LOCAL 665
IATSE
HEALTH & WELFARE
FUND

IATSE MIXED LOCAL 665

Hawaii's Technicians for Film, Television, Stage and Projection

Since 1937

875 WAIMANU STREET SUITE 610
HONOLULU, HAWAII 96814

DECEMBER 2011

This Plan is administered by

Group Plan Administrators, Inc.
222 South Vineyard Street, PH 4
Honolulu, Hawaii 96813
Telephone: (808) 523-9411

Toll Free: 1 (877) 523-9411

IMPORTANT NOTICE

If you have any questions concerning this Plan, such as eligibility or benefits, please contact the Local 665 IATSE Health and Welfare Fund Office at 222 South Vineyard Street, PH 4, Honolulu, Hawaii 96813, Telephone: (808) 523-9411, Neighbor Islands Toll Free: 1 (877) 523-9411, 8:00 a.m.-4:30 p.m., Monday through Friday.

Benefits for actives are neither guaranteed nor vested and will be provided only as long as funds are available. The Board of Trustees reserves the right, at its sole discretion, to modify the Plan with regard to eligibility requirements and benefits available, to require a contribution for the cost of benefits, or to terminate benefits at any time.

Since changes made may affect you and your dependents, please read this booklet and subsequent notices that are mailed to you carefully.

LOCAL 665 IATSE
HEALTH AND WELFARE FUND

BOARD OF TRUSTEES

Employer Trustees	Union Trustees
Naomi Carter	Allan F. Omo
Leroy Jenkins	Henry Fordham, III
Jack Schneider	Michael J. Downing
	Kenneth K. Sato (Alternate)

CONTRACT ADMINISTRATOR

Group Plan Administrators, Inc.

CONSULTANT

Benefit Plan Solutions, Inc.

LEGAL COUNSEL

Fujikawa & Yasunaga, Attorneys At Law

AUDITOR

Lemke, Chinen & Tanaka, CPA, Inc.

INVESTMENT MANAGER

Central Pacific Bank

INVESTMENT MONITOR

Morgan Stanley Smith Barney

CUSTODIAN

Central Pacific Bank

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

LOCAL 665 IATSE
HEALTH AND WELFARE FUND

TO ALL PLAN PARTICIPANTS:

Several important changes have been made in your Health and Welfare benefits over the past few years. You have been previously notified of these changes and their effective dates. However, as part of our ongoing process to familiarize you with the benefit programs and to comply with Federal law, the changes have been incorporated in this booklet.

YOU ARE URGED TO READ THIS BOOKLET CAREFULLY AND BECOME FAMILIAR WITH ALL THE BENEFITS YOU AND YOUR DEPENDENTS ARE ENTITLED TO RECEIVE.

THIS BOOKLET EXPLAINS, AS BRIEFLY AS POSSIBLE, THE BENEFITS PROVIDED TO ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS. THE TRUST AGREEMENT, POLICIES, CONTRACTS, AND VARIOUS RULES AND REGULATIONS ADOPTED BY THE TRUSTEES, AS REFLECTED IN PARTICIPANT NOTICES, ARE THE FINAL AUTHORITIES IN ALL MATTERS RELATED TO THE LOCAL 665 IATSE HEALTH AND WELFARE FUND. COPIES OF THESE DOCUMENTS ARE AVAILABLE FOR INSPECTION AT THE LOCAL 665 IATSE HEALTH AND WELFARE FUND OFFICE DURING REGULAR BUSINESS HOURS.

LOCAL 665 IATSE
HEALTH AND WELFARE FUND

TABLE OF CONTENTS

STATEMENT OF ERISA RIGHTS

As a participant in the Local 665 IATSE Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

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

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request a certificate before losing coverage, or up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion in your coverage for 12 months (18 months for late enrollees) after your enrollment date in a new plan.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Honolulu, Hawaii 96813. You will not be retaliated against, in any way, for filing a complaint.

The Fund has designated Group Plan Administrators, Inc. as the Fund's Privacy Officer and its contact person for all issues regarding patient privacy and your privacy rights. For a copy of the privacy notice which provides a complete description of your rights under HIPAA's privacy rules, contact the Fund's Privacy Officer at *222 South Vineyard Street, PH4, Honolulu, Hawaii 96813, phone: (808) 523-9411 or Neighbor Islands Toll Free 1 (877) 523-9411, Monday through Friday, 8:00 a.m. to 4:30 p.m.*

FOR BENEFITS PROVIDED THROUGH CARRIERS

For any questions or complaints regarding your health information and privacy rights related to the benefits provided through the plans listed below, contact the following:

UHA Medical and Prescription Drug Plans
Privacy Officer
UHA
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813
Phone: 532-4000 (Members Services)

Kaiser Medical, Prescription Drug and Vision Plans
Privacy Officer
Kaiser Foundation Health Plan, Inc.
711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Phone: 432-5090

Vision Service Plan
Member Service Department
3333 Quality Drive
Rancho Cordova, California 95670
Phone: 1 (800) 877-7195

HDS Dental Plan
Privacy Officer
Hawaii Dental Service
700 Bishop Street, Suite 700
Honolulu, Hawaii 96813
Phone: 529-9248 (Customer Service)

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

PLAN SPONSOR AND ADMINISTRATOR

Board of Trustees
International Alliance of Theatrical Stage Employees and
Moving Picture Machine Operators of the United States
and Canada, Local 665, AFL-CIO (IATSE)
222 South Vineyard Street, PH 4
Honolulu, Hawaii 96813

Participants and Beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan and, if so, the sponsor's address.

IDENTIFICATION NUMBERS

Assigned by Internal Revenue Service (EIN) — 99-0228405
Assigned by Plan Sponsor — Plan No. 501

TYPE OF PLAN

Welfare — medical, prescription drug, vision, dental, and life insurance benefits.

TYPE OF ADMINISTRATION

The Board of Trustees has engaged Group Plan Administrators, Inc. at 222 South Vineyard Street, PH 4, Honolulu, Hawaii 96813 to serve as Contract Administrator for the Health and Welfare Fund.

AGENT FOR SERVICE OF LEGAL PROCESS

Dennis K. Kawasaki, Contract Administrator
Group Plan Administrators, Inc.
222 South Vineyard Street, PH 4
Honolulu, Hawaii 96813

Service of legal process may also be made upon a Plan Trustee.

NAME, TITLE, AND PRINCIPAL PLACE OF BUSINESS ADDRESS OF PLAN TRUSTEES

Employer Trustees

Naomi Carter
2311 Halehaka Street
Honolulu, Hawaii 96821

LeRoy Jenkins
President
Production Partners, Inc.
229 Paoakalani Avenue, Suite 600
Honolulu, Hawaii 96815

Jack Schneider
J.S. Services
3160 Waialae Avenue
Honolulu, Hawaii 96816

Union Trustees

Allan F. Omo
President
IATSE Local 665
875 Waimanu Street, Suite 610
Honolulu, Hawaii 96813

Henry Fordham, III
Business Representative
IATSE Local 665
875 Waimanu Street, Suite 610
Honolulu, Hawaii 96813

Michael J. Downing
Member
IATSE Local 665
875 Waimanu Street, Suite 610
Honolulu, Hawaii 96813

Kenneth K. Sato (Alternate)
Member
IATSE Local 665
875 Waimanu Street, Suite 610
Honolulu, Hawaii 96813

APPLICABLE COLLECTIVE BARGAINING AGREEMENT

The current Collective Bargaining Agreement between the International Alliance of Theatrical Stage Employees and Moving Picture Machine Operators of the United States and Canada, Local 665, AFL-CIO and signatory Employers provides for participation in the Local 665 IATSE Health and Welfare Fund.

A copy of the Collective Bargaining Agreement may be obtained by Participants and Beneficiaries upon written request to the Contract Administrator and is available for examination by Participants and Beneficiaries at the Trust Fund Office.

SOURCE OF CONTRIBUTIONS

The funds, out of which all Plan benefits are paid, are contributed by Employers who are parties to the Collective Bargaining Agreement, by the Union on behalf of its staff employees, and by Plan participants (i.e., self-payments and COBRA payments). The amount of Employer contributions is calculated by 1) multiplying the number of hours worked during the month by each Employee by the hourly contribution rate, or 2) multiplying the gross wages by a percentage factor, or 3) multiplying the number of days worked during the month by the daily contribution rate, as specified in the Collective Bargaining Agreement. Participant contribution rates for the Self-Payment and COBRA programs are set annually by the Trustees.

written request for review with the Board of Trustees. Your written request must be filed within 60 days after receipt of the Administrator's decision and describe your version of the facts and reasons why you feel that the decision was not proper.

Upon receipt of your written request for review, the Board of Trustees (or a subcommittee thereof) will review your case. The Board of Trustees (or a subcommittee thereof) will determine whether or not a hearing will be held on your case. If a hearing is to be held, you will be notified of the time and place of the hearing at least two (2) weeks in advance of the hearing (unless you agree in writing to a shorter notice period). You and/or your authorized representative may appear at the hearing.

The decision of the Board of Trustees (or a subcommittee thereof) will be made within 60 days after receipt of your written request, unless special circumstances require an extension of time for reviewing your case, in which case the decision will be rendered as soon as possible, but not later than 120 days after receipt of your written request.

The decision of the Board of Trustees (or a subcommittee thereof) will be in writing and include specific reasons for their decision and shall be final.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The Local 665 IATSE Health and Welfare Fund is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, to maintain the privacy of your health information. The Fund and its business associates may use or disclose your health information for the following purposes:

- Treatment;
- Payment;
- Health plan operations and plan administration; and
- As permitted or required by law.

Other than for the purposes stated above, your health information will not be used or disclosed without your written authorization. If you authorize the Fund to use or disclose your health information, you may revoke that authorization at any time in writing.

Under HIPAA, you have the following rights regarding your health information. You have the right to:

- Request restrictions on certain uses and disclosures of your health information;
- Receive confidential communications of your health information;
- Inspect and copy your health information;
- Request amendment of your health information if you believe your health records are inaccurate or incomplete; and
- Request a list of certain disclosures by the Fund of your health information.

You also have the right to make complaints to the Fund as well as to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to: *Privacy Officer, Local 665 IATSE Health and Welfare Fund, 222 South Vineyard Street, PH4,*

APPEALS PROCEDURES

INSURED CLAIMS

Medical and prescription drug benefits are provided through University Health Alliance (UHA) and Kaiser Foundation Health Plan, Inc. Vision care benefits are provided through Kaiser Foundation Health Plan, Inc. and Vision Service Plan. Dental benefits are provided through Hawaii Dental Service. Life insurance is provided by Pacific Guardian Life.

Participants and beneficiaries may obtain information regarding the claims and appeals procedures for these insurance plans by contacting the respective carrier at the address listed below:

UHA
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813
Attn: Appeals Coordinator

KAISER FOUNDATION HEALTH PLAN, INC.
711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Attn: Customer Service

HAWAII DENTAL SERVICE
700 Bishop Street, Suite 700
Honolulu, Hawaii 96813-4196
Attn: Dental Consultant

VISION SERVICE PLAN
3333 Quality Drive
Rancho Cordova, California 95670
Attn: Member Appeals

PACIFIC GUARDIAN LIFE
1440 Kapiolani Boulevard, Suite 1700
Honolulu, Hawaii 96814
Attn: Group Claims Department

OTHER APPEALS

The Trust Fund Office serves as the Administrator of the Local 665 IATSE Health and Welfare Fund and maintains the Trust records regarding your eligibility for benefits. Questions concerning enrollment, change of employee status, or change in dependent coverage should be directed to the Trust Fund Office. Any disagreement regarding your eligibility status or the status of your dependent that cannot be resolved by the Administrator may be submitted to the Board of Trustees for review.

You have the right to appeal any decision of the Administrator based on Plan rules adopted by the Board of Trustees (e.g., denial of eligibility or loss of eligibility) by filing a

FUNDING MEDIUM

All contributions to the Health and Welfare Fund are transmitted to the Trust Fund Office and deposited into an interest-bearing checking account out of which premium payments are made to the insurance carriers that provide benefits. Funds in excess of those needed for immediate requirements are invested by the investment manager in accordance with general investment guidelines determined and reviewed by the Trustees.

FISCAL YEAR

June 1 through the following May 31.

AMENDMENT AND ELIMINATION OF BENEFITS AND TERMINATION OF PLAN

The Trust Agreement gives the Board of Trustees the authority to terminate the Plan or to amend or eliminate eligibility requirements and benefits available under the Plan, at any time.

Benefits may be amended or eliminated if the Trustees determine that the Trust Fund does not have funds to pay for the benefits being provided.

The Trust may be terminated by the Union(s) and the Employers, or by termination of the Labor Agreements.

If benefits under the Local 665 IATSE Health and Welfare Fund are amended or eliminated, Participants and Beneficiaries are eligible for only those benefits which are available after the amendment or elimination of benefits. Participants and Beneficiaries have the obligation to read all participant and beneficiary notices issued pertaining to the amendment or elimination of benefits.

If the Local 665 IATSE Health and Welfare Fund is terminated, benefits will be provided to Participants and Beneficiaries who have satisfied the eligibility requirements established by the Board of Trustees only as long as funds are available. Benefits under the Trust Fund are not vested or guaranteed. Participants and Beneficiaries have the obligation to read the Summary Plan Description (SPD) and all Participant and Beneficiary notices issued pertaining to the termination of the Trust Fund and once notified by the insurance carriers of the termination of the plan, should contact the various insurance carriers for information on conversion to an individual plan offered by the respective insurance carriers.

Upon the termination of the Local 665 IATSE Health and Welfare Fund, any assets remaining shall be used solely to pay for benefits and for expenses of administration incident to providing said benefits. Participants and beneficiaries have no right to any remaining assets of the Trust Fund.

ELIGIBILITY RULE CHANGES

Several important changes have been made in your Health and Welfare benefits over the past few years. You have been previously notified of these changes and their effective dates. However, as part of our ongoing process to familiarize you with the benefit programs and to comply with Federal law, the changes have been incorporated in this booklet revision.

1. Effective with the September 2004 work month for coverage effective December 1, 2004, the amount of employer contributions needed for eligibility is $300.00 per month, whether an employee selects single, two-party, or family coverage (formerly $270.00 per month).
2. Effective with the September 2005 work month for coverage effective December 1, 2005:
   a) The Fund's subsidy for employee benefits is $100.00 per eligible employee per month (page 9).
   b) In order to be eligible for benefits in any given month, the amount of employer contributions received on your behalf plus your bank reserve must be equal to or greater than the net premium cost for the plan you select after deducting the Fund's subsidy of $100.00 (page 9).
   c) The bank reserve maximum increased to $2,900.00 (formerly $2,750.00) (page 10).
3. Effective with the June 2007 work month for coverage effective September 1, 2007, the amount of employer contributions needed for eligibility is $456.84 per month for HMSA (formerly $399.60) and $343.54 per month for Kaiser (formerly $337.09).
4. Effective January 1, 2008, the amount of employer contributions needed for eligibility is $456.44 per month for HMSA (formerly $456.84) and $343.14 per month for Kaiser (formerly $343.54) to reflect a reduction in the premium rate for life insurance.
5. Effective July 1, 2009, after the initial COBRA payment, each subsequent payment must be made by the 10th day of the month for which payment is being made in order to continue COBRA coverage (page 13).
6. Effective with the April 2010 work month for coverage effective July 1, 2010, the amount of employer contributions needed for eligibility is $388.72 per month for UHA and $472.64 per month for Kaiser (formerly $410.87).
7. Effective June 1, 2011, in accordance with the Patient Protection and Affordable Care Act of 2010, dependent children who are not eligible for other employer-sponsored health plan coverage (other than the group health plan of a parent) are eligible for dependent coverage up to age 26 (page 16).

(3) If no beneficiary is named, or if no named beneficiary survives you, Pacific Guardian Life will pay the first of the following classes of successive preference beneficiaries who survive you:
   (a) All to your surviving spouse; or
   (b) If your spouse does not survive you, in equal shares to your surviving children; or
   (c) If no child survives you, in equal shares to your surviving parents; or
   (d) If no parent survives you, in equal shares to your surviving brothers and sisters; or
   (e) Your estate.

If the beneficiary is a minor or is otherwise incapable of giving a valid release for any payment due, Pacific Guardian Life may pay the legal guardian.

Any payment made in accordance with the preceding provisions shall release Pacific Guardian Life from further liability for the amount paid.

CONVERSION RIGHTS

If you become ineligible for coverage, your life insurance will be continued for 31 days following the termination of your eligibility.

During this 31-day period, you have the right to obtain any regular individual policy issued by Pacific Guardian Life (except Term Insurance). The individual policy will be issued without medical examination at Pacific Guardian Life's regular premium rates. The amount of your individual policy cannot exceed the amount of insurance for which you were covered under the group policy. You must apply and pay for the first premium within 31 days after your insurance terminates. However, no conversion is allowed unless the member has been insured through the Policyholder for at least five (5) years prior to the termination.

The preceding life insurance benefits are fully insured under an insurance contract issued by Pacific Guardian Life (PGL), 1440 Kapiolani Boulevard, Suite 1700, Honolulu, Hawaii 96814. The services provided by PGL include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes and is only a summary of the life insurance coverage. Its contents are subject to the provisions of the Group Life Insurance Master Contract with Pacific Guardian Life, and all amendments thereto, which contain all of the terms and conditions governing life insurance benefits. These documents are on file with the Local 665 IATSE Health and Welfare Fund Office. Please refer to these documents for specific questions about coverage.

PACIFIC GUARDIAN LIFE

LIFE INSURANCE BENEFIT CHANGES

Several important changes have been made in your Health and Welfare benefits over the past few years. You have been previously notified of these changes and their effective dates. However, as part of our ongoing process to familiarize you with the benefit programs and to comply with Federal law, the changes have been incorporated in this booklet revision.

1. Effective December 1, 2009, self-payment for life insurance is available as an option under the Self-Payment Program and the COBRA Program at a premium determined by Pacific Guardian Life (pages 11 and 13).

LIFE INSURANCE BENEFITS

COVERAGE

You are covered for life insurance in accordance with the following schedule:

	LIFE INSURANCE BENEFIT
ACTIVE EMPLOYEES	
Under Age 65	$10,000
Age 65 through 69	$ 6,500
Age 70 through 74	$ 4,500
Age 75 through 79	$ 3,000
Age 80 and Over	$ 2,000

BENEFICIARY

On your Trust Fund Personnel Information Form, you may name anyone you wish as your beneficiary to receive your life insurance. You may change your beneficiary at any time by submitting a new Trust Fund Personnel Information Form to the Local 665 IATSE Health and Welfare Fund Office. The change is effective on the date you sign the form. Pacific Guardian Life will honor a beneficiary change request only if it is recorded before any payment has been made.

When Pacific Guardian Life receives due proof of your death, the amount of life insurance on your life will be paid.

Unless you request otherwise in your filed beneficiary designation, payment shall be made as follows:

(1) If more than one (1) beneficiary is named, each will be paid an equal share.

(2) If any named beneficiary dies before you, his/her share will be divided equally among the named beneficiaries who survive you.

ELIGIBILITY RULES FOR ACTIVE EMPLOYEES

WHO IS ELIGIBLE

In order to qualify for benefits, you must work in the Union Local 665 Bargaining Unit for Employers who have a signed Collective Bargaining Agreement or Contribution Agreement obligating them to contribute to the Local 665 IATSE Health and Welfare Fund on your behalf at the negotiated contribution rate and the Employers must actually make the contributions.

ESTABLISHING ELIGIBILITY

The amount of employer contributions required for eligibility may change periodically at the discretion of the Trustees.

Effective with the September 2005 work month, the Fund's monthly subsidy for employee benefits will be $100.00 per eligible employee. The amount of employer contributions that you must earn to be eligible for benefits is equal to the net premium cost for the plan you select (UHA or Kaiser) after deducting the Fund's subsidy of $100.00. You will be eligible for medical, prescription drug, vision, dental, and life insurance benefits beginning on the first day of the third month following any work month in which you accumulate the required net premium amount in paid employer contributions. The net premium amount is the same whether you select single, two-party, or family coverage.

Example: You accumulate $500.00 in paid employer contributions for your September work hours. You selected the Kaiser plan that costs $572.64 per month. After applying the $100.00 Fund subsidy, your net premium cost is $472.64. Since the $500.00 in employer contributions is sufficient to cover the net premium cost, you will be eligible for benefits effective December.

You will not receive credit for any contribution until the contribution is actually received by the Trust Fund. If the required contribution is not received when due, you will not be credited for that contribution until the month in which the contribution is actually received. You will then be eligible for benefits prospectively, and not retroactively, on the first day of the third month following the month in which the contribution is actually received, or as soon as administratively feasible.

If you are credited with contributions determined to have not been actually received by the Trust Fund, you will not receive credit again when the contributions are actually received.

