount the Plan agrees is satisfactory if your proceeds are less than the Plan's lien), then the Plan will pay future benefits related to the injury or illness, to the extent that medical treatment subsequent to these events would otherwise be a covered benefit payable under the Plan, but only to the extent that future eligible charges exceed the amount of any net recovery obtained by or on behalf of the Beneficiary (including by the Beneficiary's estate, legal representative, or parent). Net recovery means the total proceeds recovered minus only attorneys' fees, costs and liens directly related to or arising from the injury or illness and actually paid from the recovery.

If the Beneficiary has complied with the above conditions and rules and has made reasonable efforts to obtain recovery for the Beneficiary's illness or injury, but have received a final dismissal or denial of the Beneficiary's legal action without recovering any proceeds for the illness or injury, then the Employer will forgive any loan made under these rules, and will provide benefits for the illness or injury to the extent that they would otherwise be a covered benefit payable under the Plan.

For any payment made by the Plan under these rules, the Beneficiary is still responsible for copayments, deductibles, and timeliness in submission of claims, and other obligations under the Plan

18.5 Release of Information.

By accepting benefits described in this Plan, the Beneficiary agrees that the Claims Administrator or Employer 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 Employer and the Beneficiary;
(b) complying with government requirements; and
(c) bona fide research or education.

18.6 Plan Termination.

The Plan Administrator intends to maintain this Plan indefinitely; however, in its capacity as Plan Sponsor, the Plan Administrator reserves the right to amend, suspend or terminate the Plan, in whole or in part, at any time. This includes amending the benefits under the Plan. If this Plan ends in whole or in part, an affected individual's coverage under this Plan will terminate.

COBRA Rights

To comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan may include a continuation of coverage option. COBRA applies to employers with twenty (20) or more employees on a typical business day in the preceding Calendar Year. COBRA is available to certain Plan participants whose health care coverage(s) under the Plan would otherwise terminate. Plan participants should review the applicable Benefit Document or contact their COBRA Administrator for governing details. The following is only a summary of the major features of the law.

NOTE: Life insurance, accidental death and dismemberment benefits and long-term disability benefits (if part of the employer's Plan) are not eligible for continuation under COBRA

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

- Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered employee, or the covered dependent spouse or child of a covered employee.

  Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered employee has at the time of the child's birth or placement for adoption, the same coverage that a dependent child of an active employee would receive. The employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

  An individual who is not covered under the Plan on the day before a Qualifying Event because he/she was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

  Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered employee is attributable to a period in which he/she was a nonresident alien who received no earned income from the employer that constituted income from sources within the United States. If such an employee is not a Qualified Beneficiary, then a spouse or dependent child of the employee is not a Qualified Beneficiary by virtue of the relationship to the employee.
- Qualifying Event - Any of the following events which would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

  voluntary or involuntary termination of employee's employment for any reason other than employee's gross misconduct;

  reduction in an employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not employee actually works and may include absence

from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the employee fails to return to work at the expiration of the leave, even if the employee fails to pay his/her portion of the cost of Plan coverage during the FMLA leave;

for an employee's spouse or child, employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the employee has been notified that his/her Medicare coverage is in effect;

for an employee's spouse or child, the divorce or legal separation of the employee and spouse;

for an employee's spouse or child, the death of the covered employee;

for an employee's child, the child's loss of dependent status (e.g., a child reaching the maximum age limit).

- Non-COBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification – If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election, etc.), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred which permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the "COBRA Notice Requirements for Plan Participants" in the **IMPORTANT NOTICES** section (or see the employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA continuation coverage. See NOTE.

If the COBRA election of a covered employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled

to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

Open enrollment rights which allow Non-COBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to

Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he/she does not have special enrollment rights, even though active employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the “Effect of the Trade Act” provision for information regarding a second 60-day election period allowance.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his/her waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated Non-COBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his/her deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan’s full cost of coverage during the period for similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The “full cost” includes any part of the cost which is paid by the employer for NonCOBRA Beneficiaries. Qualified Beneficiaries will be charged 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. If payment is not made within such time period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage

are due on the first of each month thereafter, with a 30-day grace period allowed for payment.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase during the Plan's 12-month determination period if:

the cost previously charged was less than the maximum permitted by law;

the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

the Qualified Beneficiary changes his/her coverage option(s) which results in a different coverage cost.