You will only receive credit for contributions received from Employers who have a signed Memorandum of Agreement or other written agreement that requires the Employer to make contributions to the Trust Fund. The Trust Fund cannot receive contributions from any Employer without such a written agreement. If you work for an Employer who does not have a signed agreement with the Trust Fund, you will not receive credit for any work performed for that Employer.

BANK RESERVE

All monthly employer contributions paid on your behalf are placed in your bank reserve, which is maintained for your future use towards benefit coverage when needed.

Effective with the September 2005 work month, you may accumulate up to a maximum of $2,900.00 in contributions in your bank reserve.

Example: You select single coverage and earn $500.00 in employer contributions for work in September, which is paid in October and placed in your bank reserve. You selected the Kaiser plan that costs $572.64 per month. After applying the $100.00 Fund subsidy, your net premium cost is $472.64. The required net premium amount of $472.64 is deducted from your bank reserve for your eligibility for the month of December. The excess of $27.36 will remain in your bank reserve for future eligibility.

Example: You select two-party coverage. You have a bank reserve of zero (0) and you earn $300.00 in employer contributions for work in September, which is paid in October and placed in your bank reserve. You have selected the UHA Plan that costs $488.72 per month. After applying the $100.00 Fund subsidy, your net premium cost is $388.72. Since the amount of employer contributions earned is not sufficient to cover the net premium cost, you will not be eligible for benefits and the $300.00 in employer contributions will remain in your bank reserve and will be accumulated with any future employer contributions earned. For work in October, you earn $180.00 in employer contributions, which is paid in November and placed in your bank reserve. Since you have now accumulated sufficient employer contributions to cover the net premium cost, $388.72 is deducted from your bank reserve for your eligibility in January. The excess of $91.28 will remain in your bank reserve for future eligibility.

Note: Effective September 1, 2005, $30.00 per month will be deducted from the bank reserve of those employees who have not selected a medical plan to offset administrative expenses associated with maintaining such accounts.

CONTINUING ELIGIBILITY

You will continue to be covered for benefits as long as you have sufficient contributions in your bank reserve for continued eligibility. During any month that you do not earn or have enough contributions in your bank reserve to meet your net premium cost, you may accumulate these contributions for future eligibility. However, if 1) you do not earn any employer contributions for ten (10) consecutive work months and 2) either your bank reserve is insufficient for eligibility or you fail to enroll in one of the medical plans, any remaining balance in your bank reserve will be reduced to zero (0).

Example: You select family coverage. You have a bank reserve of zero (0) and you earn $100.00 in employer contributions for work in September, which is paid in October and placed in your bank reserve. You have selected the UHA Plan that costs $488.72 per month. After applying the $100.00 Fund subsidy, your net premium cost is $388.72. Since the amount of employer contributions earned is not sufficient to cover the net premium cost, the $100.00 in employer contributions will remain in your bank reserve and will be accumulated with any future employer contributions earned. If you do not earn any contributions in October, November, December, January, February, March, April, May, June, and July, your bank reserve will then be reduced to zero (0).

How To Contact HDS

HDS Website:
www.deltadentalhi.org

Visit the HDS website to search for a participating dentist, check your eligibility and plan benefits, access Explanation of Benefits (EOB) reports to view information about dental services you have received, or even print your membership identification card.

HDS DenTel
From Oahu: 545-7711
Toll-free: 1-800-272-7204

HDS DenTel is an automated phone service that allows HDS members to find out when they are eligible for coverage for their next dental visit, to obtain claims information, or even to have a summary of their plan benefits faxed or mailed to them, simply by following the prompts on the phone. Available everyday, 24 hours a day.

Customer Service Representatives:

Phone Line
From Oahu: 529-9248
Toll-free 1-800-232-2533 extension 248

Fax: 529-9366
Toll-free fax: 1-866-590-7988

HDS customer service representatives are available Monday through Friday from 7:30 a.m. - 4:30 p.m. Hawaii Standard Time.

Send written correspondence to:

Hawaii Dental Service
Attn: Customer Service
700 Bishop Street, Suite 700
Honolulu, HI 96813-4196

The preceding dental benefits are fully insured under a contract issued by Hawaii Dental Service (HDS), 700 Bishop Street, Suite 700, Honolulu, Hawaii 96813-4196. The services provided by HDS include the payment of claims and the handling of claims appeals.

The preceding is for informational purposes and is only a summary of coverage. Its contents are subject to the provisions of the Contract for Dental Services which contains all the terms and conditions of membership and benefits. This document is on file with the Local 665 IATSE Health and Welfare Fund Office. Please refer to this document for specific questions about coverage.

BENEFIT	PLAN COVERS
PERIODONTICS	70%
• Periodontal scaling and root planing (once every two years)	
• Gingivectomy, flap curettage and osseous surgery (once every three years)	
• Periodontal Maintenance – twice per calendar year	
PROSTHODONTICS (12-month wait period applies)**	70%
• Fixed bridges (once every 5 years; ages 16 and older)	
• Removable Dentures — Complete and Partial (once every 5 years; ages 16 and older)	
• Repairs and adjustments	
• Relines and rebase	
• Implants (covered as alternate benefit) when one tooth is missing between two natural teeth	
****Note: Prosthodontic coverage is provided after 12 months of cumulative enrollment in the plan.**	
ORAL SURGERY	70%
• Extractions	
• Other oral surgery procedures to supplement medical care plan	
ADJUNCTIVE GENERAL SERVICES	70%
• Consultations	
• Office Visits (injury related)	
• Sedation: General & IV	
• Palliative (emergency) treatment for relief of pain but not to cure	

Benefit Exclusions

The following are general exclusions not covered by the plan:

- Services for injuries and conditions that are covered under Workers' Compensation or Employer's Liability Laws; services provided by any federal or state government agency or those provided without cost to the eligible person by the government or any agency or instrumentality of the government.
- Congenital malformations, medically related problems, cosmetic surgery or dentistry for cosmetic reasons.
- Procedures, appliances or restorations other than those for replacement of structure loss from cavities that are necessary to alter, restore or maintain occlusion.
- Treatment of disturbances of the temporomandibular joint (TMJ).
- Orthodontic services.
- Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to a patient by a dentist.
- Other exclusions are listed in the Schedule of Benefits, which is included in your trust fund's dental contract.

LOSS OF ELIGIBILITY

You will continue to be eligible for health and welfare benefits provided you have sufficient employer contributions in your bank reserve to meet your net premium cost. You will lose eligibility on the earliest of the following dates:

1. The first day of the third calendar month following the month in which you do not have sufficient employer contributions in your bank reserve to meet your net premium cost, or
2. The date this plan terminates.

HOW TO CONTINUE YOUR COVERAGE IF YOU LOSE YOUR ELIGIBILITY

When your eligibility for benefits terminates, you may continue your coverage by electing one (1) of the following two (2) options:

1. Self-Payment Program, or
2. COBRA Program.

Self-Payment Program

Effective July 1, 2001, the Local 665 IATSE Health and Welfare Fund has been offering the Self-Payment Program as an option to the COBRA Program for you to continue your benefits when you become ineligible for benefits.

Under the Self-Payment Program, you may continue medical, prescription drug and life insurance benefits only for twelve (12) consecutive months. If you choose to continue your benefits under the Self-Payment Program, you give up your right to choose the COBRA Program option described in the following section.

To continue coverage under the Self-Payment Program, you and/or your dependents must pay an amount equal to the cost of the benefits chosen, as determined by the Board of Trustees.

At the time that you elect to be covered under the Self-Payment Program, you will be allowed to change from family coverage to two-party or single coverage or from two-party coverage to single coverage. If you do not change your coverage at the time you elect the Self-Payment Program, you may not change your coverage until the open enrollment period.

When you have exhausted the maximum number of months available under the Self-Payment Program, you may **not** continue coverage under the COBRA Program.

If you wish to continue your benefits under the Self-Payment Program, please contact the Local 665 IATSE Health and Welfare Fund Office.

Continuation of Coverage Under COBRA

The Local 665 IATSE Health and Welfare Fund, in compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, currently offers qualified employees and/or dependents of employees who lose coverage as a result of a "qualifying event" the opportunity to continue coverage for a specified period of time as outlined below:

Qualifying Event	Maximum Period of Continuation Coverage
Employee's termination of employment (for reasons other than gross misconduct)	18 months
Reduction in hours worked by employee	18 months
Death of employee	36 months
Divorce or legal separation	36 months
Employee becomes entitled to Medicare	36 months
Dependent child ceases to be eligible as a dependent as defined by the Trust Fund	36 months

If the continuation coverage period is for a maximum period of 18 months and during that period another qualifying event occurs which would entitle your spouse or dependent child to coverage for a maximum of 36 months, the coverage for your spouse and/or dependent child will be extended to 36 months from the date of the first qualifying event.

If the continuation coverage period is for a maximum period of 18 months and you, your spouse, or your covered dependent child is determined to be disabled under the Social Security Act at any time during the first 60 days of your COBRA continuation coverage, coverage for all covered family members will be extended to 29 months. However, in order to be eligible for this extended coverage, the Local 665 IATSE Health and Welfare Fund Office must be notified of the qualification for Social Security disability within 60 days after the disabled individual receives the Social Security determination letter and before the end of the 18-month COBRA continuation period. In addition, if such individual is determined to no longer be disabled, the Trust Fund Office must be notified within 30 days after the receipt of the Social Security determination letter by such individual.

In order for you, your spouse, and/or dependent child to be eligible for COBRA continuation coverage, the Local 665 IATSE Health and Welfare Fund must receive appropriate written notice within 60 days after 1) the date the COBRA qualifying event occurred or 2) the date that coverage under the Local 665 IATSE Health and Welfare Fund terminated.

The Local 665 IATSE Health and Welfare Fund Office will determine the occurrence of a qualifying event in the event of your termination or reduction in hours. The qualifying event in these cases will be the date of your loss of coverage under the plan. Your employer is responsible for notifying the Trust Fund Office within 30 days in the event of your death or entitlement to Medicare benefits. You, your spouse, or your dependent children are responsible for notifying the Trust Fund Office within 60 days in the event of divorce, legal separation, entitlement to Medicare benefits, or if a dependent child ceases to be an eligible dependent.

When the Local 665 IATSE Health and Welfare Fund Office receives notice or otherwise determines that a qualifying event has occurred, the Trust Fund Office will notify you regarding COBRA continuation coverage within 14 days. You, your spouse, and/or dependent children have 60 days after the date your coverage under the Trust Fund

SUMMARY OF DENTAL BENEFITS

Prior to June 1, 2011, Dependent age limit through age 18 and Dependent full-time student age limit through age 24.
Effective June 1, 2011, Dependent age limit to age 26.

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per calendar year	$1,000
DIAGNOSTIC	
• Examinations - twice per calendar year	100%
• Bitewing X-rays	100%
◦ Twice per calendar year through age 14;	
◦ Once per calendar year thereafter	
• Other X-rays (full mouth X-rays limited to once every 5 years)	100%
PREVENTIVE	
• Cleanings – twice per calendar year	100%
◦ Diabetic Patients – four cleanings or *periodontal maintenance	
◦ Expectant Mothers – three cleanings or *periodontal maintenance	
*Periodontal maintenance benefit level	*70%
• Topical fluoride (once per calendar year through age 19)	70%
◦ Fluoride Varnish – once per calendar year; limited to patients who are at high risk of caries due to root exposure, dry mouth syndrome, history of radiation therapy or other conditions as documented by the dentist.	
• Space maintainers (through age 17)	70%
• Sealants (through age 18) – one treatment application, once per lifetime only to permanent molar and bicuspid teeth with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.	70%
RESTORATIVE	
• Amalgam (silver-colored) fillings	70%
• Composite (white-colored) fillings – limited to the anterior (front) teeth	70%
• Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	70%
Note: Composite restorations or porcelain (white) crowns on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the Amount Charged by the dentist.	
ENDODONTICS	70%
• Pulpal therapy	
• Root canal treatment, retreatment, apexification, apicoectomy	

Calculating Your Benefit Payments

Determining the amount you should pay your HDS participating dentist is based on a simple formula (see box to the right). HDS will pay the "% plan covers" amount. You are responsible for the balance owed to your participating dentist and any applicable deductible amount and taxes. Participating dentists are paid based upon their Allowed Amount.

Dentist's Allowed Amount X % plan covers
HDS Payment
Dentist's Allowed Amount <minus HDS Payment>
Patient Share

Dual Coverage/Coordination of Benefits

- Please be sure to let your dentist know if you are covered by any other dental benefits plan(s).
- When you are covered by more than one dental benefits plan, the amount paid will be coordinated with the other insurance carrier(s) in accordance with guidelines and rules of the National Association of Insurance Commissioners. Total payments or reimbursements will not exceed the participating dentist's Allowed Amount when HDS serves as the second plan.
- There is a limit on the number of times certain covered procedures will be paid and payment will not be made beyond these plan limits.
- Coverage of identical procedures will not be combined in cases where there are multiple plans. For example, if you have two plans and each includes two cleanings during each calendar year, your benefits will cover two cleanings (not four) in each calendar year.

Quality Assurance

Quality assurance is taken seriously at HDS. In-office reviews are periodically conducted to ensure that you are being charged in accordance with HDS's contract agreements.

GLOSSARY

Allowed Amount: The amount the participating dentist agrees to accept for services that are covered benefits.

Amount Charged: The amount submitted by the dentist on the claim for each service performed.

Plan Maximum: The maximum amount HDS will pay within a plan year for services per member. When visiting a participating dentist, any covered benefits rendered after your Plan Maximum has been depleted will be processed with the Patient Share equal to the Allowed Amount.

Patient Share: Out-of-pocket amount for which the patient is responsible.

Wait Period: The period of time that must pass before a member qualifies for coverage for the specified % plan benefit. No HDS payments are made prior to the Wait Period being met.

terminates or the date the Trust Fund Office sends notice to you, your spouse, and/or dependent children, whichever is later, in which to elect COBRA continuation coverage (the "election period").

Each qualified beneficiary is entitled to make his or her own independent election to continue coverage under COBRA. A qualified beneficiary who is the covered employee may elect COBRA on behalf of the other qualified beneficiaries. However, if the covered employee rejects COBRA continuation coverage, the covered employee's spouse and/or dependent children have their own independent right to elect COBRA continuation coverage. If the qualified beneficiary is a minor child, the child's parent or legal guardian may make the election.

If a qualified beneficiary waives coverage under the COBRA Program, the qualified beneficiary can revoke the waiver at any time before the end of the election period.

A qualified beneficiary is any employee, spouse, or dependent child who is covered by the Local 665 IATSE Health and Welfare Fund on the day before a qualifying event occurs. A qualified beneficiary also includes a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.

If you are covered under another employer's group health plan or Medicare prior to your COBRA election, your prior coverage will not disqualify you from being able to elect COBRA.

Under the COBRA Program, an individual may choose to be covered for only core benefits (medical, prescription drug, and vision benefits) or core plus non-core benefits (medical, prescription drug, vision, dental, and life insurance benefits).

At the time that you elect to be covered under the COBRA Program, you will be allowed to change from family coverage to two-party or single coverage or from two-party coverage to single coverage. If you do not change your coverage at the time you elect COBRA, you may not change your coverage until the open enrollment period.

To continue coverage under the COBRA Program, you and/or your dependents must pay an amount equal to 102% of the actual cost of the benefits chosen, as determined by the Board of Trustees. However, if you or your dependent is determined to be disabled by the Social Security Administration, the payment amount will increase to 150% of the actual cost of the benefits chosen, as determined by the Board of Trustees, beginning with the 19th month of coverage.

The first COBRA payment must be received by the Local 665 IATSE Health and Welfare Fund Office within 45 days after the COBRA election date and must include payment for the period from the date that coverage is terminated under the Local 665 IATSE Health and Welfare Fund through the date that COBRA election is made. Each subsequent payment must be made monthly and received by the Trust Fund Office by the 10th day of the month covered by the payment.

Coverage under the COBRA Program may be terminated if:

1. The Local 665 IATSE Health and Welfare Fund no longer provides health coverage, or
2. The required payment is not made on time, or
3. The qualified beneficiary becomes entitled to Medicare, or

4. The qualified beneficiary becomes eligible under another employer's group health plan. (Exception: If the group plan contains an exclusion or limitation with respect to any pre-existing condition, COBRA may be continued until the end of the limitation or exclusion period.)

When you have exhausted the maximum number of months available under the COBRA Program, you may **not** continue coverage under the Self-Payment Program.

If you have any questions about your COBRA rights and obligations, please contact the Local 665 IATSE Health and Welfare Fund Office.

IF YOU ENTER THE ARMED FORCES

When you enter the Armed Forces, coverage for you (and your dependents, if applicable) will be continued until the end of the month for which contributions were last paid. After the end of that month, you may elect to continue coverage for you (and your dependents, if applicable) in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended in December 2004.

To continue coverage for military leave of 31 days or more, you have two (2) options from which you may select. The first option is to use the contribution amount remaining in your Bank Reserve to continue your coverage. Once the remaining contribution amount in your Bank Reserve is insufficient for coverage, you must then self-pay an amount which is equal to 102% of the actual cost of the benefits chosen, as determined by the Board of Trustees. The maximum amount of time that coverage may be continued through a combination of Bank Reserve contribution amounts and self-payments is a total of 24 months.

The second option is to have any contribution amounts remaining in your Bank Reserve frozen until you have been discharged and return to covered employment. If this option is selected, to continue coverage you must self-pay an amount which is equal to 102% of the actual cost of the benefits chosen, as determined by the Board of Trustees. The maximum amount of time that coverage may be continued through self-payments is 24 months.

Your coverage under either of the above-mentioned options will continue until your discharge from military service or 24 months, whichever occurs first.

GENERAL INFORMATION

ENROLLMENT FORMS

In order to be eligible for benefits, you and your eligible dependents must complete a current Trust Fund Personnel Information Form and all other applicable insurance carrier enrollment forms. If you have not done so already, you should complete the Personnel Information Form, listing your beneficiary or beneficiaries, and all your eligible dependents (if applicable). Once you have made a selection on your choice of medical plan, you may not change your selection until the Fund's open enrollment period during the month of June, to be effective July 1. However, if there is a change in your marital status or family content, you will be allowed to change your selection within 30 days.

that the non-participating dentist actually charges and the amount paid by HDS in accordance with your plan.

Because non-participating dentists have no agreement with HDS limiting the amount they can charge for services, your Patient Share is likely to be higher. Further, the amount reimbursed by HDS is generally lower if a non-participating dentist renders the services.

- On your first visit, advise the non-participating dentist that you have an HDS dental plan and present your HDS member identification card.
- In most cases you will need to pay in full at the time of service.
- The non-participating dentist will render services and may send you the completed claim form (universal ADA claim form) to submit to HDS. Mail the completed claim form for processing to:

  HDS – Dental Claims
  700 Bishop Street, Suite 700
  Honolulu, HI 96813-4196
- HDS payment will be based on the HDS non-participating dentist fee schedule and a reimbursement check will be sent to you along with your Explanation of Benefits (EOB) report.

Whether you visit a participating or non-participating dentist, please be sure to discuss the total charges and your financial obligations with your dentist before you receive treatment.

Helping You Manage Your Costs

Your participating dentist may submit a preauthorization request to HDS **before** providing services. With HDS's response, your dentist should explain to you the treatment plan, the dollar amount your plan will cover and the amount you will pay. This pre-authorization will reserve funds for the specified services against your Plan Maximum. It will also help you to plan your dental services accordingly should you reach your Plan Maximum.

Questions on Your Claims

If you have any questions or concerns about your dental claims, please call the HDS Customer Service Department at 529-9248 on Oahu or toll-free at 1-800-232-2533 extension 248. A copy of HDS's claims appeal process may be obtained from Customer Service.

HDS REPORTS AND PAYMENTS

Explanation of Benefits (EOB) Report

You will receive an HDS Explanation of Benefits (EOB) Report that provides payment information about the services you received from your dentist. It is important to note that the EOB report is **not** a bill. Depending on your dentist's practice, your dentist may bill you directly or collect any portion not covered by your plan at the time of service.

Completion of Procedures When Eligibility Ends

If a dental procedure is in progress when your eligibility ends, coverage for services in progress may continue for a maximum of 30 days after the date your eligibility ends.

HDS will determine the applicable plan benefit for dental work within 30 days of the termination of eligibility or Contract Agreement cancellation, as long as the specific dental procedure has been started before the date of ineligibility or Contract Agreement cancellation.

SELECTING A DENTIST

In Hawaii, Guam and Saipan - Choose an HDS Participating Dentist

You may select any dentist; however, you save on your out-of-pocket costs when you visit an HDS participating dentist for services received in Hawaii, Guam and Saipan. HDS participating dentists have agreed to partner with HDS to make oral health care more affordable by limiting their fees to the Allowed Amount for services that are covered.

About 95% of all licensed, practicing dentists in Hawaii participate with HDS, so it is more than likely your dentist is an HDS participating dentist. For a current listing of HDS participating dentists, visit the HDS website at www.deltadentalhi.org or call the HDS Customer Service department.

On the Mainland - Choose A Delta Dental Participating Dentist

HDS is a member of the Delta Dental Plans Association (DDPA), the nation's largest and most experienced dental benefits carrier with a network of more than 198,000 dentist locations.

If your job takes you out of state or your child attends school on the Mainland, we recommend that you and/or your dependents visit a Delta Dental participating dentist to receive the maximum benefit from your plan.

For a list of Delta Dental participating dentists, visit the HDS website at www.deltadentalhi.org and click on "Members: Search for a Dentist," then "Delta Dental National Provider Database." Select "DeltaPremier" as your plan type and complete the remaining questions. Or you may call the HDS Customer Service department.

Visiting a Delta Dental Participating Dentist

- When visiting a dentist on the Mainland, let the dentist know that you have an HDS plan and present your HDS member identification card.
- If the dentist is a Delta Dental participating dentist, the claim will be submitted directly to HDS for you.
- Provide the dentist with the HDS mailing address and toll-free number located on the back of your member identification card.
- HDS's payment will be based upon HDS's participating dentist's Allowed Amount.
- Your Patient Share will be the difference between the Delta Dental dentist's Amount Charged and HDS's payment amount.

Visiting a Non-Participating Dentist

If you choose to have services performed by a dentist who is not an HDS or Delta Dental participating dentist, you are responsible for the difference between the amount

Newly hired employees and employees of employers who have just signed the Collective Bargaining Agreement should obtain their Personnel Information Form from the Local 665 IATSE Health and Welfare Fund Office.

The completed Personnel Information Form and insurance carrier enrollment forms are to be returned to the Local 665 IATSE Health and Welfare Fund Office. The Trust Fund Office will process the insurance carrier enrollment forms and retain the Trust Fund Personnel Information Form.

No premiums will be paid until the Trust Fund Personnel Information Form and all insurance carrier enrollment forms are completed and filed with the Local 665 IATSE Health and Welfare Fund Office.

It is important to keep the Local 665 IATSE Health and Welfare Fund Office informed of any change in your personal or family situation or mailing address. **Let the Trust Fund Office know if:**

- **You change your mailing address or telephone number,**
- **You get married, divorced, or widowed,**
- **You wish to add an additional dependent child (such as a new baby or an adopted child).**

ELIGIBLE DEPENDENTS [Prior to June 1, 2011]

Eligible dependents include your legal spouse and all unmarried children under 19 years of age. The term "children" includes natural children, stepchildren, legally adopted children, and any other children who are wholly dependent upon you for support, as attested by income tax information, and live with you in a regular parent-child relationship.

In order to add a new spouse or dependent child, you must notify the Local 665 IATSE Health and Welfare Fund Office within 30 days of the date of marriage, birth, adoption, or placement for adoption. If you do not notify the Trust Fund Office within this 30-day period, retroactive coverage will not be made. Instead, coverage for your new dependent(s) will be effective on the first day of the month following the date of notification and receipt of the proper documentation (e.g., a copy of your marriage certificate, birth certificate, or adoption papers) by the Trust Fund Office.

A dependent child who, upon attaining age 19 has a mental or physical disability which renders the child incapable of self-support, will continue to be covered for benefits as long as such child remains unmarried, disabled, and incapable of self-support, provided that the child was disabled and covered under the plan prior to age 19. You must, however, submit satisfactory proof to the Trust Fund of the child's incapacity when he or she attains age 19 and periodically, thereafter, when requested by the Trust Fund. Coverage for such child shall terminate upon the earliest of the following: 1) the child's marriage, 2) the child becoming capable of self-support, 3) failure to provide proof of the child's continued disability when requested, or 4) termination of your eligibility.

Dependent children who are full-time students will continue to be covered for medical, prescription drug, vision care, and dental benefits from ages 19 through 24. To secure such coverage, you must complete a student certification form and provide the Trust Fund Office with 1) the name and age of each dependent student, 2) the name of the

accredited school, college, or university that he or she is attending, and 3) a statement that the dependent student is a legal resident of Hawaii.

Effective January 1, 2010, when a serious illness or injury interrupts the ability of a dependent child who is covered as a full-time student from continuing to attend school, Federal law requires health plans to provide up to one (1) year of continued coverage as though such dependent child was still attending school. However, such coverage shall not extend beyond the normal termination date for student coverage which, under this plan, ends when the dependent child reaches age 25. At the end of the extension period or upon the termination of student coverage, the student may continue coverage under the COBRA program, if applicable. To obtain this special extension, you must notify the Trust Fund Office and furnish the required documentation as requested.

Note: Effective June 1, 2011, in accordance with the Patient Protection and Affordable Care Act of 2010, student certification was removed as a requirement for continued dependent coverage under the Local 665 IATSE Health and Welfare Fund. Therefore, the requirements of Michelle's Law relating to continued coverage of a dependent child who becomes seriously ill or injured while attending school no longer apply.

ELIGIBLE DEPENDENTS [Effective on and after June 1, 2011]

Eligible dependents include your legal spouse and all children under 26 years of age who are not eligible for other employer-sponsored health plan coverage other than a group health plan of a parent. Coverage is available to an eligible dependent child without regard to marital status, dependency upon you (or anyone else) for financial support, residency with you, or full-time student status. The term "children" includes natural children, stepchildren, legally adopted children, and children placed in the home in anticipation of adoption.

In order to add a new spouse or dependent child, you must notify the Local 665 IATSE Health and Welfare Fund Office within 30 days of the date of marriage, birth, adoption, or placement for adoption. If you do not notify the Trust Fund Office within this 30-day period, retroactive coverage will not be made. Instead, coverage for your new dependent(s) will be effective on the first day of the month following the date of notification and receipt of the proper documentation (e.g., a copy of your marriage certificate, birth certificate, or adoption papers) by the Trust Fund Office. The Board of Trustees may require any information necessary to determine the eligibility of a dependent under this section.

In compliance with the Patient Protection and Affordable Care Act of 2010, a special enrollment period from May 6, 2011 through June 6, 2011, for coverage effective June 1, 2011, was given to adult dependent children whose coverage ended, or who were denied coverage, or were not eligible for coverage because the availability of dependent coverage ended before the attainment of age 26. If you did not add your adult dependent child during this special enrollment period because he or she was covered under another plan, and your dependent child subsequently loses coverage under the other plan, you may request enrollment for your dependent child within 30 days of the loss of coverage under the other plan (see Special Enrollment Periods on page 17).

A dependent child who, upon attaining age 26 has a mental or physical disability which renders the child incapable of self-support, will continue to be covered for benefits as long as such child is unmarried, disabled, and incapable of self-support, provided that

HDS
Hawaii Dental Service
DELTA DENTAL

HAWAII DENTAL SERVICE (HDS) PLAN CHANGES

Several important changes have been made in your Health and Welfare benefits over the past few years. You have been previously notified of these changes and their effective dates. However, as part of our ongoing process to familiarize you with the benefit programs and to comply with Federal law, the changes have been incorporated in this booklet revision.

1. Effective January 1, 2006, a patient's share for dental services received from out-of-state Delta Dental participating dentists will be calculated up to the Delta Dental National Provider filed fee which, in most cases, will result in lower out-of-pocket costs.
2. Effective July 1, 2007, evidence based benefit changes relating to the frequency of x-rays and cleanings, the addition of fluoride varnish and sealants for the prevention of tooth decay, and coverage of endosteal implants as an alternative prosthodontic benefit were implemented by HDS (pages 92 and 93).

DENTAL PLAN

GETTING STARTED

Effective Date of Eligibility

If you are a new HDS member enrolling in this plan, the Local 665 IATSE Health and Welfare Fund will let you know the start date (effective date) of your dental coverage. An HDS member identification card will be mailed directly to you after HDS is notified of your start date.

- At your first appointment, let your dental office know that you are covered by HDS and present your HDS member identification card.
- If you need dental services immediately after your effective date of dental coverage but have not received your HDS member identification card, you may print or request a card through the HDS website at www.deltadentalhi.org or you may ask your dentist to confirm your eligibility with HDS prior to receiving services.

Eligible Persons

Check with your trust fund to determine who is eligible to be covered as your dependent(s) under your plan.

Updating Information

To ensure that you and your family receive the full benefits of your plan and to ensure HDS processes your dental claims accurately, please notify your trust fund immediately of any of the following:

- Name change
- Address change
- Add/remove dependent(s)

Step 3: VSP will reimburse you up to the scheduled amounts for covered services.

For faster reimbursement, you may complete a claim form on-line:

- Simply go to www.vsp.com, click on the "Members" link and log in. Your individual member information will appear.
- Select "Out-of-Network Reimbursement" under "My Benefits>Benefit Resources." Complete the submission form in its entirety and print the form.
- Verify that the information is correct, attach itemized receipts to the form and mail to:
  VSP
  P.O. Box 997105
  Sacramento, CA 95899-7105

OR, you may call VSP Customer Service at (808) 532-1600 or 1-800-522-5162 (toll free Hawaii Office) or 1-800-877-7195 (toll free Mainland Office) to obtain a hard copy Out-of-Network Reimbursement Form. Complete the form and submit along with your itemized receipts to the address listed above.

IMPORTANT: Out-of network requests for reimbursement must be submitted to VSP within (6) six months of the date of service.

EXCLUSIONS

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than ± .50 diopter power)
- Two (2) pairs of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Corrective vision treatment of an experimental nature such as, but not limited to RK and PRK surgery
- Solutions or cleaning products for glasses or contact lenses
- Services and/or materials not indicated as covered benefits

The preceding vision care benefits are fully insured under a contract of insurance issued by VSP (Vision Service Plan), 3333 Quality Drive, Rancho Cordova, California 95670. The services provided by VSP include the payment of claims, when necessary, and the handling of claims appeals.

The preceding is for informational purposes and is only a summary of coverage. Its contents are subject to the provisions of the Group Vision Care Agreement which contains all the terms and conditions of membership and benefits. This document is on file with the Local 665 IATSE Health & Welfare Fund Office. Please refer to this document for specific questions about coverage.

the child was disabled and covered under the plan prior to age 19. You must, however, submit satisfactory proof to the Trust Fund of the child's incapacity when he or she attains age 26 and periodically, thereafter, when requested by the Trust Fund. Coverage for such child shall terminate upon the earliest of the following: 1) the child's marriage, 2) the child becoming capable of self-support, 3) failure to provide proof of the child's continued disability when requested, or 4) termination of your eligibility.

A former spouse, upon divorce, or a child who ceases to be eligible for dependent coverage under the Local 665 IATSE Health and Welfare Fund, may call or write to the applicable carrier (University Health Alliance or Kaiser Foundation Health Plan, Inc.) for information on conversion to an Individual or Family Plan offered directly by these carriers within 30 days of the date the change in eligibility status occurs

NO DUAL COVERAGE

Effective April 1, 2008, no individual may be covered under the Local 665 IATSE Health and Welfare Fund as both an Employee and a Dependent.

- An eligible person may be covered either as an Employee, or as a Dependent of an eligible Employee, but not both.
- If both parents are covered as Employees under the Fund, only one parent may cover their children as dependents.
- When two Employees are married and eligible to be covered under a family plan, only one Employee may elect to take a family plan that covers the other Employee as a Dependent spouse. In this instance, the other Employee's bank reserve will not be assessed the $30.00 monthly administrative charge.

SPECIAL ENROLLMENT PERIODS

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Local 665 IATSE Health and Welfare Fund may allow enrollment during a special enrollment period if you qualify under one (1) of the following two (2) requirements:

1. You declined coverage for yourself and/or your dependent(s) as a result of coverage under another group health plan, or
2. You obtain a new dependent through marriage, birth, adoption, or placement for adoption.

If you declined enrollment for yourself or your dependent(s) (including your spouse) because of other health insurance coverage, you may enroll yourself and/or your dependent(s) provided you request enrollment within 30 days after your coverage under the other health plan ends.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your new dependent(s) provided you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you fail to request enrollment during this special 30-day period, coverage for yourself and/or your dependents will not be effective until the first day of the month following the date of your request for enrollment. To request Special Enrollment, contact the Trust Fund Office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Local 665 IATSE Health and Welfare Fund is required to provide benefits in accordance with the requirements of a "qualified medical child support order". A "qualified medical child support order" is a judgment, decree, or order (including a court's approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that requires a group health plan to provide coverage to the child(ren) of a plan participant pursuant to state domestic relations law.

The Trust Fund has adopted procedures for determining whether a medical child support order is "qualified." A copy of these procedures will be provided to the interested parties when an order is received by the Trust Fund. In order to be "qualified", the order must clearly specify:

1. The name and last known address of the participant and each alternate recipient;
2. A reasonable description of the type of coverage to be provided by the group health plan, or the manner in which the coverage is to be determined;
3. The period for which coverage must be provided; and
4. Each plan to which the order applies.

In addition, the medical child support order cannot require the Trust Fund to provide any type or form of benefit, or benefit option, that the Trust Fund does not already offer (except to the extent required by law).

All medical child support orders shall be delivered to the Administrator of the Local 665 IATSE Health and Welfare Fund. The Trust Fund will determine whether or not the order meets the criteria to be considered a qualified medical child support order and notify the participant and alternate recipient(s) of such determination. An alternate recipient is any child of a participant who is recognized as being entitled to coverage under the participant's group health plan.

For further information, contact the Trust Fund Office.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Local 665 IATSE Health and Welfare Fund has agreed to allow those contributing employers who are required to provide family and medical leave for their employees, pursuant to the Family and Medical Leave Act (FMLA) or applicable State law, to make contributions to the Trust Fund to continue coverage for those employees while they are on family and medical leave. If your employer is required to provide family and medical leave and you are eligible for family and medical leave benefits, your coverage will continue under the Local 665 IATSE Health and Welfare Fund **provided your employer continues to make contributions to the Trust Fund on your behalf**.

For further information on the Family and Medical Leave Act, contact your employer.

Copayment

A copayment of $10.00 for exams and $25.00 for lenses and/or frames for eyeglasses is payable at the time services are rendered by a VSP doctor.

Elective Contact Lenses. An allowance of $130 is provided toward contact lenses obtained from a VSP Doctor and $100 for contact lenses obtained from an out-of-network provider. Any costs exceeding the allowance are the responsibility of the patient. If you use a VSP Doctor, a 15% discount will be applied toward your professional services. This discount is applicable for the 12 months following the covered exam and must be used in the original doctor's office.

Medically Necessary Contact Lenses. Coverage for medically necessary contact lenses is subject to review and approval by VSP. When medically necessary contact lenses are prescribed by a VSP Doctor, they are covered in full with prior approval from VSP. Medically necessary contact lenses obtained from an out-of-network provider are covered up to $100 when approved by VSP.

Extra Discounts and Savings

Glasses & Sunglasses

- Average 20-25% savings on all non-covered lens options (such as tints, progressive lenses, anti-scratch coatings, etc.)
- 20% off additional glasses & sunglasses, including lens options, from any VSP doctor within 12 months of your last Exam.

Contact Lenses

- Current soft contact lens wearers may qualify for a special program that includes a contact lens evaluation and initial supply of lenses. Ask your VSP doctor if you qualify.

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities with referral from VSP Doctor.

HOW DO I USE THE PLAN?

When you are ready to obtain vision care services, call your VSP Doctor. If you need to locate a participating doctor, call VSP toll-free at 1-800-877-7195 to request a list of VSP Choice doctors in your area, or locate one on-line by logging on to the VSP website at www.vsp.com.

VSP DOCTOR

Step 1: Call the VSP Doctor of your choice to make an appointment and identify yourself as a VSP member.

Step 2: The VSP Doctor will collect a $10 copayment for the exam and $25 copayment if you order glasses (lenses and/or frame).

Step 3: The VSP Doctor will itemize the charges so you will know exactly what portion of the bill is covered under your VSP plan.

HOW DO I RECEIVE OUT-OF-NETWORK REIMBURSEMENT?

If you have received services from an Out-of-Network Provider:

Step 1: Pay the out-of-network provider in full at the time you receive services.

Step 2: Submit a claim to VSP for reimbursement.

VISION PLAN CARRIER CHANGE

Several important changes have been made in your Health and Welfare benefits over the past few years. You have been previously notified of these changes and their effective dates. However, as part of our ongoing process to familiarize you with the benefit programs and to comply with Federal law, the changes have been incorporated in this booklet revision.

1. Effective July 1, 2009, HMSA was replaced by Vision Service Plan (VSP) as the carrier of the vision plan.

VISION BENEFITS

If you are covered under the UHA Comprehensive Medical Plan, you and your dependents are eligible for the following vision benefits through Vision Service Plan (VSP) Vision Plan. If you are covered under the Kaiser Plan, you are not eligible for the following vision benefits. Kaiser members are eligible for vision benefits through the Kaiser Plan.

WHAT ARE THE BENEFITS?

Eye examinations and glasses or contact lenses will be covered according to the following schedule:

Eye Examination	Once every 12 months*
Lenses	Once every 12 months*
Frame	Once every 24 months*

*From the date of your last service

BENEFIT	PLAN PAYS	
	VSP Doctor	**Out-of-Network Provider**
Eye Exam - $10 copayment		
Optometrist (O.D.) or Ophthalmologist (M.D.)	100% after copayment	Up to $43
Glasses - $25 copayment (Lenses &/or Frame)		
Lenses		
Single Vision Lenses	100% after copayment	Up to $26
Bifocal Lenses	100% after copayment	Up to $43
Trifocal Lenses	100% after copayment	Up to $60
Frames	Up to $130 after copayment	Up to $40
Contact Lenses (in lieu of glasses) – no copayment	Up to $130	Up to $100

MEDICAL PLAN CHANGES

Several important changes have been made in your Health and Welfare benefits over the past few years. You have been previously notified of these changes and their effective dates. However, as part of our ongoing process to familiarize you with the benefit programs and to comply with Federal law, the changes have been incorporated in this booklet revision.

1. Effective July 1, 2009, the Hawaii Medical Service Association (HMSA) was replaced by Summerlin Life & Health Insurance Company (Summerlin) as the carrier of the medical and prescription drug plans.
2. Effective April 1, 2010, Summerlin was replaced by the Hawaii Medical Assurance Association (HMAA) as the carrier of the medical and prescription drug plans by purchase.
3. Effective July 1, 2010, HMAA was replaced by the University Health Alliance (UHA) as the carrier of the medical and prescription drug plans.
4. Effective June 1, 2011, in accordance with the Patient Protection and Affordable Care Act of 2010, there is no lifetime limit on the dollar value of essential health benefits provided under the Local 665 IATSE Health and Welfare Fund.

MEDICAL BENEFITS

CHOICE OF PLANS

You may choose one (1) of the following two (2) medical-hospital-surgical plans:

1. The University Health Alliance (UHA) Comprehensive Medical Plan available on all islands, or
2. The Kaiser Foundation Health Plan available on Oahu, Maui, and Hawaii.

If you reside outside the Kaiser Hawaii service area for more than 90 days, you are not eligible to enroll in the Kaiser Plan. If you enroll in the Kaiser Plan and subsequently move outside of the Kaiser Hawaii service area for more than 90 days, you will not be allowed to continue coverage under the Kaiser Plan and must enroll in the UHA Plan.

The principal benefit provisions of the UHA and Kaiser Plans are summarized in this booklet. You and your spouse should compare the benefits of each plan carefully before selecting your medical plan.

If you are a new employee, you should make sure that the Local 665 IATSE Health and Welfare Fund Office has your Personnel Information Form which lists your dependents.

OPEN ENROLLMENT PERIOD

You may change medical plans during the Annual Open Enrollment Period in the month of June. If you wish to change plans, contact the Local 665 IATSE Health & Welfare Fund Office during the month of June of any year. The change will become effective July 1st. No change between medical plans may be made at any other time, except if:

1. You are enrolled in the Kaiser Plan and subsequently move outside of the Kaiser Hawaii service area for more than 90 days, or
2. You meet one (1) of the requirements specified in the "Special Enrollment Periods" section on page 17.

HOW TO SECURE BENEFITS

The medical plan you select will send you an ID card. Contact the Trust Fund Office if you have not received, or have lost, your ID card.

If you are a UHA Plan member, show your doctor, hospital, or laboratory your UHA ID card. If you do not have your ID card, be sure to tell the provider in advance that you are a UHA Plan member and your benefits are provided by the Local 665 IATSE Health and Welfare Fund.

If you are a Kaiser Plan member, show your Kaiser ID card when you go to the Kaiser Hospital or Clinic for services. If you do not have your ID card when you are scheduling medical care, be sure to tell the appointment clerk that you are a Kaiser member and your benefits are provided by the Local 665 IATSE Health and Welfare Fund.