Timely payments which are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The employer's human resources department or personnel office should be contacted for additional information.

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a dependent due to employee's enrollment in the Medicare program before the employee himself/herself experiences a Qualifying Event, the maximum coverage period for the dependent is 36 months from the date the employee is enrolled in Medicare;

for any other Qualifying Event, the maximum coverage period ends 36 months after the loss of coverage.

If a Qualifying Event occurs which provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date which falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial

18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his/her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself/herself.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the loss of coverage due to the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the employer ceases to provide any group health plan to any employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his/her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). <u>The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment</u>.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

Effect of the Trade Act - In response to Public Law 107-210, referred to as the Trade Act of 2002 (“TAA”), the Plan is deemed to be “Qualified Health Insurance” pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

<u>Eligible Individuals</u> - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation (“PBGC”), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc.

The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

Non-electing TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Non-electing TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than 6 months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

HIPAA Creditable Coverage Credit

With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Non-electing TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's pre-existing condition exclusion provision.

Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

Certain federal laws apply to group health programs in addition to those addressed in the **IMPORTANT NOTICES**. Many of these laws are amendments to ERISA. The following is an overview of the laws and their impact. The effect of these laws on Plan benefits is as reflected in the various Benefit Documents (i.e., the certificates or evidences of coverage) provided to Plan participants.

FEDERAL LAWS AFFECTING HEALTH & WELFARE BENEFITS

Family and Medical Leave Act (FMLA)

If the employer is subject to the Family and Medical Leave Act (FMLA) and a covered employee ceases active employment due to an employer-approved leave in accordance with the requirements of FMLA,

coverage will be continued under the same terms and conditions that would have applied had the employee continued in active employment. Contributions will remain at the same employer/employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other employees in the same classification).

In accordance with the FMLA, an employee is entitled to continued coverage if he/she: (1) has worked for the employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the employer employs at least fifty employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

- the birth of an employee's child and in order to care for the child;
- the placement of a child with the employee for adoption or foster care;
- to care for a spouse, child or parent of the employee where such relative has a serious health condition;
- employee's own serious health condition that makes him/her unable to perform the functions of his or her job;
- the employee has a "qualifying exigency" (as defined by DOL regulations) arising because the employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An employee can obtain a more complete description of his/her FMLA rights from the Plan Sponsor's human resources department or personnel office. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered service member. A "covered service member" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a "serious injury or illness" (an injury or illness incurred in line of duty on active duty in the Armed Forces that may render the service member medically unfit to perform his or her duties).

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA amended ERISA and applies to the health benefits of a Plan. HIPAA was enacted, among other things, to improve portability and continuity of health care coverage. The following are summaries of HIPAA's primary impact on group health plans.

- Non-Discrimination Due to Health Status

Application to Eligibility - Any rule for eligibility that discriminates based on a "health factor" of an individual or a dependent of that individual is prohibited. For instance, a Plan is prohibited from containing an actively-at-work requirement that is based on a health factor of an employee.

An exception is made with regard to an employee's first day of work (e.g., if an individual does not report to work on his/her first scheduled work day he/she need not be covered and any waiting period for coverage need not begin). Similarly, a dependent cannot be refused enrollment or coverage based on a "health factor" such as confinement in a health care facility.

An individual's engagement in recreational activities (including high-risk recreational activities) cannot be used to deny an individual enrollment in a Plan.

A "health factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability

- disability
- genetic information

"Rules for eligibility" include, but are not limited to, rules relating to:

- enrollment;
- the effective date of coverage;
- waiting (or affiliation) periods;
- late and special enrollment;
- eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);
- benefits (including rules related to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, co-payments and deductibles);
- continued eligibility; and
- terminating coverage of any individual under a Plan.

Application to Benefits – Any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual Plan participants or beneficiaries based on any health factor or the participants or beneficiaries. Similarly, any amendment limiting benefits under a Plan based on a health factor must be universally applicable to all individuals. A Plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the Plan and made effective no earlier than the first day of the first Plan Year after the amendment is adopted is not considered to be directed at individual participants and beneficiaries.

- **Special Enrollment Rights**

  An individual who enrolls in accordance with HIPAA's "Special Enrollment Rights" is not a "late enrollee" as that term may apply to any pre-existing condition limitations of a Plan or a Component Benefit. The following is an overview of such rights and the minimum requirements of the law.