If you do not have your ID card available, ask the doctor or facility rendering services to contact the Trust Fund Office to confirm your eligibility.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (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 section. 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). In any case, health plans and insurance issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

You will be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request a certificate before losing coverage, or up to 24 months after losing coverage. Any certificate that you receive should be kept in a safe place. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion in your coverage for 12 months (18 months for late enrollees) after your enrollment date in a new plan.

OTHER KAISER PERMANENTE INFORMATION

KAISER FOUNDATION HEALTH PLAN OFFICE
Contract and policy interpretations 432-5127

CUSTOMER SERVICE
Service assistance, individual plan enrollment,
benefit information, out-of-plan emergency claims 432-5955

MEMBERSHIP ACCOUNTING
Name and address changes, eligibility, group and direct pay billings 432-5310

PATIENT ACCOUNTING
Industrial, No-Fault, Tri Care, and filing other insurances 432-5340

MAINLAND KAISER FACILITIES
Kaiser Permanente offers medical care in Washington, D.C. and nine (9) states. If you need medical care while you are in one of the following service areas, call for information during normal business hours. Kaiser Permanente service areas are subject to change at any time.

- California ..... (800) 464-4000
- Colorado
  - Metropolitan Denver and Boulder ..... (303) 338-3800
  - Colorado Springs ..... (888) 681-7878
  - Other areas ..... (800) 632-9700
- District of Columbia ..... (800) 777-7902
- Georgia
  - Atlanta ..... (800) 611-1811
- Maryland
  - Baltimore ..... (800) 777-7902
- Ohio
  - Cleveland ..... (800) 686-7100
  - Akron ..... (888) 606-8759
- Oregon
  - Portland ..... (503) 813-2000
  - Other areas ..... (800) 813-2000
- Virginia ..... (800) 777-7902
- Washington
  - Kaiser Permanente ..... (800) 813-2000
  - Group Health ..... (888) 901-4636

The preceding medical, prescription drug, and vision benefits are fully insured under an insurance contract issued by Kaiser Foundation Health Plan, Inc., 711 Kapiolani Boulevard, Honolulu, Hawaii 96813. The services provided by Kaiser Foundation Health Plan, Inc. include the payment of claims, when necessary, and the handling of claim appeals.

The preceding is for informational purposes and is only a summary of coverage. Its contents are subject to the provisions of the Group Medical and Hospital Service Agreement, Benefit Schedule Kaiser Permanente Group Plan, Prescription Drug Rider 12, and Optical Rider 1 which contain all the terms and conditions of membership and benefits. These documents are on file with the Local 665 IATSE Health and Welfare Fund Office. Please refer to these documents for specific questions about coverage.

VISION CARE BENEFITS

The Kaiser Foundation Optical Care Plan is designed to supplement regular Health Plan benefits which pertain to eye care. The following benefits are available when prescribed by a physician or optometrist associated with the Hawaii Permanente Medical Group.

BENEFITS	MEMBER COPAYMENT
GLASSES	
• One (1) pair every 24 months and one (1) pair of new lenses after 12 months Glasses are regular scratch resistant lenses (plastic single vision, flat top 28 mm multi-focal, or lenticular lenses having refractive values) placed in a frame costing $40.00 or less.	No Charge
• Eye examinations for glasses should be scheduled in advance (covered under the medical plan)	$20.00 per visit
OR	
CONTACT LENSES (in lieu of glasses)	
• One (1) pair of contact lenses every 24 months	$45.00 less than the regular cost
• Eye examination for contact lenses and fitting services	Eye examination for contact lenses is excluded. However, member will receive a professional fee credit of $70 for required fitting service if contact lenses are purchased at a Kaiser Permanente facility.

Members may elect to order items not covered under this plan. The following items are available at additional charge:

- Tints, including photochromic, polarized, or tinted plastic lenses
- Multi-focal styles such as progressive lenses
- Special lens materials such as polycarbonate and high-index materials
- Other lens options not specifically included
- Frames over $40.00
- Sunglasses

OPTICAL SERVICES LOCATIONS AND PROVIDERS

For information on Kaiser Permanente's optical services locations and providers, please contact the Customer Service Center at 432-5955 (Oahu), or 1 (800) 966-5955 (neighbor islands), or visit the website at "www.kaiserpermanente.org".

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

In compliance with the Women's Health and Cancer Rights Act, the UHA and Kaiser Permanente Plans provide coverage for the following services in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery or reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications in all stages of the mastectomy, including lymphedemas.

MICHELLE'S LAW [No longer applicable on and after June 1, 2011]

Effective January 1, 2010, when a serious illness or injury interrupts the ability of a dependent child who is covered as a full-time student from continuing to attend school, Federal law requires health plans to provide up to one (1) year of continued coverage as though such dependent child was still attending school. However, such coverage shall not extend beyond the normal termination date for student coverage. At the end of the extension period or upon the termination of student coverage, the student may continue coverage under the COBRA Program, if applicable.

Note: Effective June 1, 2011, the requirements of Michelle's Law no longer apply to this plan due to the removal of student certification as a requirement for continued dependent coverage.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

Effective June 1, 2010, the following provisions apply to the Local 665 IATSE Health and Welfare Fund. 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 for underwriting purposes;
- 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 treatment of a health condition. Then, the group health plan and health insurance issuers may obtain and use the results of a genetic test to make a determination regarding payment for 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; and
- The plan clearly indicates to the participant or beneficiary that compliance with the request is voluntary.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPA)

Effective July 1, 2010, the UHA and Kaiser Permanente Plans implemented benefit changes in accordance with the Mental Health Parity and Addiction Equity Act of 2008, a Federal law that requires parity with respect to financial requirements and treatment limitations between mental health or substance abuse disorder benefits and medical/surgical benefits.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (PPACA) - GRANDFATHERED HEALTH PLAN STATUS

The Local 665 IATSE Health and Welfare Fund believes that its medical and prescription drug coverage, provided through the University Health Alliance (UHA) Plan and the Kaiser Permanente Plan, is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010 (PPACA or Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Fund Office at *222 S. Vineyard Street, PH-4, Honolulu, Hawaii 96813, telephone: (808) 523-9411 or Neighbor Islands Toll Free 1 (877) 523-9411.* You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at *1 (866) 444-3272* or *www.dol./gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

- Drugs related to sexual dysfunction.
- Drugs to shorten the duration of the common cold.
- Drugs to enhance athletic performance (including weight training or body building).
- Any packaging other than the dispensing pharmacy's standard packaging.
- Immunizations, including travel immunizations.
- Abortion drugs.
- Replacement of lost, stolen or damaged drugs.

Your Kaiser Permanente membership contract entitles you to a maximum one-month supply per prescription (for each copayment, if applicable). It is the policy of Kaiser Permanente's pharmacies, as a convenience to Kaiser Permanente members, to dispense as much as a three-month supply of certain prescriptions, if so requested. This is done in good faith, presuming the member will remain with Kaiser Permanente throughout the three-month period. If you terminate your membership with Kaiser Permanente before the end of the three-month period, you will be charged the retail price for your remaining drugs that exceed the one-month allowable supply.

BENEFITS **MEMBER COPAYMENT**

For each prescription or refill, ... $12.00 per prescription or refill when the quantity does not exceed:

- A 30-day consecutive supply of a prescribed drug, or
- An amount as determined by the Formulary.

Self-administered drugs are covered only when all of the following criteria are met:

- Prescribed by a Kaiser Permanente physician or licensed prescriber,
- On the Health Plan Formulary and used in accordance with Formulary criteria, guidelines, or restrictions,
- The drug is one for which a prescription is required by law,
- Obtained at pharmacies in the service area that are operated by Kaiser Foundation Hospital, or Kaiser Foundation Health Plan, Inc., or pharmacies Kaiser Permanente designates, and
- Drug does not require administration by, or observation by medical personnel.

Insulin ..... $12.00 per prescription

MAIL ORDER PRESCRIPTIONS

Members may also request refills of maintenance drugs through the mail order service, in which members are entitled to a 90-day supply for a $24.00 copayment. Please mail your refill order before you are down to your last 14 days supply. Allow one (1) week to receive your medication for refillable orders. The mail order program does not apply to the delivery of certain pharmaceuticals (i.e., narcotics, tranquilizers, bulky items, medication affected by temperature, and injectables).

EXCLUSIONS

- Drugs for which a prescription is not required by law (e.g., over-the-counter drugs) including condoms, contraceptive foams and creams, or other non-prescription substances used individually or in conjunction with any other prescribed drug or device, except insulin.
- Drugs and their associated dosage strengths and forms in the same therapeutic category as a non-prescription drug that have the same indication as the non-prescription drug.
- Drugs obtained from a non-Kaiser Permanente pharmacy.
- Non-prescription vitamins.
- Drugs and medications when used primarily for cosmetic purposes.
- Medical supplies such as dressings and antiseptics.
- Reusable devices such as glucose monitors and lancet cartridges.
- Diabetes supplies such as blood glucose test strips, lancets, syringes and needles.
- Non-formulary drugs or supplies, unless a non-formulary drug or supply has been specifically prescribed and authorized by a Kaiser Permanente physician, licensed prescriber, or a prescriber Kaiser Permanente designates.
- Brand name drugs requested by a member when there is a generic equivalent.
- Prescribed drugs or supplies that are necessary for or associated with excluded or non-covered services.

University Health Alliance

UNIVERSITY HEALTH ALLIANCE (UHA) COMPREHENSIVE MEDICAL PLAN

UNIVERSITY HEALTH ALLIANCE

700 BISHOP STREET
SUITE 300, HONOLULU, HAWAII 96813

MEMBER SERVICES DEPARTMENT

PHONE: (808) 532-4000
TOLL FREE: 1 (800) 458-4600
FAX: 1 (866) 572-4393
WEBSITE: www.uhahealth.com

IMPORTANT FACTS

The UHA 3000I Comprehensive Medical Plan ("UHA Plan" or "Plan") has been designed to cover a wide range of medical services while keeping the cost affordable. The Plan does this by paying benefits based on Eligible Charges (see page 25 for an explanation) and by the use of some copayments. A copayment is the amount of the Eligible Charge that you owe when you receive certain medical services covered by the Plan. It can be a fixed dollar amount (for example, a $12 copayment for a visit to your Personal Physician) or a percentage of the Eligible Charge (for example, 20% of the Eligible Charge if you utilize Hospital services).

Knowing what services the UHA Plan covers and using them only as needed, are ways of getting the best protection from your medical plan. When you need medical services, talk to your physician about different methods and places of treatment and their cost. Together, you and your physician can make the right decisions about your health care.

ANNUAL AND LIFETIME MAXIMUM BENEFITS

This Plan will cover up to $2,000,000 in annual benefits per member per calendar year. There is no lifetime maximum. However, certain benefits do have annual maximums.

ANNUAL DEDUCTIBLE

An Annual Deductible will be applied in each calendar year for the first $100 in Eligible Charges incurred by each beneficiary for selected services received under this Plan. However, if you and your dependents are covered as a family under this Plan, the Annual Deductible for the entire family shall not exceed $300 per calendar year.

For those services subject to the Annual Deductible, Plan benefits will be paid only after the Annual Deductible has been met.

The following services are subject to the Annual Deductible:

- Anesthesia (Physician Services)
- Surgical Services
- Hospital Services
- Skilled Nursing Facility Services
- Home Health Care Services
- Diagnostic Testing (Inpatient)
- Genetic Testing and Counseling
- Laboratory and Pathology Services (Inpatient)
- Radiology Services
- Chemotherapy and Radiation Therapy Services
- Organ Transplant Services
- Mental Health and Substance Abuse Facility Services
- Psychological Testing (Inpatient)
- Newborn Care
- Family Planning Services
- Tubal Ligation
- Termination of Pregnancy
- Vasectomy
- Erectile Dysfunction
- In Vitro Fertilization
- Emergency Ambulance Services (Ground or Inter-island Air)
- Appliances and Durable Medical Equipment
- Bariatric Surgery
- Blood, Blood Products and Blood Bank Service Fees
- Dialysis and Supplies
- Growth Hormone Therapy
- Home Infusion Therapy
- Hyperbaric Treatment
- Implants
- Inhalation Therapy
- Injectable Medications (Outpatient)
- Medical Foods
- Orthotics
- Prosthetics

MAXIMUM ANNUAL COPAYMENT

The Maximum Annual Copayment is $2,500 per person or $7,500 per family per calendar year. When the total of your copayments, including Plan deductibles, reach $2,500 per person or $7,500 per family in any calendar year, the Plan pays 100% of the Eligible Charge for covered services rendered for medical care for the rest of that calendar year. However, you will still owe Non-Participating Providers all charges in excess of Eligible Charges.

YOUR IDENTIFICATION CARD

Your Kaiser Permanente identification card is all that's needed to receive care and service from Kaiser Permanente. Please carry it with you at all times. It's good for a lifetime — as long as you remain a member. If you lose or damage your ID card or were a previous Kaiser Permanente Hawaii member and no longer have your ID card, call the Customer Service Center at (808) 432-5955 (Oahu) or 1 (800) 966-5955 (Neighbor Islands) to request a new one. Both new and returning health plan members should carry a temporary ID (found on the last page of the enrollment form) for at least 30 days or, for first time Kaiser Permanente members, until the permanent card is mailed to your home.

YOUR CURRENT ADDRESS

It is vitally important that Kaiser Permanente has your current address and phone number. "Partners in Health" and other publications are mailed regularly. Kaiser Permanente also may need to contact you quickly if a member of your family comes in for emergency treatment. Notify the Customer Service Center of any changes.

CLAIMS FOR BENEFITS

Specific information about Kaiser's claims procedures are contained in the Kaiser Permanente Member Handbook which is provided to you at no charge.

CONVERSION PRIVILEGE

If your Kaiser Permanente Plan membership through the Local 665 IATSE Health and Welfare Fund is terminated for any reason, you may apply for a Kaiser Permanente conversion membership under an individual account. However, you must apply within 30 days. Full details on how to retain your Kaiser Permanente membership are available from the Customer Service Center at 432-5955.

PRESCRIPTION DRUG BENEFITS

The Kaiser Permanente Prescription Drug Plan partially covers the cost of drugs for which a prescription by a Kaiser Permanente licensed prescriber is required by law when such prescriptions are purchased at a Kaiser Permanente facility within the Hawaii service area. The drug benefit includes only the drugs listed on the Kaiser Permanente list of covered drugs (Formulary) that meet Formulary criteria and restrictions. Any other drugs will not be covered unless medically necessary and prescribed and authorized by a Kaiser Permanente licensed prescriber. Kaiser Permanente pharmacies may substitute a chemical or generic equivalent unless prohibited by the Kaiser Permanente licensed prescriber. If a member wants a brand name drug that has a generic equivalent, or a member requests a drug that is not on the Formulary, the member will be charged for these drugs since they are not covered under the Prescription Drug Plan.

If you have any questions on a particular drug, contact the Customer Service Center and/or a clinic pharmacy.

THIRD PARTY LIABILITY, MOTOR VEHICLE ACCIDENTS AND SURROGACY HEALTH SERVICES

Kaiser Permanente has the right to recover the cost of care for a member's injuries or illness caused by another person or in an auto accident from a judgment, settlement, or other payment paid to the member by an insurance company, individual, or other third party.

Kaiser Permanente has the right to recover the cost of care for Surrogacy Health Services. Surrogacy Health Services are services the member receives related to conception, pregnancy, or delivery in connection with a Surrogacy Arrangement. The member must reimburse Kaiser Permanente for the costs of Surrogacy Health Services out of the compensation the member or the member's payee is entitled to receive under the Surrogacy Arrangement.

BINDING ARBITRATION

If you, or someone with a relationship to you, believe that some conduct arising from Kaiser Permanente's relationship to you as a Health Plan Member or as a patient has caused any harm, or if any claim (including but not limited to contract, medical malpractice, and premises liability claims) is made against (i) Kaiser Foundation Health Plan, Inc., (ii) Kaiser Foundation Hospitals, (iii) Hawaii Permanente Medical Group, Inc., (iv) the Permanente Federation, LLC, (v) the Permanente Company, LLC, and (vi) any individual or organization that contracts with an organization named in (i), (ii), (iii), (iv), or (v) above to provide services to health plan members, that claim is subject to binding arbitration, unless it is solely for the money within the jurisdictional limit of the Small Claims Court. For all claims subject to binding arbitration, all parties give up the right to jury or court trial. After exhausting Kaiser Permanente's internal appeals process, members with Employee Retirement Income Security Act (ERISA) benefit claims (whose plans are governed by ERISA) have the option of choosing binding arbitration or filing a lawsuit.

ADDITIONAL KAISER PERMANENTE INFORMATION

CUSTOMER SERVICE

When you need help, ask the Customer Service Center:

- Oahu: (808) 432-5955
- Neighbor islands and outside the Hawaii service area: 1 (800) 966-5955
- Phone line hours:

Monday through Friday	8:00 a.m. - 4:30 p.m.
Saturday	8:00 a.m. - 12:00 noon

Specially trained Customer Service personnel can tell you about:

- Your benefits
- Claims and billing
- How to file an appeal
- Changing your address on Kaiser Permanente's records
- Replacing your ID card
- Professional qualifications of primary and specialty practitioners

The following payments do not apply toward meeting the Maximum Annual Copayment:

- Payments for penalties resulting from not obtaining a required Prior Authorization for services subject to approval;
- Copayments for prescription drug benefits;
- Copayments for contraceptives, diabetic drugs and supplies, insulin and medical foods;
- Copayments for Chiropractic and Acupuncture benefits;
- Your payments for charges that exceed the Eligible Charge when services are received from a Non-Participating Provider;
- Your payments for non-covered services; and
- If a service is subject to a maximum limitation, any amounts that you pay after reaching the maximum.

CHOICE OF HEALTH CARE PROVIDERS

You are free to go to any licensed physician of your choice and receive coverage under this Plan. Your choice of physician or other health care provider can make a difference in how much you will owe after Plan benefits have been paid.

Participating Providers

UHA has contracted with more than 2,400 participating medical professionals and facilities throughout Hawaii to provide you with the medical services covered by this Plan. When you go to one of these Participating Providers, UHA sends the provider the benefit payment for the service and you owe only the copayment shown in this booklet (see example on page 26) and the tax, if any.

Non-Participating Providers

When you go to a Non-Participating Provider, UHA has no contract with the provider to guarantee the amount of your copayments. UHA bases the benefit payment on Eligible Charges (see below) and sends the payment directly to you. You will then owe the provider the total charge and any tax for the service.

ELIGIBLE CHARGES

Benefit payments are based on UHA's determination of an Eligible Charge for a covered service.

Eligible Charges for Participating Providers

Eligible Charges for covered services of Participating Providers are part of the contract UHA has arranged with each Participating Provider to guarantee your copayment.

Eligible Charges for Non-Participating Providers

The Eligible Charge for covered services of Non-Participating Providers is the lesser of:

- UHA's determination of an Eligible Charge for a covered service, or
- The actual charge to you.

INFREQUENT SERVICES

There may be times when a service is performed for the first time in Hawaii or so infrequently that an Eligible Charge as described above is not available. In these cases, UHA's medical consultants who are qualified practicing physicians will determine the Eligible Charge by comparing the complexity of the infrequent service with similar frequent services.

HOW TO USE THE UHA PLAN

This is an example of benefits and copayments for a Physician Office Visit under this Plan. Let's say that you have a sore throat and go to a physician to have it checked. The physician's submitted or actual charge is $100 and UHA's Eligible Charge is $60.

If you Go to A Participating Provider	If you Go to A Non-Participating Provider
• **Plan Pays Physician** - The remaining Eligible Charge ($48) after your $12 copayment.	• **Plan Pays You** - The remaining Eligible Charge ($48) after your $12 copayment.
• **You Owe Physician** - Only the $12 copayment and tax.	• **You Owe Physician** - Total charge ($100) made up of: Plan payment ($48), your $12 copayment, any amount above the Eligible Charge ($40), and tax.

The Plan suggests that you discuss charges with your health care provider before receiving services.

You should ask your physician or call the UHA Member Services Department to find out if your physician is a Participating Provider. You will receive a Participating Physicians and Health Care Provider Directory when you join the UHA Plan. Updated directories are available on request from the UHA Member Services Department.

KEEPING YOUR COVERAGE AFFORDABLE

To keep your Plan affordable, each claim is reviewed to make sure that the Plan pays for services that are covered benefits and that are Medically Necessary. In order for UHA to pay for a covered service, all of the following payment determination criteria must be met:

- The service must be listed as a covered benefit and not be excluded as a benefit under this Plan;
- The service must be Medically Necessary for the diagnosis or treatment of your illness or injury;
- The service must be provided in an appropriate setting and at an appropriate level of care; and
- When required under this Plan, the service must be Prior Authorized and consistent with UHA's Guidelines for Prior Authorizations.

The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets these payment criteria, even if the service or supply is listed as a covered service.

logical and/or musculoskeletal function is sufficient when one of the following first occurs:

  - Neurological and/or musculoskeletal function is the level of the average healthy person of the same age;
  - Further significant functional gain is unlikely, or
  - The frequency and duration of therapy for a specific medical condition as specified in the Kaiser Permanente Hawaii Clinical Practice Guidelines has been reached.

- Occupational therapy is limited to hand rehabilitation services and medical services to achieve improved self-care and other customary activities of daily living.
- Speech-language pathology is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin.
- Tuberculin skin test is limited to one (1) per calendar year, unless medically necessary.
- Transplant services for transplant donors. Health Plan will pay for health care services for living organ and tissue donors and prospective donors if the services meet all of the following requirements. Health Plan pays for these services as a courtesy to donors and prospective donors, and this document does not give donors and prospective donors any of the rights of Kaiser Permanente members.
  - Regardless of whether the donor is a Kaiser Permanente member or not, the terms, conditions, and supplemental charges of the transplant-recipient Kaiser Permanente member will apply. Supplemental charges for medical services provided to transplant donors are the responsibility of the transplant-recipient Kaiser Permanente member to pay and count toward the transplant-recipient Kaiser Permanente member's limit on supplemental charges.
  - The medical services required are directly related to a covered transplant for a Kaiser Permanente member and required for screening of potential donors, harvesting the organ or tissue, or treatment of complications resulting from the donation.
  - For medical services to treat complications, the donor receives the medical services from Kaiser Permanente practitioners inside a Health Plan Region or Group Health service area.
  - Health Plan will pay for emergency services directly related to the covered transplant that a donor receives from non-Kaiser Permanente practitioners to treat complications.
  - The medical services are provided not later than three months after donation.
  - The medical services are provided while the transplant recipient is still a Kaiser Permanente Member, except that this limitation will not apply if membership terminates because he or she dies.
  - Health Plan will not pay for travel or lodging for donors or prospective donors.
  - Health Plan will not pay for medical services if the donor or prospective donor is not a Kaiser Permanente member and is a member under another health insurance plan, or has access to other sources of payment.

The above policy does not apply to blood donors.

ment of sexual dysfunction, except evaluations and health care practitioners' services for treatment of sexual dysfunction.

- All services, drugs, prosthetic devices, or surgery related to gender re-assignment.
- Take-home supplies for home use, such as bandages, gauze, tape, antiseptics, ace type bandages, drug and ostomy supplies, catheters and tubing.
- The following costs and services for transplants:
  - Non-human and artificial organs and their transplantation.
  - Bone marrow transplants associated with high-dose chemotherapy for the treatment of solid tissue tumors, except for germ cell tumors and neuroblastoma in children.
- Services for injuries or illnesses caused or alleged to be caused by third parties or in motor vehicle accidents.
- Transportation (other than covered ambulance services), lodging, and living expenses.
- Travel immunizations.
- Services for which coverage has been exhausted, services not listed as covered, or excluded services.

LIMITATIONS

Benefits and services are subject to the following limitations:

- Services may be curtailed because of major disaster, epidemic, or other circumstances beyond Kaiser Permanente's control such as a labor dispute or a natural disaster.
- Coverage is not provided for treatment of conditions for which a member has refused recommended treatment for personal reasons when Kaiser Permanente physicians believe no professionally acceptable alternative treatment exists. Coverage will cease at the point that the member stops following the recommended treatment.
- Members are covered for contraceptive drugs and devices only when the drug or device is 1) prescribed by a licensed prescriber, 2) one for which a prescription is required by law, and 3) obtained at pharmacies in the Hawaii service area operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc.
- Internally implanted prosthetic devices, such as pacemakers and hip joints, are subject to Medicare coverage guidelines and limitations.
- Diabetes equipment and supplies necessary to operate them are subject to Medicare coverage guidelines and limitations, must be preauthorized in writing by Kaiser Permanente, and obtained from a Health Plan designated vendor.
- Short-term physical, occupational, and speech therapy services means medical services provided for those conditions meeting all of the following criteria:
  - The therapy is ordered by a Physician under an individual treatment plan;
  - In the judgment of a Physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy;
  - The therapy is provided by or under the supervision of a Physician-designated licensed physical, speech, or occupational therapist, as appropriate; and
  - The therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury. Neuro-

Medical Necessity

It is the responsibility of UHA's Health Care Services Department to determine if a recommended service is medically necessary and is being provided in an appropriate setting and at an appropriate level of care. In making a determination of medical necessity, UHA follows the definition established by Hawaii State law, HRS 432E-1.4:

"A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is:

(1) For the purpose of treating a medical condition;

(2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient;

(3) Known to be effective in improving health outcomes; provided that:

(A) Effectiveness is determined first by scientific evidence;

(B) If no scientific evidence exists, then by professional standards of care; and

(C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and

(4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price."

If you have any questions about the medical necessity of a particular service or treatment that is being recommended by a physician, you may ask the physician to write to UHA for a determination regarding the medical necessity of the service before it is performed.

HEALTH CARE SERVICES PROGRAM

The UHA Health Care Services Program is designed to ensure that you receive quality health services in the most appropriate setting. This program includes several components including concurrent review and Prior Authorization.

Prior Notification of Admissions and Concurrent Review

Health Care Services nurses monitor all hospital admissions and assist with discharge planning to make sure that needed care is provided promptly and effectively. In order for this review process to work for your benefit, UHA requires that you or your physician notify the Health Care Services Department at least **72 hours in advance** of:

- Elective hospital admissions (including skilled nursing facilities and rehabilitation facilities);
- Provision of any chemical dependency/substance abuse treatment.

For emergency admissions, UHA must be notified within one (1) business day of admission.

Prior Authorization

Prior Authorization is a special pre-approval process to ensure that certain treatments, procedures, or supplies are medically necessary covered services that will be provided in an appropriate setting. If you are under the care of a UHA Participating Provider, the provider should obtain authorization for you. If you are under the care of a Non-Participating Provider, you are responsible for obtaining authorization. **If you do not obtain prior authorization, benefits may be denied.**

Services Requiring Prior Authorization

The following services require Prior Authorization:

Inpatient and Ambulatory (Outpatient) Surgical Procedures

- Ambulatory surgery proposed to be done in an inpatient setting
- Autologous chondrocyte implantation and Carticel
- Bariatric surgery
- Blepharoplasty (upper eyelids **only;** lower eyelids are **NON-COVERED)**
- Hyperbaric oxygen treatment
- Intensity modulated radiation therapy (IMRT)
- *In vitro* fertilization services
- Kyphoplasty and vertebroplasty
- Organ, bone marrow, and stem cell transplant services: transplant evaluations, organ donor services, transplant procedures
- Osteochondral allograft
- Panniculectomy
- Photodynamic therapy for actinic keratoses and other skin lesions. (Photodynamic therapy for acne is **NON-COVERED*)**
- Spinal cord stimulator for pain management
- Stereotactic radiosurgery (e.g. gamma-ray radiosurgery [gamma-knife])
- Thoracic sympathectomy for hyperhidrosis
- Treatment of varicose veins: all procedures require prior authorization **(CPT 36468 and CPT 36469, sclerotherapy for spider veins are NON-COVERED*)**

***COSMETIC PROCEDURES ARE NON-COVERED SERVICES.**

For the most current list of cosmetic procedures, visit the UHA website at **http://www.uhahealth.com/forms.asp.**

Diagnostic Testing and Radiology Procedures

- CTCA – Computerized tomography of the coronary arteries **(CPT 75571 is NON-COVERED)**
- DEXA central bone density study (ages up to and including 64) (CPT 77080). Peripheral bone density study **DOES NOT** require prior authorization (CPT 77081)
- Genetic testing

law; services for any military service-connected illness, injury or condition when such services are reasonably available to the member at a Veterans Administration facility; services required by law to be provided only by, or received only from, a government agency.

- Experimental or investigational services.
- Eye examinations for contact lenses (eye exams for contact lenses may be partially covered if you have an Optical Rider) and vision therapy, including orthoptics, visual training and eye exercises.
- Eye surgery solely for the purpose of correcting refractive defects of the eye, such as Radial keratotomy (RK) and Photo-refractive keratectomy (PRK).
- Routine foot care, unless medically necessary.
- Health Education: specialized health promotion classes and support groups.
- Homemaker services.
- The following costs and services for infertility, in vitro fertilization or artificial insemination:
  - The cost of equipment and of collection, storage, and processing of sperm.
  - In vitro fertilization using either donor sperm or donor eggs.
  - Services related to conception by artificial means other than artificial insemination or in vitro fertilization, such as ovum transplants, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), including prescription drugs related to such services and donor sperm and donor eggs used for such services.
  - Services to reverse voluntary, surgically-induced infertility.
- Non FDA-approved drugs and devices.
- Certain exams, services, and related reports and paperwork, in connection with third party requests, such as those for: employment, participation in employee programs, sports, camp, insurance, disability, governmental licensing, or on court-order or for parole or probation. Physical examinations that are authorized and deemed medically necessary by a Kaiser Permanente physician and are coincidentally needed by a third party are covered according to the member's benefits.
- Long-term physical, occupational, and speech therapy; maintenance therapies; physical, occupational, and speech therapy deficits due to developmental delay; and therapies not expected to result in significant, measurable improvement in physical function with short-term therapy.
- Services not generally and customarily available in the Hawaii Region service area.
- Services and supplies not medically necessary. A service or item is medically necessary (in accord with medically necessary state law definitions and criteria) only if, 1) recommended by the treating Kaiser Permanente physician or licensed health care practitioner, 2) is approved by Kaiser Permanente's medical director or designee, and 3) is for the purpose of treating a medical condition, is the most appropriate delivery or level of service (considering potential benefits and harms to the patient), and known to be effective in improving health outcomes. Effectiveness is determined first by scientific evidence, then by professional standards of care, then by expert opinion. Coverage is limited to the services which are cost effective and adequately meet the medical needs of the member.
- All services, drugs, injections, equipment, supplies, and prosthetics related to treat-

Be sure you have your ID card with you at all times to ensure that you receive proper medical coverage at those facilities.

If you are relocating to another Kaiser Permanente service area or are visiting for more than 90 days, you should contact your Trust Fund Office to discuss your plan/coverage options. If you move outside any Kaiser Permanente service area, the Health Plan may terminate your membership. Until that time, you will only be covered for initial emergent care in accordance with your Health Plan benefits.

EXCLUSIONS

When a service is excluded or non-covered, all services that are necessary or related to the excluded or non-covered service are also excluded. "Service" means any treatment, diagnosis, care, procedure, test, drug, injectable, facility, equipment, item, device, or supply. The following services are excluded:

- Acupuncture.
- Alternative medical services not accepted by standard allopathic medical practices such as: hypnotherapy, behavior testing, sleep therapy, biofeedback, massage therapy, naturopathy, rest cure, and aromatherapy.
- Artificial aids, corrective aids and corrective appliances such as external prosthetics, braces, orthopedic aids, orthotics, hearing aids, corrective lenses and eyeglasses.
- All blood, blood products, blood derivatives, and blood components, whether of human or manufactured origin and regardless of the means of administration, except units of whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin. Donor directed units are not covered.
- Cardiac rehabilitation.
- Chiropractic services.
- Contraceptive foams and creams, condoms, or other non-prescription substances used individually or in conjunction with any other prescribed drug or device.
- Cosmetic services, such as plastic surgery to change or maintain physical appearance, which is not likely to result in significant improvement in physical function. However, Kaiser Permanente physician services to correct significant disfigurement resulting from an injury or medically necessary surgery, incident to a covered mastectomy, or cosmetic service provided by a Physician in a Health Plan facility are covered.
- Custodial services or intermediate level nursing facility services.
- Dental care services such as dental x-rays, dental implants, dental appliances, orthodontia, and services relating to Temporomandibular Joint Dysfunction (TMJ) or Craniomandibular Pain Syndrome.
- Durable medical equipment, such as crutches, canes, oxygen-dispensing equipment, hospital beds, and wheelchairs used in the member's home (including an institution used as his or her home), except diabetes glucose monitors and external insulin pumps.
- Employer or Government Responsibility: Services that an employer is required by law to provide or that are covered by Workers' Compensation or employer liability

- PET Scans
- Oncotype DX
- Psychological Testing
- Sleep Study without CPAP titration - CPT 95810 (Polysomnography ordered **WITHOUT** CPAP titration) **REQUIRES** prior authorization. CPT 95811 (Polysomnography ordered **WITH CPAP** titration) **DOES NOT** require prior authorization.

Durable Medical Equipment (DME) and Supplies

- Durable medical equipment purchase greater than $500
- Durable medical equipment rental greater that $100/month

Nutritional Counseling

- Only covered for anorexia nervosa, bulimia, cardiovascular disease, hypertension, chronic kidney disease, Crohn's disease, ulcerative colitis, gout, morbid obesity (BMI > 35) in adults, pediatric obesity (BMI >95%), post-bariatric surgery; and poor weight gain during pregnancy.
- Nutritional counseling is covered for diabetes and **DOES NOT** require prior authorization
- Counseling must be provided by a Registered Dietician (RD), Certified Nutrition Specialist (CNS), or Certified Diabetes Educator (CDE) with experience in the condition being treated.

Out-Of- State Services (requests require at least 2 weeks for processing)

Prosthetics with cost greater than *$500*

Rehabilitative Services

- Physicial and Occupational therapy (after a combined total of **48** units [1 unit = 15 minutes] or **12** sessions; per calendar year) **Payment is limited to 4 units/ session**
- Speech Therapy

Home Health Services Including Infusion Services after the first 12 visits

Injectables and Over-the-Counter Pharmacological Agents

Injectable Medications *(covered under medical plan)*

- Antiviral agents including but not limited to RespiGam, Synagis, Fuzeon
- Bisphosphonates including but not limited to Reclast, Zometa, Boniva
- Botulinum Toxin – Type A (Botox)
- Erythrocyte and Granulocyte Stimulating Factors including but not limited to Darbepoetin alfa (Aranesp),Epoetin Alfa (Eprex, Epogen, Procrit), Filgastrim (Neupogen), Pegfilgrastim (Neulasta)
- Fabrazyme
- Growth Hormone (Somatropin) including but not limited to Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Nutropin, Nutropin AQ, Nutropin Depot, Saizen, Serostim

- Immune globulin intravenous including but not limited to Carimune NF, Flebogamma, Gammagard S/D, Gammar-P I.V., Gamunex, Iveegam EN, Octagam, Panglobulin, Panglobulin NF, Polygam S/D, Venoglubulin-S
- Interferon beta 1a (Avonex, Rebif) and 1b (Betaseron)
- Leuprolide Acetate (Lupron)
- Oncological agents not listed in one of the nationally recognized cancer compendiums as an indication for treatment of specific neoplasm
- Parathyroid hormone including but not limited to Forteo

Oral Medications (covered under prescription drug plan)

- Actiq (Fentanyl Citrate Oral Transmucosal)
- Anabolic Androgens
- Afinitor (everolimus)
- Emend (aprepitant)
- Exjade (defer asirox)
- Lexiva (fosamprenavir calcium)
- Lotronex (alosteron hydrochloride)
- Nexavar (sorafenib)
- Oncological agents not listed in one of the nationally recognized cancer compendiums as an indication for treatment of specific neoplasm
- Oxycontin (oxycodone HCL controlled release)
- Selzentry (maravir oc)
- Sprycel (dasatinib)
- Sutent (sunitinib malate)
- Tasigna (nilotinib)
- Zyvox (linezolid)

Prior Authorization requirements are subject to change. You may contact UHA's Health Care Services Department for the most current list or review the list online at *www.uhahealth.com*.

How to Obtain Prior Authorization

Prior authorization may be requested by mailing or faxing your request to UHA's Health Care Services Department at:

UHA HEALTH CARE SERVICES DEPARTMENT
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813

Oahu (808) 532-4006
Toll Free (800) 458-4600, ext. 300
FAX (866) 572-4384

The Health Care Services Department is open from 8:00 a.m. to 4:00 p.m., Monday through Friday. Prior Authorization Request forms may be downloaded from the UHA website: *www.uhahealth.com*.

Permanente may arrange for your transfer to a Kaiser Permanente facility as soon as it is medically appropriate to do so.

Emergency care is available seven days a week, 24 hours a day at Kaiser Permanente's Moanalua Medical Center, 3288 Moanalua Road, Honolulu, Hawaii 96819, phone: (808) 432-0000. On the neighbor islands, emergency care is available seven days a week, 24 hours a day at these facilities:

Maui

On Maui, Kaiser Permanente members may receive emergency medical services at Maui Memorial Medical Center.

Maui Memorial Medical Center
221 Mahalani Street
Wailuku, Hawaii 96793
(808) 242-2343

Hawaii

On the Big Island, Kaiser Permanente members may receive emergency medical services at Hilo Medical Center, Kona Community Hospital, and North Hawaii Community Hospital.

Hilo Medical Center
1190 Waianuenue Avenue
Hilo, Hawaii 96720
(808) 974-6800

Kona Community Hospital
Haukapila Street
Kealakekua, Hawaii 96750
(808) 322-4413

North Hawaii Community Hospital
67-1125 Mamalahoa Highway
Kamuela, Hawaii 96743
(808) 881-4730

CARE RECEIVED OUTSIDE THE SERVICE AREA

At a non-Kaiser Permanente facility (or non-health plan designated facility), benefits are limited to care authorized under a written referral when your Kaiser Permanente physician refers you for care that is not available from Kaiser Permanente and emergency benefits.

Outside the Hawaii service area, benefits are limited to care authorized under a written referral, urgent care for members who are temporarily away from the Hawaii service area, and emergency benefits. When you are temporarily traveling outside of the Hawaii service area, you may require medical services for emergent or urgent problems. Please have your ID card with you at all times. If you are admitted to a hospital, you or a family member must call the toll-free number found on the back of your ID card within 48 hours of your hospital admittance or your claim may be denied.

Services at other Kaiser Permanente Regional facilities are provided while you are temporarily visiting the area for less than 90 days. Visiting member benefits apply.

drugs requiring skilled administration, emergency services, family planning office visits, health evaluation office visits for adults, home health care, imaging (including X-rays), immunizations (excluding travel immunizations), in vitro fertilization procedure (excluding drugs), infertility office visits, inpatient room (semi-private), interrupted pregnancy/abortion, laboratory, mental health services, obstetrical (maternity) care, covered office visits for services listed in this Basic Health Services section, outpatient surgery and procedures, radiation and respiratory therapy, reconstructive surgery, short-term physical, speech and occupational therapy, testing services, transplant procedures and urgent care.

The following benefits are not considered Basic Health Services and charges for these services or items are not applicable toward the Supplemental Charges Maximum: all services for which coverage has been exhausted, all excluded or non-covered services, all other services not specifically listed above as a Basic Health Service, allergy test materials, blood or blood processing, braces, complementary alternative medical services (chiropractic, acupuncture, or massage therapy), contraceptive drugs and devices, dental services, diabetes supplies and equipment, dressings and casts, durable medical equipment, external prosthetics, handling fees or taxes, health education services, classes or support groups, hospice services, internal prosthetics, internal devices and aids, medical foods, medical social services, office visits for services which are not Basic Health Services, orthopedic devices, radioactive materials, self-administered/ outpatient prescription drugs, skilled nursing care, take-home supplies, and travel immunizations.

EMERGENCY SERVICES

GENERAL PROVISIONS

A medical emergency is a sudden, unexpected, and potentially life-threatening situation that requires immediate medical attention. Examples include, but are not limited to:

- Heart attack or stroke symptoms
- Extreme difficulty breathing
- Sudden or extended loss of consciousness
- Uncontrollable bleeding
- Sudden loss of vision

If you think you are having an emergency, go immediately to the Emergency Department. Do not take the time to call Kaiser Permanente as precious time may be wasted. If you think you need an ambulance, call 911.

Emergency services (when judged to be an emergency) or ambulance services (when judged to be medically necessary) will be paid in accordance with your health plan benefits. Emergency Room visits that do not meet the prudent lay person definition of an emergency will be deemed non-emergent and will not be covered.

If you are admitted to a non-Kaiser Permanente facility, you or a family member must notify Kaiser Permanente within 48 hours after care begins (or as soon as reasonably possible) by calling the phone number on the back of your Kaiser Permanente identification card. This must be done, or your claim for payment may be denied. Kaiser

Your request for Prior Authorization must include the following information:

- Member name, address, birth date and UHA Member Number
- Requesting provider's name, specialty, phone and fax numbers
- Information about the member's other health insurance, if any
- Name of the provider of the requested service
- Name of the facility where the requested service will be performed
- Diagnoses, procedures and supporting medical information
- Information about whether the member's condition is employment or automobile related
- If the Prior Authorization is for a drug override, the name of the drug and reason for the override
- Provider acknowledgement that the requested service meets the definition of Medically Necessary

You must provide sufficient information to allow UHA to make a decision regarding your request. If you do not provide the information requested, or if the information you provide does not show entitlement to coverage under this Plan, your request may be denied.