  Entitlement Due to Loss of Other Coverage - An individual who did not enroll when previously eligible, will be allowed to apply for coverage at a later date if:

  - he/she was covered under another group health plan or other health insurance coverage at the time coverage was initially offered or previously available to him/her. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
  - the employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;
  - the individual lost the other coverage as a result of a certain event such as, but not limited to:
    - loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
    - loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
    - loss of eligibility when an individual incurs a claim that would meet or exceed a

lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit;
- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
- loss of eligibility when COBRA continuation coverage is exhausted; and

o the employee requested Plan enrollment within thirty (30) days of termination of the other coverage.

o If the above conditions are met, coverage will be effective not later than the first day of the first calendar month that begins after the date on which the completed application was received.

NOTE: For a dependent to enroll under the terms of this provision, the employee must be enrolled or must enroll concurrently.

Entitlement Due to Acquiring New Dependent(s) - If an employee acquires one (1) or more new eligible dependents through marriage, birth, adoption, or placement for adoption (as defined by federal law), he/she will have at least thirty (30) days from the date acquired (the "triggering event") to apply for their coverage and coverage will be effective as follows - see NOTE:

o where employee's marriage is the "triggering event" - not later than the first day of the first calendar month after the enrollment request is received; and

o where birth, adoption or placement for adoption is the "triggering event" - on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth.

NOTE: For a newly-acquired dependent to be enrolled under the terms of this provision, the employee must be enrolled or must enroll concurrently. If the newly-acquired dependent is a child, the spouse is also eligible to enroll. However, other dependent children who were not enrolled when first eligible are not considered to be "newly acquired" and may be subject to the late enrollment provisions of the health coverages.

- **Allowance for Prior "Creditable Coverage**"

An individual who transfers to health plan coverage from another plan of "creditable coverage" within 63 days (i.e., with not more than 62 days of non-coverage, not counting any days applied toward waiting period requirements), has a right to demonstrate "creditable coverage" and to request a certificate of creditable coverage from the prior health plan(s). The Plan Sponsor will help any such individual in obtaining such certificate(s). An individual also has the right to demonstrate creditable coverage through the presentation of documentation or other means where a certificate of creditable coverage cannot be obtained from the prior health plan(s).

If the prior coverage is determined to be "creditable coverage", the enrollee will be credited with time covered under such prior plan(s) toward the time limits of any pre-existing condition limitations that may apply.

"Creditable coverage" includes coverage under a group health plan (including a governmental or church plan), individual health insurance coverage, Medicare (other than coverage solely under § 1928 of the Social Security Act – the program for distribution of pediatric vaccines), Medicaid, military-sponsored health care, a program of the Indian Health Services, a State health benefits risk pool, the Federal Employees Health Benefit Program, The State Children's Health Insurance Program, a public health plan as defined in regulations (i.e., any plan established or maintained by a State, the U.S. government, a foreign country,

or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan), and a health benefit plan under the Peace Corps Act. A coverage can be "creditable coverage" even if such coverage remains in effect.

- **Source of Injury Restrictions** - A Plan cannot exclude benefits for injury which results from a medical (physical or mental) condition or domestic violence. For example, any restriction for injury resulting from criminal activity or self-inflicted injury will not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression). Similarly, an injury sustained while intoxicated may not be excluded from coverage if the injury resulted from alcoholism (a medical condition).
- **Wellness Programs** - A Plan cannot impose higher cost-sharing factors (i.e., deductibles, copayments, etc.) on individuals based on an adverse health factor (e.g., smoking), unless the benefit differential is based on participation in an employer's bona fide wellness program as defined by IRS Regulations Section 54.9802-1(f). Participation in such program must waive any adverse benefit differentials.

Mental Health Parity Act

Except in limited circumstances, federal law requires that any mental health care coverage provided by a group health plan may not be subject to annual or lifetime dollar maximums that are less than those applied to any other sickness.

Michelle's Law

On October 9, 2009, the President signed Michelle's Law. This law was enacted to guarantee medical coverage for full time college students who must take a medically necessary leave of absence that would cause them to reduce their class schedule or withdraw from their classes. The law amends ERISA of 1974, the Public Health Service Act and the Internal Revenue Code.

Effective January 1, 2010, your health plan is subject to Michelle's Law. Pursuant to Michelle's Law, if your dependent was a full time student and is on medically necessary leave of absence or has had a change in enrollment due to a serious illness or injury, your dependent may continue coverage for up to one year, or if earlier, until the date of graduation, marriage, or other loss of eligibility under the terms of your health plan.