UHA will make a decision on your request for Prior Authorization within 15 days of receiving your request. This period may be extended if the information necessary to make a determination is incomplete, in which event, UHA will tell you what additional information is required and you will have at least 45 days after receiving notice to submit the additional information. UHA may also extend this period one time, for up to 15 days, if the extension is necessary due to reasons beyond UHA's control. In that event, UHA will notify you of the circumstances warranting the extension and the date by which a decision will be rendered.

If your request is denied in whole or in part, UHA will provide an explanation, including the specific reason for denial and reference to the health plan terms upon which the denial was based. If you disagree with UHA's denial, you may file an appeal in accordance with the appeal procedures on page 64.

If your health or ability to regain maximum function could be seriously harmed by waiting 15 days for a decision, you or your physician may request an expedited decision, in which event, UHA will make a decision within 72 hours of receiving your request and all required information.

For further information or assistance, please contact UHA's Health Services Department.

MEDICAL PLAN BENEFITS

The UHA 3000I Comprehensive Medical Plan provides for payment of all covered services described in the following sections. The Plan pays a percentage of the Eligible Charge or the remainder of the Eligible Charge after your copayment. The portion that is not paid is your copayment.

PREVENTIVE CARE SERVICES

PREVENTIVE CARE SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Well Child Care Office Visits (Newborn to Age 5)	You owe no copayment	You owe any difference between actual and Eligible Charges
Well Child Care Laboratory Tests (Newborn to age 5)	You owe no copayment	You owe any difference between actual and Eligible Charges
Preventive Medicine Office Visit (Age 6 and Older) *One exam per calendar year*	You owe no copayment	You owe any difference between actual and Eligible Charges
Screening Laboratory Services *Covered as part of Preventive Medicine Office Visit*	You owe no copayment	You owe any difference between actual and Eligible Charges
Preventive Screenings • Mammography • Pap Smear • Chlamydia screening • Osteoporosis screening • Tuberculin skin test • Colorectal cancer screening • PSA test	You owe no copayment	You owe any difference between actual and Eligible Charges
Immunizations All recommended childhood and adult immunizations and vaccines in accordance with guidelines	You owe no copayment	You owe any difference between actual and Eligible Charges

OTHER SERVICES

Prescribed drugs that are on the Formulary and administered at Kaiser Permanente Medical Offices, Emergency Departments and urgent care centers.....No charge for most drugs (Members pay the office visit fee)

Home health services (for home-bound members when prescribed by a Kaiser Permanente physician)

- Nurse and Home Health Aide visits.....No charge

Hospice care (in lieu of any other plan benefits for the treatment of terminal illness).....No charge

Internal prosthetics, devices and aids.....No charge

Diabetes equipment and supplies..... 50% of applicable charges

LIFETIME BENEFIT MAXIMUM .....$3,000,000 per Member

The Lifetime Maximum is the maximum benefit paid by the Kaiser Health Plan for covered services for a Member. The Plan will pay the accumulated cost of services that a Member receives up to the Lifetime Maximum while a Member is enrolled under the same Group Plan and product. Once a Member has met the Lifetime Maximum, Kaiser will no longer pay for the cost of services received by the Member.

Note: Effective June 1, 2011, in accordance with the Patient Protection and Affordable Care Act of 2010, there is no Lifetime Maximum limit on the dollar value of benefits payable by the Kaiser Health Plan for covered services received by a Member.

SUPPLEMENTAL CHARGES MAXIMUM

Your out-of-pocket expenses for covered Basic Health Services are capped each year by the following Supplemental Charges Maximum:

- Single (per member per calendar year)..... $2,500
- Family (3 or more members per calendar year)..... $7,500

You must retain your receipts for the charges you have paid, and when the maximum amount has been paid, present these receipts to the Kaiser Business Office at Moanalua Medical Center, Honolulu Clinic, Waipio Clinic, or Wailuku Clinic, or to the cashier at other clinics. After verification that the Supplemental Charges Maximum has been paid, you will be given a card which indicates that no additional Supplemental Charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits to get the Supplemental Charges waived.

All payments are credited toward the calendar year in which the services were received. Once you have met the Supplemental Charges Maximum, please submit your proof of payment as soon as reasonably possible. No refunds will be made for receipts turned in after February 28 of the year following the one in which the services were received.

Supplemental Charges for the following covered Basic Health Services can be applied toward the Supplemental Charges Maximum: ambulance service, artificial insemination, chemical dependency services (including residential services), dialysis,

- General nursing care
- Special duty nursing when prescribed

Blood transfusions ..... No charge

EXTENDED CARE SERVICES

Up to 60 days of extended care services in a skilled nursing facility per benefit period ..... No charge

EMERGENCY CARE SERVICES

Coverage for initial emergency treatment only

- At a facility in the Hawaii service area ..... $75.00 per visit
- At a facility outside the Hawaii service area ..... 20% of applicable charges

Out-of-area Urgent Care services (coverage for initial urgent care treatment only while temporarily outside the Hawaii service area) ..... 20% of applicable charges

Ambulance services ..... 20% of applicable charges

OBSTETRICAL CARE, FAMILY PLANNING, AND INFERTILITY SERVICES

Doctors' services after confirmation of pregnancy (routine prenatal visits, delivery, and postpartum visit) ..... No charge

Inpatient stay and inpatient care for newborn during or after mother's hospital stay ..... $75.00 per day

Cesarean sections (medically necessary) ..... No charge

Elective interrupted pregnancy (limited to 2 procedures per lifetime) ..... $20.00 per visit

Family planning office visits ..... $20.00 per visit

Contraceptive drugs and devices (FDA approved) to prevent unwanted pregnancies ..... 50% of applicable charges

Involuntary Infertility office visits ..... $20.00 per visit

Artificial Insemination ..... $20.00 per visit

In Vitro Fertilization ..... 20% of applicable charges

- Limited to 1 procedure per lifetime under Kaiser Permanente
- Limited to female members using spouse's sperm

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

Outpatient office visits ..... $20.00 per visit

Hospital Inpatient Care ..... $75.00 per day

Specialized Facility Services

(Services in a specialized mental health or chemical dependency treatment unit or facility approved by Kaiser Permanente Group)

Day treatment or partial hospitalization services ..... $20.00 per visit

Non-hospital residential services ..... $75.00 per day

PREVENTIVE CARE SERVICES SPECIAL NOTES

Well Child Care (Newborn to Age 5)

- Office visits for history, physical examinations, developmental assessments, anticipatory guidance, laboratory tests, and immunizations are covered according to the following schedule and limitations:
  - Birth to one year: six (6) visits (one additional visit is covered when a newborn child is discharged within 48 hours of birth)
  - Age one year: two visits
  - Ages two to five years: one visit per year
- If your child requires medical care for an illness or injury, benefits for Physician Visits apply, not Well Child Care.
- Well Child Immunizations are covered in accordance with Hawaii law and the guidelines set by the Advisory Committee on Immunization Practices.
- The following Well Child Care laboratory tests are covered:
  - Urinalysis
  - Hematocrit
  - Hemoglobin

Preventive Medicine (Age 6 and Older)

- One preventive health examination will be covered per calendar year. The following screening laboratory services are covered as part of the preventive health exam office visit:
  - Complete blood count
  - Basic metabolic panel
  - Lipid panel
  - Urinalysis
  - TSH panel
- Adult immunizations are covered for standard immunizations (cholera, diphtheria, hemophilus influenza, hepatitis, influenza, measles, mumps, pneumococcal disease, polio, smallpox, tetanus, typhoid, typhus, whooping cough, varicella and rubella) and for high risk conditions such as Hepatitis B and other vaccines in accord with the guidelines set by the Advisory Committee on Immunization Practices.
- Breast cancer screening (mammography) is covered, one per calendar year. A woman of any age may receive a screening mammogram more often if she has a history of breast cancer or if her mother or sister has a history of breast cancer. Diagnostic mammography benefits are covered under Diagnostic Testing, Laboratory and Radiology Services.
- Cervical cancer screening (Pap smear) and Chlamydia screening are covered, one per calendar year.
- Osteoporosis screening is covered one per calendar year for the Peripheral Dexa scan or Ultrasound of the heel. Prior Authorization is required for Central Dexa scans which are not covered for screening purposes.
- Coverage is provided for one tuberculin (TB) skin test per calendar year.
- Colorectal cancer screening is covered for males and females over 50 years of age as follows:

- One annual fecal occult blood testing
- One fecal occult blood testing and flexible sigmoidoscopy every five years or one colonoscopy every ten years

- Coverage is provided for one prostate specific antigen (PSA) test per calendar year for men age 50 or older.

DISEASE MANAGEMENT SERVICES

DISEASE MANAGEMENT SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Smoking Cessation Program	You owe no copayment	Not a benefit
Nutrition Counseling	You owe no copayment	Not a benefit
Disease Education Programs	You owe no copayment	Not a benefit
Prenatal Program	You owe no copayment	Not a benefit

DISEASE MANAGEMENT SERVICES SPECIAL NOTES

- Smoking cessation program is a covered service but only through UHA participating providers and with a completed Smoking Cessation Program Rebate Form. Forms may be downloaded from the UHA website at www.uhahealth.com.
- Nutrition counseling is a covered service but only through UHA participating providers and with Prior Authorization.
- Disease education programs are currently provided for members with Diabetes and Asthma through UHA participating providers.

PHYSICIAN SERVICES

PHYSICIAN SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Physician Visits • Office • Hospital • Emergency Room	You owe a copayment of $12 per visit	You owe a copayment of $12 per visit and any difference between actual and Eligible Charges
Second Opinions		
• With Prior Authorization	You owe no copayment	You owe any difference between actual and Eligible Charges
• Without Prior Authorization	You owe a copayment of $12 per visit	You owe a copayment of $12 per visit and any difference between actual and Eligible Charges

BASIC MEDICAL BENEFITS

SERVICES — **MEMBER CHARGES**

OUTPATIENT SERVICES

Doctors' and other health professionals' office visits ..... $20.00 per visit
Outpatient surgery and procedures ..... $20.00 per visit
Well child office visits (birth to age 2) ..... No charge
Preventive care office visit (age 2 and older), one per calendar year ..... No charge
Preventive Gynecological office visit (female members), one per calendar year ..... No charge
Eye exams for eyeglasses ..... $20.00 per visit
Ear exams to determine the need for hearing correction ..... $20.00 per visit
Routine Immunizations ..... No charge
Flu and Pneumococcal Immunizations ..... No charge
Unexpected Mass Immunizations ..... 50% of applicable charges
Short-term physical, occupational and speech therapy ..... $20.00 per visit
Dialysis
- Physician and facility services ..... 10% of applicable charges
- Equipment, training and medical supplies for home dialysis ..... No charge

Radiation therapy ..... $20.00 per visit
Chemotherapy medications for the treatment of cancer
- If skilled administration is required ..... No charge (Members must pay the office visit fee)
- If self-administered ..... Not covered

Materials for casts and dressings ..... No charge

LABORATORY, IMAGING AND TESTING SERVICES

Outpatient ..... 10% of applicable charges
Inpatient ..... No charge

HOSPITAL SERVICES — Semiprivate, Private *(when prescribed)*, or Intensive Care Unit, 365 days each year
Hospital Inpatient Care ..... $75.00 per day
- Room and board
- Operating and recovery room
- Doctor's medical and surgical services
- Hospital anesthesia services
- Drugs and dressings
- Short-term physical, speech, and occupational therapy
- Respiratory therapy and Radiation therapy

HOW TO USE
THE KAISER PERMANENTE PLAN

PERSONAL DOCTOR

You obtain your medical care directly from Kaiser Permanente facilities and physicians. You may choose your personal doctor from a staff of over 350 highly qualified physicians representing all major specialties. Your personal Kaiser Permanente physician is responsible for your medical care and arranges consultations with other specialists, as necessary. All care and services need to be coordinated by a Kaiser Permanente physician.

A list of providers is included in the Kaiser Permanente Member Handbook which is provided to you at no charge.

LIVE OR WORK

Subscribers may live or work in the Hawaii service area and enroll (or continue to be enrolled) in a Kaiser Permanente plan as long as they live in the State of Hawaii. Family dependents must live in the Hawaii service area to enroll (or continue to be enrolled) in a Kaiser Permanente plan.

LOCATIONS

For your convenience, Kaiser Permanente operates multiple outpatient facilities on Oahu, Maui, and the Big Island. You can obtain care at the facility or facilities of your choice. Members on Oahu receive hospital care at the Moanalua Medical Center. Members on Maui receive hospital care at the Maui Memorial Medical Center. Members on the Big Island receive hospital care at the Kona Community Hospital, Hilo Medical Center, or North Hawaii Community Hospital.

For detailed information on the Kaiser Permanente locations, please contact the Customer Service Center at 432-5955 (Oahu), or 1 (800) 966-5955 (neighbor islands), or visit the website at "www.kaiserpermanente.org".

OFFICE VISITS

You may schedule routine visits to physicians or other health professionals by calling in advance to arrange appointments. In cases of sudden illness, you can be seen by a physician that same day by calling one of Kaiser Permanente's conveniently located facilities and describing your condition. Referrals to non-Kaiser Permanente physicians and hospitals may be made for very specialized care.

PHYSICIAN SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Consultations	You owe a copayment of $12 per visit	You owe a copayment of $12 per visit and any difference between actual and Eligible Charges
Anesthesia	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductble has been met and any difference between actual and Eligible Charges

PHYSICIAN SERVICES SPECIAL NOTES

Physician Visits

- Physician visits are covered for the treatment of an illness or injury when you are an inpatient or are seen in a physician's office, clinic, outpatient center, emergency room or your home.
- Emergency Room physician services are covered if received in connection with a medical condition that a prudent layperson could reasonably expect in the absence of immediate medical attention to result in:
  - Serious jeopardy to the health of the individual, or with respect to a pregnant woman, to the health of the woman or her unborn child;
  - Serious impairment to bodily function;
  - Serious dysfunction of any bodily organ or part.
- Home visits or house calls are covered only when provided within the service area and only when your physician determines that necessary care can best be provided in the home.
- Services provided by Advanced Practice Registered Nurses and Physician Assistants are covered as Physician Services.

Second Opinions

- Second opinions on the necessity of surgery or other treatment are fully covered without copayment.
- Prior Authorization is required for opinions rendered by out-of-state providers.

Consultations

- Consultations are covered when requested by your physician. If you are hospitalized, the Plan will only pay for one consultation for each specialty per confinement. Follow-up visits by consultants are covered if UHA determines that additional visits are medically necessary.

Anesthesia

- Anesthesia is covered as required by the attending physician and when appropriate for your condition. Covered services include general and regional anesthesia.

SURGICAL SERVICES

SURGICAL SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Assistant Surgeon	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Cutting and Non-Cutting Surgery (Inpatient and Outpatient)	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Surgical Supplies	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges

SURGICAL SERVICES SPECIAL NOTES

- Covered surgical services include operating room, surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics, and blood transfusion services in an inpatient or outpatient facility.
- Certain surgical procedures require Prior Authorization before they are performed.
- When multiple surgical services are performed at the same time, UHA will pay full benefits for the primary surgical service. Benefits for the secondary surgical service will be paid only when UHA determines that the secondary surgical service was necessitated by the complexity and risk of the primary surgical service. If benefits are determined to be payable, allowances for the secondary surgical services will be based on the additional complexity and risk.
- If you choose to have surgery as an inpatient in a hospital or other facility when it could have been done safely and effectively in a physician's office or in an outpatient surgical center, the benefits paid will not exceed those for surgery in a physician's office or surgical center, whichever is most appropriate. Similarly, if you choose to have surgery in a surgical center when it could have been done safely and effectively in a physician's office, the benefits paid will not exceed those for surgery in a physician's office.
- When the services of another physician may be necessary during a surgery so that the physician must "stand by", benefits will be paid for covered services that the physician actually provides but no payment will be made for the waiting or "stand by" time.

5. Effective July 1, 2007,
   a) The office visit copayment increased from $14.00 to $15.00 per visit.
   b) The copayment for Inpatient Lab, X-Ray and Diagnostic Testing Procedures is 10% of applicable plan charges (formerly no charge).
6. Effective July 1, 2008,
   a) The copayment for Inpatient Hospital care is $50.00 per day (formerly no charge).
   b) The copayment for In-area Emergency Services increased from $25.00 to $50.00 per visit.
   c) The supplemental charges maximum increased to $2,000 per member and $6,000 per family per calendar year (formerly $1,500 per member/$4,500 per family).
7. Effective July 1, 2010,
   a) The Office Visit copayment increased from $15.00 to $20.00 per visit (page 70).
   b) The Emergency Services copayment increased from $50.00 to $75.00 per visit (page 71).
   c) The Hospital Inpatient Services copayment increased from $50.00 to $75.00 per day (page 70).
   d) The Supplemental Charges Maximum increased to $2,500 per person and $7,500 per family per calendar year (formerly $2,000 per person/$6,000 per family) (page 72).
   e) There is a lifetime maximum benefit of $3,000,000 per member (previously unlimited). Once a member has met the lifetime maximum, Kaiser will no longer pay for the cost of services received by the member (page 72).
   f) The prescription drug copayment increased from $10.00 to $12.00 per prescription (page 81).
8. Effective June 1, 2011, in accordance with the Patient Protection and Affordable Care Act of 2010, there is no lifetime maximum benefit limit under the Kaiser Plan (formerly $3,000,000 per person) (page 72).

KAISER PERMANENTE®
KAISER FOUNDATION HEALTH PLAN, INC.

The Kaiser Permanente Plan is designed to provide quality medical care at a reasonable cost. The Kaiser Permanente Plan provides prepaid medical and hospital services for members, as well as preventive health benefits like health evaluations.

When you join, you and other enrolled members of your family are encouraged to follow a health maintenance program with covered benefits such as periodic health evaluations, eye examinations for glasses, and pediatric checkups. When an illness does occur, your benefit coverage enables your personal Kaiser Permanente physician to provide the necessary services.

KAISER PLAN BENEFIT CHANGES

Several important changes have been made in your Health and Welfare benefits over the past few years. You have been previously notified of these changes and their effective dates. However, as part of our ongoing process to familiarize you with the benefit programs and to comply with Federal law, the changes have been incorporated in this booklet revision.

1. Effective July 1, 2004,
   a) The supplemental charges maximum increased to $1,500 per member and $4,500 per family per calendar year (formerly $1,000 per member/$3,000 per family).
   b) The prescription drug copayment increased from $7.00 to $10.00 per prescription.
2. Effective January 1, 2005, the Kaiser Plan is no longer offered on the island of Kauai.
3. Effective July 1, 2005,
   a) The office visit copayment increased from $10.00 to $12.00 per visit.
   b) The copayment for Outpatient Lab, X-Ray and Diagnostic Testing Procedures is 10% of applicable plan charges (formerly no charge). This copayment will not apply to certain screening services such as routine pap smears; however, the office visit copayment still applies (page 70).
   c) If you have outstanding balances, Kaiser may charge you 12% simple interest on amounts that are 60 days past due, and/or reschedule future non-urgent appointments until you have paid the outstanding balance or made other payment arrangements.
   d) Contraceptive Drugs and Devices are covered under the medical plan instead of the drug plan at a 50% copayment (formerly $10.00 per 30-day supply) (page 71).
4. Effective July 1, 2006, the office visit copayment increased from $12.00 to $14.00 per visit.

Assistant Surgeon

- Services of an Assistant Surgeon are covered when:
  - Assistance is medically necessary based on the complexity of the surgery; and
  - The facility does not have a residency or training program or the facility has such a program but a resident or intern on staff is not available to assist the surgeon.

Cutting Surgery

- Pre- and postoperative care provided in connection with surgical procedures is included in the Eligible Charge for the surgery. If a physician charges separately for the preoperative and postoperative care in excess of this single Eligible Charge, the Plan will not pay the excess charges.

Non-Cutting Surgery

- Examples of non-cutting surgical procedures include:
  - Diagnostic and endoscopic procedures
  - Diagnostic and therapeutic injections
  - Orthopedic castings
  - Acne treatment
  - Destruction of localized lesions by chemotherapy (excluding silver nitrate), cryotherapy or electrosurgery

Reconstructive Surgery

- Reconstructive surgery requires Prior Authorization and is covered only for:
  - Corrective surgery required to restore or correct any bodily function that was lost, impaired or damaged as a result of an illness or injury;
  - Reconstructive surgery to correct congenital anomalies (defects present from birth) if the anomaly severely impairs or impedes normal, essential bodily functions;
  - Reconstructive surgery following a mastectomy. Covered procedures include reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses.
- Reconstructive or plastic surgery that is intended to improve your appearance and is unrelated to an injury, illness, or physical or birth defect is considered cosmetic and is not covered.
- Services related to complications of non-covered reconstructive surgery are not covered.

Oral Surgery

- Benefits are available for certain oral surgical services provided by a physician or a dentist. Services of a dentist (DDS or DMD) are covered services only when:
  - The dentist is performing emergency service for an accidental injury or surgical services, and
  - These covered services could also be performed by physicians (MD or DO).
- Benefits are available if you have a medical problem such as hemophilia that makes hospitalization necessary for you to safely receive dental services or when the oral surgery itself requires hospitalization.

- Dental services that are generally done only by dentists and not physicians are not covered under this Plan. This includes services such as orthodontia; dental splints and other dental appliances; dental prostheses; osseointegration; removal of impacted teeth; and any other dental procedure involving the teeth, structures supporting the teeth, and gum tissues. In addition, any services in connection with the diagnosis or treatment of temporomandibular joint (TMJ) problems or malocclusion (misalignment of teeth or jaw) are not covered. These exclusions apply regardless of the symptoms or illnesses being treated.

HOSPITAL SERVICES

HOSPITAL SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Ambulatory Surgery Center	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Hospital Room and Board Based on semiprivate room rate. Includes Special Care Units (intensive care, coronary care, isolation or telemetry), Operating and Recovery Room, Labor and Delivery Room, and General Nursing Care	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Ancillary Inpatient Services Includes hospital anesthesia and supplies, diagnostic and therapy services, dressings, drugs, oxygen, special diets and hospital blood transfusion services	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Emergency Room Coverage is limited to emergencies only	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges

UHA will pay the arbitrator's fee and each party must pay its own attorney's and witness fees, if any. The arbitrator will decide who will pay all other costs of the arbitration.

The preceding medical and prescription drug benefits are fully insured under a contract of insurance issued by University Health Alliance (UHA), 700 Bishop Street, Suite 300, Honolulu, Hawaii 96813. The services provided by UHA include the payment of claims, when necessary, and the handling of claims appeals.

The preceding is for informational purposes and is only a summary of coverage. Its contents are subject to provisions of the Group Contract, UHA 3000I Comprehensive Medical Plan Medical Benefits Guide and UHA Drug Plan Q, which contain all the terms and conditions of membership and benefits. These documents are on file with the Local 665 IATSE Health and Welfare Fund Office. Please refer to these documents for specific questions about coverage.

on which the decision was based, a statement of your external review rights, and other information regarding the denial.

Independent Physician Review

If a request for coverage was denied based on medical necessity and you disagree with the decision, you may request external review of the decision by a physician reviewer selected by an independent review organization. Your request must be submitted in writing to the Appeals Coordinator and must be received by UHA within 60 days from the date of the decision by UHA's Appeals Committee.

UHA will pay for the services of the independent review organization and its physician reviewer if you make a timely request. The physician reviewer will be provided all information considered by UHA's Appeals Committee (including any prior submissions by you), your request for external appeal and any accompanying documentation you provided with your request, and any other pertinent documentation. The physician reviewer will render a decision within 60 days of receipt of all information needed for the reviewer's decision. The physician reviewer's decision shall be binding as to the medical necessity of the service in question but not as to other disputes that may exist. If you elect to have review by a Physician Reviewer, you waive your right to arbitration and court or jury trial on the issue of medical necessity for the services in question.

If the Appeals Committee's decision was based on a determination other than medical necessity and you disagree with the decision, or if the Committee's decision was based on medical necessity but you elected not to request review by an independent physician reviewer, you may request binding arbitration before a mutually selected arbitrator, or file a lawsuit against UHA. UHA waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.

Arbitration

Your request for arbitration will not affect your rights to other benefits under this Plan. If you select arbitration, you must have complied with UHA's appeals procedures as described above and submit a written request for arbitration to the Appeals Coordinator within one (1) year from the date of the Appeals Committee's decision. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the disagreement. The arbitrator's decision is binding and the parties waive their right to a court and jury trial.

Before arbitration actually starts, both parties (you and UHA) must agree on the selection of the arbitrator. If the parties cannot agree within 30 days of your request for arbitration, either party may ask a court of appropriate jurisdiction to appoint an arbitrator.

The arbitration shall be held in Hawaii and conducted in accord with the Hawaii Arbitration Act (Chapter 658A, HRS) and the arbitration rules of Dispute Prevention and Resolution. The questions for the arbitrator shall be whether UHA was in violation of the law, or acted arbitrarily, capriciously, or in abuse of its discretion.

The arbitrator will make a decision and will give both parties a copy of this decision. The decision of the arbitrator is final and binding and no further appeal or court action can be taken except as provided under the Hawaii Arbitration Act.

HOSPITAL SERVICES SPECIAL NOTES

- Inpatient hospital services are covered up to 365 days per calendar year.
- When you require hospital care, the hospital facility and your participating physician are responsible for notifying UHA prior to your admission. If you have elected to receive care from a Non-Participating provider, you are responsible for this prior notification to UHA.
- Benefits for Hospital Room and Board are based on the participating facility's semi-private medical/surgical room rate unless a private room is authorized by UHA. If the facility does not have semi-private rooms, or is a Non-Participating facility, benefits will be paid based on UHA's maximum allowable Eligible Charge for semi-private rooms. You will be responsible for your coinsurance on the Eligible Charge and any difference between the Eligible Charge for the semi-private room rate and the facility's room rate.
- Emergency Room services are covered if received in connection with a medical condition that a prudent layperson could reasonably expect in the absence of immediate medical attention to result in:
  - Serious jeopardy to the health of the individual, or with respect to a pregnant woman, to the health of the woman or her unborn child;
  - Serious impairment to bodily function;
  - Serious dysfunction of any bodily organ or part.
- Examples of an emergency include:
  - Chest pain or other signs of a heart attack
  - Shortness of breath and/or difficulty breathing
  - Loss of consciousness, convulsions or seizures
  - Sudden onset of a severe and unexplained headache
  - Sudden weakness on one side of your body
  - Poisoning
  - Broken back, neck or other bones
  - Drug overdose
  - Significant loss of blood
  - Severe allergic reaction
  - Severe burn
- If you require emergency services, call 911 or go to the nearest emergency room. Prior notification is not required.
- If you are admitted to the hospital as an inpatient following a visit to the emergency room, hospital inpatient benefits apply, not emergency room benefits.

SKILLED NURSING FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Room and Board Up to 120 days per calendar year based on semi-private room rate *(Prior Authorization required)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Ancillary Services Includes routine supplies, prescribed drugs and medications, dressings, oxygen, diagnostic and therapeutic services	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges

SKILLED NURSING FACILITY SERVICES SPECIAL NOTES

- Skilled Nursing Facility services are covered up to 120 days per calendar year.
- When a physician recommends admission to a skilled nursing facility, you or your physician must notify UHA's Health Care Services Department and obtain Prior Authorization.
- Coverage is provided for medically necessary care in a facility that meets Medicare standards. You must be admitted by a physician and be under the care of an attending physician while in the facility. If the stay exceeds 30 days, the attending physician must submit a report showing the need for skilled nursing care at the end of each 30-day period.
- Benefits will not be paid for services furnished primarily for comfort, convenience, rest cure, domiciliary care or custodial care.

HOME HEALTH CARE SERVICES

HOME HEALTH CARE SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
HOME HEALTH CARE SERVICES Up to 150 visits per calendar year *(Prior Authorization required)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges

HOME HEALTH CARE SERVICES SPECIAL NOTES

- Home health care services are covered only when prior authorized by UHA and received from a qualified home care agency that meets Medicare requirements. Coverage is provided for up to 150 visits per calendar year.

- The date of the service that was denied or paid in error
- A description of the facts related to the appeal and why you believe UHA's decision was in error
- Any other documents relating to your appeal that you would like UHA to review.

Upon written request to UHA, you will be provided, free of charge:

- A copy of documents and information relevant to your claims for payment, request for authorization, or your appeal
- Any rule, guideline, or protocol relied upon in denying a claim for payment or request for prior authorization
- The identity of any experts whose advice was obtained in connection with denial of your claim for payment, request for prior authorization, or appeal.

Appeal of a Prior Authorization Decision

If you are appealing a Prior Authorization decision, UHA will respond to your appeal as soon as possible given the medical circumstances of your case, but not later than 30 days after your appeal is received.

Appeal of Any Other Decision

For all other appeals, UHA will respond within 60 days of receiving your appeal.

Expedited Appeals

An expedited appeal may be requested for an acute or urgent condition if the standard response time (60 days) for reviewing an appeal would:

- Seriously jeopardize your life or health;
- Seriously jeopardize your ability to regain maximum functioning;
- Subject you to severe pain that cannot be adequately managed without the care or treatment requested.

Expedited appeals are appropriate when denial affects care that is in progress or to be initiated.

You may request an expedited appeal by writing to the Appeals Coordinator or by calling UHA's Health Care Services Department (532-4006 from Oahu or Toll-free 1-800-458-4600, ext. 300 from the Neighbor Islands). If UHA determines, or your health care provider states that the criteria for an expedited appeal are met, UHA will respond to your request for an expedited appeal within 72 hours.

Appeals Committee Review

UHA's Appeals Committee will review your appeal request. When necessary, UHA will obtain the opinion of outside experts not affiliated with UHA to advise the committee. UHA will notify you in writing of its decision within the timeframes specified above. If special circumstances arise requiring additional time to complete the review, you will be notified that additional time is needed.

UHA's review on appeal will consider all information submitted by you whether or not that information was submitted in your initial claim for payment or request for Prior Authorization. The review will be conducted by someone other than the person who decided your original request and without regard to the initial decision.

If the decision on appeal denies your request in whole or in part, UHA will provide an explanation, including the specific reason for denial, reference to the health plan terms

party injury or illness to directly pay to UHA so much of such payment as is necessary to reimburse UHA for benefits paid.

If UHA is not reimbursed for its total payment of benefits in connection with your illness or injury, UHA shall have a right of subrogation for all causes of action and all rights of recovery you have against such other person or party or other source of recovery, to the extent of UHA's unreimbursed payments on your behalf.

UHA's rights of reimbursement, lien, and subrogation described above are in addition to all other rights of equitable subrogation, constructive trust, equitable lien and/or statutory lien UHA may have for repayment of benefits paid, all of which rights are preserved and may be pursued at UHA's option against you or any other appropriate person or entity.

No reductions for attorneys' fees, costs, or other expenses may be made from the amounts owing to UHA under these third party liability rules, unless required by ERISA.

For any payment made by UHA under these rules, you will still be responsible for co-payments, deductibles, timely submission of claims, and other duties under this Plan.

If you comply with the above requirements and have made reasonable efforts to obtain recovery for your illness or injury, but receive a final dismissal or denial of all of your legal claims without receiving any recovery for your illness or injury, then no reimbursement is owing to UHA for covered benefits paid for the illness or injury.

GRIEVANCES AND APPEALS

If for any reason you are dissatisfied with the services you receive under this Plan or if you believe that UHA incorrectly denied a claim, paid an incorrect amount, or incorrectly determined that a service is not a covered benefit, contact UHA's Member Services Department (532-4000 from Oahu or Toll-free 1-800-458-4600 from the Neighbor Islands) and explain your concern. Member Services will investigate and attempt to respond to your concern fairly and promptly.

Requesting a Formal Appeal

If you are not satisfied with the response you receive from Member Services, you may appeal the decision by writing to:

Appeals Coordinator
UHA
700 Bishop Street, Suite 300
Honolulu, Hawaii 96813

You or your designated representative may request an appeal. Designated representatives may include a provider, a court-appointed guardian or agent under a health care proxy, or other person whom you designate in writing to represent you on your appeal. You must provide UHA with documentation of your designation of a representative to act on your behalf with your appeal.

Your appeal must be filed within one (1) year of the date that UHA first informed you of the denial or limitation of the claim or coverage for any requested service and should include the following information:

- The date of your request for appeal
- Your name

- To be eligible for benefits, the following statements must be true:
  - Home care services must be prescribed in writing by a physician for the treatment of an illness or injury when you are homebound. Homebound means that due to an illness or an injury, you are unable to leave home unless you use devices or have assistance from another person and you meet homebound standards defined by Medicare.
  - Part-time skilled health services are required for the treatment of your condition and without home care you would require inpatient hospital or skilled nursing facility care.
  - Home health care services are not more costly than other covered services that would be effective for the treatment of your condition.
- If you need home health care services for more than 30 days, a physician must certify that there is further need for the services and provide a continuing plan of treatment at the end of each 30-day period of care.

HOSPICE CARE SERVICES

HOSPICE CARE SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
HOSPICE SERVICES Care relating to a terminal illness in lieu of other covered services for such illness	You owe no copayment	You owe any difference between actual and Eligible Charges

HOSPICE CARE SERVICES SPECIAL NOTES

- Hospice care is covered only if services are received from a Medicare-approved Hospice program. Covered services include:
  - Residential hospice room and board expenses directly related to the hospice care being provided.
  - Hospice referral visits during which a patient is advised of hospice care options.
- Medicare guidelines are followed in determining benefits, payment, level of care and eligibility for hospice services.
- The attending physician must certify in writing that you are terminally ill and have a life expectancy of six (6) months or less. While under hospice care, you are not eligible to receive other benefits for treatment of the terminal condition except for attending physician office visits. However, you may continue to receive covered benefits for any unrelated illness or injury.

DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES

DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Allergy Testing One testing series per calendar year	You owe a copayment of $12 per visit	You owe a copayment of $12 per visit and any difference between actual and Eligible Charges
Diagnostic Testing (Inpatient)	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Diagnostic Testing (Outpatient)	You owe a copayment of 20% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges
Genetic Testing and Counseling *(Prior Authorization required)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Laboratory and Pathology (Inpatient)	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Laboratory and Pathology (Outpatient)	You owe no copayment	You owe any difference between actual and Eligible Charges
Radiology (Inpatient and Outpatient)	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges

- You have or may have the right to recover damages or receive payment from someone else for your injury or illness without regard to fault.

When third party liability situations occur, the Plan will provide benefits only as set forth below.

- If you have coverage under Workers' Compensation insurance, such coverage will apply instead of coverage under this Plan. Medical expenses arising from injury or illness covered under Workers' Compensation insurance are excluded from coverage under this Plan.
- If you have coverage under personal injury protection insurance, you must exhaust that coverage first before the coverage under this Plan will apply (See Automobile Coverage above).
- When third party liability situations occur, you must cooperate with UHA by doing the following.
  - Give timely notice of the following, within 30 calendar days of occurrence:
    1. Your knowledge of any actual or potential claim;
    2. Any written claim or demand, including initiation of legal proceedings, by you or on your behalf;
    3. Any monetary recovery, including any settlement, judgment, award, insurance proceeds, or other payment, from any source of recovery in connection with your illness or injury.
  - Sign and deliver to UHA all papers it requires to secure its rights to repayment, including but not limited to a Reimbursement Agreement.
  - Provide UHA any information reasonably related to its investigation of liability for coverage and rights to repayment.
  - DO NOT release or otherwise impair UHA's rights to repayment without UHA's express written consent.
  - Cooperate in protecting UHA's rights under these rules, including giving notice of UHA's rights to repayment as part of any written claim or demand made against any other person, party, or source of recovery.

Failure to comply with the rules as described above may result in delay in payment or denial of your claims and will entitle UHA to reimbursement of its payments to the extent that your actions result in erroneous payment or prejudice UHA's right to repayment. If UHA is entitled to reimbursement of payments under these rules and does not promptly receive full reimbursement pursuant to its request, UHA shall have a right to off-set future benefits payable under this Plan.

Subject to the limitations and conditions described above, UHA will pay benefits in accordance with this Plan and these rules. However, any benefits paid in third party liability situations must be repaid from any recovery received by you as a result of such injury or illness, even if the award does not specifically include medical expenses, or is described as general damages only, or is less than the total actual or alleged loss suffered by you due to the injury or illness. UHA shall have a first lien against any such recovery to the extent of its total payment of benefits. This lien will attach to and follow any recovery proceeds even if the proceeds are distributed to another person or entity. UHA may file notice of its lien with the court, the other person or party, or other source of recovery, or any person or entity receiving the proceeds. You have a duty to authorize and direct any person or entity making any payment on account of any third

Before Plan benefits for any motor vehicle accident-related injury are paid, you must provide UHA an itemization of expenses paid by the motor vehicle insurance including: the date the services were provided, the provider of each service, and the amount paid for each service. Upon verification by UHA that any motor vehicle coverage has been exhausted, covered services you received that exceed the personal injury protection mandatory coverage amount may then be eligible for payment in accordance with this Plan.

MEDICARE COORDINATION RULES

If you have both this group coverage and Medicare, federal rules determine which plan pays first.

- If you are 65 or older and eligible for Medicare only because of your age, this Plan will pay first before Medicare as long as your group coverage is based on your status as a current active employee or the status of your spouse as a current active employee.
- If you are under 65 and eligible for Medicare only because of a disability, this Plan will pay first before Medicare as long as your group coverage is based on your status as a current active employee, or the status of your spouse as a current active employee, or the current active employment status of the person for whom you are a dependent.
- If you are under 65 and eligible for Medicare only because of end stage renal disease (ERSD), coverage under this Plan will pay first before Medicare, but only for the first 30 months of your ERSD coverage. After 30 months, the amount that this Plan pays will be reduced by the amount that Medicare pays for the same services.

When Medicare is allowed by law to be the primary payer, coverage under this Plan will be reduced by the amount paid by Medicare for the same covered services. Benefits under this Plan will be paid up to either the Medicare-approved charge for services by a Medicare-participating provider, or the lesser of UHA's Eligible Charge or the limiting charge (as defined by Medicare) for services rendered by a provider who does not participate with Medicare.

If you are entitled to Medicare benefits, UHA will begin paying benefits after all Medicare benefits, including all lifetime reserve days, are exhausted.

If you have coverage under Medicare Part B only, UHA will pay inpatient benefits based on the Plan's Eligible Charge less any Medicare Part B benefits for inpatient diagnostic, laboratory and radiology services.

When services are rendered by a provider that is not eligible or entitled to receive reimbursement from Medicare, and Medicare is entitled by law to be the primary payer, the Plan will limit payment to the amounts that would have been payable by Medicare had the provider been eligible to receive such payments, regardless of whether or not Medicare benefits are paid.

THIRD PARTY LIABILITY RULES

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

- The injury or illness is caused or alleged to have been caused by someone else and you have or may have the right to recover damages or receive payment in connection with the illness or injury; or

DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES SPECIAL NOTES

- Allergy testing and treatment materials are covered for only one series of tests per calendar year.
- Prior Authorization is required for Genetic Testing and Counseling services.
- Diagnostic Testing, Laboratory and Pathology, and Radiology services are covered when related to an injury or illness. Some Radiology services such as PET scans require Prior Authorization.

CHEMOTHERAPY AND RADIATION THERAPY

CHEMOTHERAPY AND RADIATION THERAPY	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Chemotherapy *(Prior Authorization required for certain treatments)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Radiation Therapy	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges

CHEMOTHERAPY AND RADIATION THERAPY SPECIAL NOTES

- Prior authorization is required for Chemotherapy when the recommended treatment plan does not conform to the current Compendia-Based Drug Bulletin.

ORGAN TRANSPLANT SERVICES

ORGAN TRANSPLANT SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Transplant Evaluation *(Prior Authorization required)*	You owe no copayment after the Annual Deductible has been met	You owe any difference between actual and Eligible Charges after the Annual Deductible has been met
Corneal Transplants	You owe no copayment after the Annual Deductible has been met	You owe any difference between actual and Eligible Charges after the Annual Deductible has been met

ORGAN TRANSPLANT SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
All Other Organ Transplants *(Prior Authorization required)*	You owe no copayment after the Annual Deductible has been met	You owe any difference between actual and Eligible Charges after the Annual Deductible has been met
Organ Donor Services *(Prior Authorization required)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges

TRANSPLANT SERVICES SPECIAL NOTES

- The following transplants are eligible for benefits: corneal; bone marrow; heart; heart-lung; kidney; liver; lung; simultaneous kidney/pancreas; small bowel and multivisceral transplants. Benefits for bone marrow transplants are limited to autologous and allogeneic bone marrow transplants for specified diseases or conditions. All other transplants, including artificial or non-human organ transplants, are not covered under this Plan.
- Prior authorization is required for all transplants, except corneal.
- To be eligible for coverage, transplant services must be provided by a facility that is under contract with UHA for the specific type of transplant and that facility must accept you as a candidate.
- Transplant Evaluations for covered transplants are eligible for benefits but only with Prior Authorization from UHA. Transplant evaluation means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations that a facility uses in evaluating a potential transplant candidate.
- Organ Donor Services are covered when prior authorized by UHA and the recipient is a Plan member. No benefits are available under this Plan if you are donating an organ to someone else. This Plan's coverage is secondary and the living donor's coverage is primary when the recipient is a Plan member and the donor's health coverage provides benefits for organs donated by a living donor. Benefits for the screening of donors are limited to the expenses of the actual donor.