In order to continue health care coverage in the above cited circumstances, you must notify the Human Resources office immediately to obtain the require certification for completion by you and your dependent's physician. If you have any questions or would like more information on Michelle's Law please contact Human Resources.

Omnibus Budget Reconciliation Act of 1993

OBRA 1993 requires that an eligible dependent child of an employee will include a child who is adopted by the employee or placed with him/her for adoption prior to age 18 and a child for whom the employee or covered dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA (section 609(a)).

See the **QMCSO Procedures** section, if any, for more information. If no such section is included, a copy of the QMCSO procedures can be obtained, without charge, from the Plan Administrator.

- **Pregnancy Discrimination Act**

  Federal law requires that an employer provide coverage for pregnancy expenses in the same manner as any other sickness. This requirement applies to pregnancy expenses of an employee or a covered dependent spouse of an employee.

- **Privacy Rules & Security Standards**

To the extent required by law, the Plan is amended and will comply with: (1) the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health

Insurance Portability and Accountability Act (HIPAA) and (2) the HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

NOTE: The Privacy Rules requirements do not apply to "summary health information" which is provided only for the purpose of obtaining premium bids or for modifying or terminating the Plan. "Summary health information" is health-related information that is in a form that excludes individual identifiers such as names, addresses, social security numbers or other unique patient-identifying numbers or characteristics.

- **Uniformed Services Employment and Reemployment Rights Act (USERRA)**
  Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.
  - An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.
  - Notice Requirements - To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.
  - If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.
  - Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.
  - Maximum Period of Coverage – The maximum period of USERRA continuation coverage is the lesser of:

- months (or 24 months for elections made on or after December 10, 2004); or
- the duration of Employee's active military service.

o Reinstatement of Coverage Following Active Duty - Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

o The Employee must return to employment:
- on the first full business day following completion of military service for military leave of 30 days or less; or
- within 14 days of completion of military service for military leave of 31-180 days; or
- within 90 days of completion of military service for military leave of more than 180 days.

o When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period or preexisting condition exclusion can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

IMPORTANT NOTICES

Additional Benefit Information - Who to Contact

A Plan participant or beneficiary can obtain additional information, free of charge, about Plan coverage of a specific drug, treatment, procedure, preventive service, etc. from his/her benefit provider (see "Provider" in the **PLAN BENEFITS** section). The name, address and phone number of the provider is as shown in the applicable benefit information section.

COBRA Notice Requirements for Plan Participants

A Plan participant must provide the following Notices as they relate to COBRA Continuation Coverage:

- Notice of Divorce or Separation - Notice of a divorce or legal separation of a covered employee from his or her spouse.
- Notice of Child's Loss of Dependent Status - Notice of a child's loss of dependent status (e.g., a dependent child reaching the maximum age limit).
- Notice of a Second Qualifying Event - Notice of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
- Notice Regarding Disability - Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.
- Notice Regarding Address Changes – It is important that the Employer be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. Any individual who is either the covered employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Send Notice To: **Times Super Market**
3375 Koapaka Street, Unit D-108
Honolulu, HI 96819

Attn: Human Resources
Phone: (808) 831-0811 ext. 268

- Form, Content & Delivery - Notification of the Qualifying Event must be in writing. Notification must include:
  - ◊ **The date of the notice**
  - ◊ **The name of your company**
  - ◊ **The name of the employer/plan administrator**
  - ◊ **The qualified beneficiary(ies) and their relationship to the subscriber**
  - ◊ **Type of coverage to be continued**
  - ◊ **The date coverage will end**
  - ◊ **The type of qualifying event**
  - ◊ **The start date of COBRA**
  - ◊ **The end date of COBRA**
  - ◊ **The current COBRA premium**
  - ◊ **The employer contact information**
  - ◊ **Copy of divorce decree (if applicable)**
  - ◊ **Copy of child's birth certificate (if applicable)**
  - ◊ **Copy of the Social Security Administration's disability determination letter (if applicable)**
- Time Requirements - In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor's General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of the Plan's Summary Plan Description or Plan Document.

  If an employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

Genetic Information Nondiscrimination Act of 2008 (GINA)

Effective January 1, 2010, the following provisions apply to Times Super Market. Under GINA, group health plans and health insurance issuers generally may not:

- Adjust premium or contribution amounts for the covered group on the basis of genetic information;
- Request or require an individual or a family member to undergo a genetic test;
- Request, require or purchase genetic information with respect to any individual, prior to such individual's enrollment or coverage under the plan.

However, a doctor or health care professional who is providing health care services to you may request that you undergo a genetic test, which you voluntarily agree to, for the treatment of a health condition. Then, the group health plan and health insurance issuer may obtain and use the results of a genetic test to make a determination regarding payment of medically necessary health care services, provided only the minimum amount of information necessary is requested.

In addition, group health plans may request, but not require, a participant or beneficiary to undergo a genetic test for research purposes, if certain conditions are met, including that:

- The request is made in writing;
- The research complies with Federal and State laws;
- The plan clearly indicates to the participant or the beneficiary that compliance with the request is voluntary on the part of the participant or the beneficiary; and
- The plan indicates that noncompliance will have no effect on eligibility or benefits

Newborns' and Mothers' Health Protection Act (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The group health plan does not need to provide the minimum period of coverage for a maternity stay if the mother and health care provider agree to an earlier discharge.

A provider is not required to obtain authorization for a length of stay that is not in excess of 48 hours (or 96 hours).

Non-discrimination Notice

This Plan, including benefits and policies, does not discriminate on the basis of race, color, national origin, sex, age or disability. It complies with applicable federal civil rights laws. Plan participants needing translation assistance should contact HMA at toll free 866-331-5913 or TTY 866-826-5334. If you feel you were discriminated in any way, you can file a grievance with your Human Resources Department at the contact information in this section or you can contact HMA by phone at toll free 866-331-5913 or in writing to Grievance Department 1440 Kapiolani Blvd. Suite 1020 Honolulu, Hawaii 96814. Or you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, by phone at toll free 800-368-1019, TDD users, call toll free 800-537-7697 or by mail at U.S. Department of Health and Human Services, 200 Independence Ave. SW., Room 509F, HHH Building, Washington, DC 20201.

Women's Health and Cancer Rights Act (WHCRA)

The health benefits of most plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the WHCRA.

STATEMENT OF ERISA RIGHTS

Plan participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that a Plan participant shall be entitled to:

- **Receive Information About His/Her Plan and Benefits**. This includes the right to:
  - examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
  - obtain, upon written request to the Plan Administrator, copies of documents governing

the operation of a Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and
    - receive a summary of a Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- **Continue Group Health Plan Coverage**. This includes:
    - the right to continue health care coverage for himself/herself, spouse or dependents if there is a loss of coverage under a Plan as a result of a Qualifying Event. The employee or his/her dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights; and
    - reduction or elimination of exclusionary periods of coverage for preexisting conditions under a Plan, if he/she has creditable coverage from another plan. An individual should be provided a certificate of creditable coverage, free of charge, from his/her group health plan or health insurance issuer when he/she loses coverage under a plan, when he/she becomes entitled to elect COBRA continuation coverage, when his/her COBRA continuation coverage ceases, if he/she requests it before losing coverage or if he/she requests it up to 24 months after losing coverage.
- **Prudent Actions by Plan Fiduciaries**
    - In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of a Plan (the fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Plan participants and beneficiaries. No one, including the employer, may fire a Plan participant or discriminate against him/her to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.
- **Enforce His/Her Rights**
    - If an individual's claim for a welfare benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. He/she has the right to have the Plan Administrator review and reconsider his/her claim.
    - Under ERISA there are steps a Plan participant can take to enforce the above rights. For instance, if he/she requests materials from a Plan and does not receive them within 30 days, he/she may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay him/her up to $110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
    - If he/she has a claim for benefits which is denied or ignored, in whole or in part, he/she may file suit in a state or Federal court. In addition, if he/she disagrees with the Plan decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he/she may file suit in Federal court.
    - If it should happen that Plan fiduciaries misuse the Plan's money, or if he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or he/she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he/she is successful, the court may order the person he/she has sued to pay these costs and fees. If he/she loses, the court may order him/her to pay these costs and fees, for example, if it finds his/her claim is frivolous.
- **Assistance With Questions**
    - If a Plan participant has any questions about a Plan, he/she should contact the Plan Administrator. If he/she has any questions about this statement or about his/her rights under ERISA, he/she should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in his/her telephone directory, or (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. A Plan participant may also obtain certain publications about his/her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.