- 100% of the Eligible Charge; or
- The amount payable by your other coverage plus any deductible and copayment you would owe if the other coverage were your only coverage.

Any deductible and copayment you owe under this Plan will first be subtracted from the benefit payment. You remain responsible for the deductible and copayment owed under this Plan, if any.

Benefit Payments under Coordination of Benefits Rules

Some general rules governing coordination of benefits are:

- The coverage you have as an employee pays first before any coverage you have as a spouse or dependent.
- The coverage you have as an active employee pays before coverage you have as a retiree or under which you are not actively employed.
- When both are group sponsored plans and one plan has no coordination of benefits rules and the other does, the plan without coordination of benefits rules pays first.
- For a child who is covered by both parents, the "birthday rule" applies; i.e., the coverage of the parent whose birthday occurs first in the calendar year pays first.
- When no other rule applies, the coverage with the earliest continuous effective date pays first.

The coverage that pays first is called "primary" and the coverage that pays second is called "secondary".

When this Plan is determined to be the primary payer, UHA will pay benefits in accordance with the provisions of the Plan.

When this Plan is determined to be the secondary payer, UHA will base its payment on the Eligible Charge and deduct from the payment:

- Any unpaid copayment or deductible that you owe under this Plan;
- The benefit amount paid by the primary plan.

The Plan will not pay benefits unless the service in question is a covered service. Benefits will not be paid for the difference in cost between a private and a semi-private hospital room, even if such private room is a benefit under the primary plan. Any payment by this Plan as the secondary payer will not exceed the amount that would have been paid for covered services you received had this Plan been your only coverage. Any payment by this Plan as secondary payer will count towards applicable Benefit Maximums of this Plan. Even if no payment is made by this Plan as the secondary payer, the service for which payment is made by the primary plan shall count toward applicable service maximums of this Plan.

AUTOMOBILE COVERAGE

For injuries sustained in an automobile accident, the motor vehicle insurance will be considered primary for payment and those benefits will be applied first before any benefits of this Plan apply. This Plan will begin paying benefits after the personal injury protection mandatory coverage amount as specified by state law has been exhausted, whether or not such coverage is in force. You are responsible for any cost-sharing payments required under any motor vehicle insurance coverage. This Plan does not cover any personal injury protection cost sharing arrangements.

of a travel Emergency. A travel emergency is a medical emergency that occurs while you are traveling outside of the Service Area.

Providers with the special mainland contractor do not qualify as UHA Participating Providers for purposes of this Plan. Except for travel emergencies, UHA will make payments for all mainland services (even services obtained from providers with the special mainland contractor) at Non-Participating Provider benefit levels and you are responsible for the provider's charges in excess of UHA's payment. In no event will the Eligible Charge for such covered services exceed the Eligible Charge for similar services rendered in the State of Hawaii.

If you require medical services that are not available in Hawaii, your physician should contact UHA's Health Care Services Department for an authorization for referral to a mainland provider.

FILING CLAIMS FOR PAYMENT

UHA claim forms and filing instructions have been distributed to providers throughout Hawaii. You may also obtain claim forms by calling the Member Services Department or down load forms from the UHA website at *www.uhahealth.com*.

- When you receive services from any provider, be sure to present your UHA identification card. If you have other coverage, you should also present the other carrier's identification card or inform your provider of the other coverage.
- Be sure that both UHA and your service provider have your current address.
- When you visit a UHA Participating Provider, the provider will file a claim for payment on your behalf and payment will be sent to the provider. UHA will send you an Explanation of Benefits (EOB) showing the services performed, the amount charged, the amount allowed, the amount paid by UHA, and the amount, if any, that you owe.
- When you visit a Non-Participating Provider, the provider may file a claim on your behalf or give you the claim to file with UHA. UHA will send payment to you along with an EOB. You are responsible for paying the entire amount charged to the provider.
- All claims for Hospital services will be filed by the Hospital. Payment will be sent to the Hospital and you will receive an EOB.
- Claims should be submitted as soon as possible after the date of service. All claims for payment must be filed with UHA within one year of the date of service. No payment will be made on any claim received more than one year after the date of service.
- Claims should be sent to:

  UHA
  700 Bishop Street, Suite 300
  Honolulu, Hawaii 96813

COORDINATION OF BENEFITS

If you have other insurance coverage that provides benefits similar to those of this Plan, UHA will "coordinate" the benefits of the two plans. When benefits are coordinated, the benefits paid under this Plan, when combined with the benefits paid under your other coverage, will not exceed the lesser of:

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Professional Services (Inpatient and Outpatient)	You owe a copayment of $12 per visit	You owe a copayment of $12 per visit and any difference between actual and Eligible Charges
Facility Services	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Psychological Testing (Inpatient)	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Psychological Testing (Outpatient) *(Prior Authorization required)*	You owe a copayment of 20% of Eligible Charges	You owe a copayment of 20% of Eligible Charges and any difference between actual and Eligible Charges

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES SPECIAL NOTES

- Mental health and substance abuse services are covered when all of the following are true:
  - You are diagnosed with a condition listed within the current version of the Diagnostic and Statistical Manual of the American Psychiatric Association;
  - The services are provided under an individualized treatment plan approved by UHA or its designee;
  - The services are provided by a licensed psychiatrist, psychologist, clinical social worker, mental health counselor, or advanced practice registered nurse; and
  - You are physically present with the provider when the services are provided.
- Conditions such as epilepsy, senility, mental retardation, or other developmental disabilities, and addiction to and use of intoxicating substances do not, in and of themselves, constitute a mental disorder.
- You are not covered for educational programs or other services performed by mutual self-help groups, even if you are referred to such groups by your provider or the judicial system.

Outpatient Services

- Outpatient visits by a psychiatrist, psychologist, clinical social worker, mental health counselor, or advanced practice registered nurse for mental health or sub-

stance abuse conditions are covered. Benefits for outpatient visits are limited to no more than 50 minutes per day.

- Prior Authorization is required for outpatient psychological testing.
- 72 hours advance notification is required for chemical dependency/substance abuse treatment.

Inpatient Services

- Inpatient care for mental health or substance abuse conditions is limited to room and care and ancillary inpatient services. No additional benefits are available for intensive or special care psychiatric units.
- Inpatient visits by a psychiatrist, psychologist, clinical social worker, mental health counselor, or advanced practice registered nurse for mental health or substance abuse conditions are covered. Benefits for inpatient visits are limited to no more than 50 minutes per day.
- 72 hours advance notification is required for chemical dependency/substance abuse treatment.

Serious Mental Illness

- Services for serious mental illness, as defined by Hawaii law, such as schizophrenia, schizo-affective disorder, bi-polar disorder, obsessive compulsive disorder, dissociative disorder, delusional disorder, and major depression, are not subject to the Inpatient and Outpatient limitations described above.

MATERNITY, FAMILY PLANNING & INFERTILITY SERVICES

MATERNITY, FAMILY PLANNING & INFERTILITY SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Maternity Care and Delivery Prenatal, delivery, and postnatal services provided by a physician or midwife	You owe no copayment	You owe any difference between actual and Eligible Charges
Birthing Room Coverage is for labor and delivery only	You owe no copayment	You owe any difference between actual and Eligible Charges
Newborn Nursery Covered for at least 48 hours from the time of delivery for normal labor and delivery or 96 hours for a cesarean birth	You owe no copayment	You owe any difference between actual and Eligible Charges

- Expenses of transporting a living donor
- Mechanical or non-human organs and related services
- The purchase of any organ
- Transplant services or supplies or related services or supplies except as previously described as covered

- Personal comfort or convenience items such as air conditioners, dehumidifiers, home remodeling, hot tubs, ramps, or swimming pools.
- Physical examinations specifically for job-related or sports-related purposes
- Physician's waiting or stand-by time
- Prescription drugs, except as covered under the Prescription Drug Plan
- Reversal of sterilization
- Sexual identification counseling
- Services related to sexual transformation
- Self-help and self-cure programs and equipment
- Travel or lodging costs
- Vision services, including eyeglasses and contact lenses, except for certain medical conditions such as following cataract surgery
- Wigs
- Services relating to complications of a non-covered treatment or procedure
- Services or supplies provided by a member of your immediate family (a parent, spouse, or child); a private duty nurse; a massage therapist; a naturopath; or a social worker, except for appropriately licensed clinical social workers providing covered mental health and substance abuse services
- Services for which no charge would be made if you had no health plan coverage
- Services provided without charge by any federal, state, municipal, or other governmental agency
- Services which are or may be covered by Workers' Compensation or any other employer's liability insurance
- Services for treatment of illness or injury received while you were on active duty military status
- Services for treatment of illness or injury related to military service when you receive treatment in a facility operated by the federal government
- Services for an injury or illness caused by another person or third party from whom you have or may have a right to recover damages
- Services or supplies received prior to the effective date of coverage or after coverage is terminated
- Services or supplies obtained due to a false statement or other misrepresentation made in an application for membership or claim for benefits

OTHER IMPORTANT INFORMATION

SERVICES OUTSIDE THE SERVICE AREA

The Service Area for this Plan is the State of Hawaii. UHA has a special arrangement with a mainland contractor to help you control your health care expenses in the event

SERVICES NOT COVERED

Your medical plan coverage does not provide benefits for certain procedures, services, or supplies that are listed below. If you are unsure whether a specific procedure, service or supply is covered, contact UHA Member Services for assistance.

- Airline oxygen
- Bereavement counseling or services of volunteers or clergy
- Biofeedback or any related diagnostic testing
- Bionic devices or related services
- Cosmetic or reconstructive services, supplies or procedures that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function, except for reconstructive surgery or services following a mastectomy or to correct congenital abnormalities that severely impair or impede normal essential bodily functions. Diagnosis and treatment of any complications resulting from non-covered cosmetic or reconstructive services are not covered, regardless of how long ago such services were performed.
- Custodial care, sanatorium care, or rest cures provided in a hospital, skilled nursing facility, or other facility
- Dental services generally done only by dentists and not physicians including orthodontia; dental splints and other dental appliances; dental prostheses; maxillary and mandibular implants (osseointegration) and all related services; removal of impacted teeth; any other procedures involving teeth, structures supporting the teeth, or gum tissues; and services in connection with the diagnosis and treatment of temporomandibular joint (TMJ) problems or malocclusion of the teeth or jaw, regardless of the reason
- Emergency Room visits for non-emergency conditions
- Experimental or investigative medical treatments, procedures, drugs, devices, or care, and all related services and supplies. Diagnosis and treatment of any complications as a result of non-covered experimental or investigative services are not covered, regardless of how long ago such services were performed.
- Fertilization by artificial means and services or supplies relating to the diagnosis or treatment of infertility, except for one (1) cycle of in vitro fertilization as a one time only outpatient procedure. This exclusion includes, but is not limited to, hysterosalpingograms; collection, storage and processing of semen; ovum transplants; gamete intrafallopian transfer (GIFT); and zygote intrafallopian transfer (ZIFT).
- Services and supplies relating to hair loss and baldness, including hair transplants and topical medications for the treatment of male and female pattern hair loss
- Marriage or family counseling or other training services
- Miscellaneous supplies billed separately by your physician such as gauze, batteries, surgical trays, diapers and tape
- Motor vehicle purchase or rental, or the equipment and costs associated with converting a motor vehicle to accommodate a disability
- The following costs and services for organ transplants:
  - Organ donor services if you are the organ donor

MATERNITY, FAMILY PLANNING & INFERTILITY SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Newborn Circumcision	You owe no copayment	You owe any difference between actual and Eligible Charges
Newborn Care Coverage is limited to the necessary services to treat medically diagnosed congenital defects and birth abnormalities	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Family Planning	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Termination of Pregnancy	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Contraceptive Cervical Caps, Diaphragms, Implants, Injections & IUDs	You owe no copayment	You owe any difference between actual and Eligible Charges
In Vitro Fertilization *(Prior Authorization required)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges

MATERNITY, FAMILY PLANNING & INFERTILITY SERVICES SPECIAL NOTES

Maternity and Newborn Care

- Maternity Care and delivery includes prenatal, false delivery, and postnatal services provided by your physician or midwife. The Eligible Charge for delivery includes prenatal and postnatal care. If payments for prenatal care are made separately prior to delivery, such payments will be considered advance payments and will be deducted from the maximum allowance for delivery. If a physician provides all or part of the antepartum and/or postpartum patient care but does not perform delivery, separate copayments may apply.

- Birthing Room coverage is for labor and delivery only.
- Maternity Length of Stay is covered for at least 48 hours from the time of delivery for normal labor and delivery, or 96 hours from the time of delivery for a cesarean birth.
- Newborn Nursery is covered for at least 48 hours from the time of delivery for normal labor and delivery, or 96 hours from the time of delivery for a cesarean birth.
- Newborn Care coverage is limited to the necessary services to treat medically diagnosed congenital defects and birth abnormalities of the newborn child.
- Benefits for routine newborn care, nursery, circumcision, premature child care, and care for illness or injury are only available if your child is added to your coverage within 31 days of birth.

In Vitro Fertilization

- Coverage is limited to one outpatient in vitro fertilization procedure whether successful or not while enrolled in any UHA medical benefit plan.
- Prior Authorization is required for in vitro fertilization services. The following limitations apply, subject to Hawaii law:
  - The in vitro fertilization is for you or your spouse.
  - You or your spouse has a history of infertility of at least five (5) years duration or the infertility is associated with one or more of the following medical conditions: a) endometriosis, b) exposure in utero to diethylstilbestrol (DES), c) blockage of, or surgical removal of one or both fallopian tubes, or d) abnormal male factors contributing to the infertility.
  - You have been unable to attain a successful pregnancy through other infertility treatments.
  - The in vitro fertilization procedures are performed at a medical facility that conforms to the American Society of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to American Fertility Society minimal standards for programs of in vitro fertilization.
  - Oocytes are fertilized with the spouse's sperm.
  - Hysterosalpingograms are not a covered benefit.

5. Diabetic supplies (unbreakable package): Syringes, needles, test strips, lancets

- Up to a 60-day supply for brand name drugs (non-diabetic) or a 90-day supply for generic and diabetic drugs may be dispensed for medications obtained by mail order service or Longs Extended Fill Program.

Longs Extended Fill Program

- You may obtain an extended supply of your maintenance medications at any Longs Drugs in Hawaii. This walk-in service allows members to purchase a 60-day supply of a brand name maintenance drug or a 90-day supply of a generic maintenance drug under a single copayment. To start the service, show your Prescription ID card when picking up your prescription from a local Longs Drugs pharmacy and ask if you are eligible for an extended fill.

Drugs Not Covered

- The following items are not covered under this Prescription Drug Plan:
  - Injectable drugs, except Insulin and anaphylaxis (Epinephrine) kits
  - Immunization agents
  - Fertility agents
  - Drugs used for cosmetic purposes
  - Supplies, appliances and other non-drug items, except Diabetic Supplies
  - Drugs furnished to Hospital or Skilled Nursing Facility inpatients
  - Drugs prescribed for treatment plans that are not medically necessary
  - Anti-obesity drugs
  - Sexual function drugs
  - Any drug that may be purchase without a prescription (i.e., Over-the-Counter), except as specified above
  - Drugs for which Prior Authorization is required but has not been obtained
  - New FDA approved drugs during the mandatory efficacy and safety evaluation period assigned by UHA of at least 4 months
  - Drugs and/or Diabetic Supplies obtained by mail order from a Non-Participating Pharmacy
- For drugs in a therapeutic class in which a former prescription drug in that class converts to an Over-the-Counter (OTC) drug, UHA reserves the right to cover only the former prescription drug that has converted to an OTC drug and to exclude from coverage all other drugs in that class.

How to File a Prescription Drug Claim

- Present your Prescription ID card to the Pharmacy.
- When drugs are purchased from a Participating pharmacy, the pharmacy will electronically file a claim on your behalf and payment will be made to the pharmacy.
- When drugs are purchased from a Non-Participating pharmacy, you are responsible for filing a claim and payment will be made to you. The pharmacy will complete Part B of the claim form and give it to you along with your prescription. You must complete Part A of the claim form and mail the form to UHA within 90 days from the date of purchase.
- Claim forms are available from providers, UHA Member Services, or online at www.uhahealth.com.

DIABETIC DRUGS AND SUPPLIES	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Mail Order Non-Preferred Brand Diabetic Supplies, Drugs and Insulin	You owe a copayment of $30.00 per 60-day supply or 20% of the Eligible Charge if the Eligible Charge for a 30-day supply is over $150	Not a benefit

UHA DRUG PLAN Q SPECIAL NOTES

Covered Drugs

- This plan covers federally approved outpatient drugs, insulin, and diabetic supplies when ordered by a physician and obtained by prescription, except those specified as exclusions. Refills will be covered for up to 12 months from the date the original prescription was written.
- The following drugs and supplies, although obtainable without a prescription, are covered if a physician orders them as part of your treatment and sends the UHA Health Care Services Department verification that they are necessary for the treatment of an illness or injury:
  - Special vitamins for specific vitamin deficiency conditions; this does not include multiple vitamin preparations which may be purchased with or without a physician's prescription
  - Diabetic drugs such as insulin
  - Diabetic supplies when purchased by an Eligible Person covered for diabetic drugs
- Some drugs require Prior Authorization before they are covered. For a list of drugs that require Prior Authorization, please contact UHA's Health Care Services Department or refer to the list of services on the UHA website at www.uhahealth.com.
- This plan has a mandatory Generic substitution policy. If a Preferred or Non-Preferred Brand covered drug or diabetic supply is obtained when a Generic equivalent is available, you are responsible for (i) the difference in Eligible Charge between the Preferred or Non-Preferred Brand drug or diabetic supply and the Generic equivalent, and (ii) the Generic copayment.
- All covered drugs are limited to a 30-day supply with the following exceptions.
  - A single, standard size package may be dispensed for the following even though a smaller quantity is prescribed:
    1. Fluoride tablets and drops
    2. Children's vitamins with fluoride (unbreakable package): Tri Vi Flor chews and drops; Poly Vi Flor chews and drops; Vi Daylin F chews and drops (and with Iron); Vi Daylin F ADC drops (and with Iron); Vi Penta F chews; Adeflor chews and drops; Luride chews and drops
    3. Nitroglycerine products (unbreakable package): NTG generic (all strengths); Nitrobide; Nitrospan; Nitrostat
    4. Miscellaneous: Prenatal vitamins (requiring a prescription); creams and ointments (standard package size); liquids (standard package size)

OTHER MEDICAL SERVICES

OTHER MEDICAL SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Ambulance (Ground or Air) *For emergencies only*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Appliances & Durable Medical Equipment *(Prior Authorization required when cost exceeds $500)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Bariatric Surgery *(Prior Authorization required)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Blood, Blood Products & Blood Bank Service Charges	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Dialysis and Supplies	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Evaluations for Use of Hearing Aids	You owe a copayment of $12 per visit	You owe a copayment of $12 per visit and any difference between actual and Eligible Charges
Growth Hormone Therapy *(Prior Authorization required)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges

OTHER MEDICAL SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Home Infusion Therapy Outpatient injections or intravenous administration of medication or nutrient solutions required for primary diet *(Prior Authorization required)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Hyperbaric Treatment *(Prior Authorization required)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Implants Surgical implants such as stents, screws and pacemakers	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Inhalation Therapy	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Injectable Medications Outpatient injections or intravenous administration of medication or nutrient solutions required for primary diet, and travel immunizations *(Prior Authorization required for certain injectables)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Medical Foods Medical foods and low protein food products prescribed for treatment of inborn metabolic disorders	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges

PRESCRIPTION DRUG TYPE	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Mail Order Preferred Brand Name	You owe a copayment of $15.00 per 60-day supply or 20% of the Eligible Charge if the Eligible Charge for a 30-day supply is over $150	Not a benefit
Mail Order Non-Preferred Brand Name	You owe a copayment of $30.00 per 60-day supply or 20% of the Eligible Charge if the Eligible Charge for a 30-day supply is over $150	Not a benefit

DIABETIC DRUGS AND SUPPLIES	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Member copayments for diabetic drugs and supplies will not count toward the Annual Deductible or the Maximum Annual Copayment		
Generic or Preferred Brand Diabetic Supplies	You owe no copayment per 30-day supply	You owe any charges that exceed 70% of the Eligible Charge
Generic or Preferred Brand Diabetic Drugs and Insulin	You owe a copayment of $7.00 per 30-day supply	You owe any charges that exceed 70% of the Eligible Charge
Non-Preferred Brand Diabetic Supplies, Drugs and Insulin	You owe a copayment of $30.00 per 30-day supply or 20% of the Eligible Charge if the Eligible Charge is over $150	You owe any charges that exceed 70% of the Eligible Charge
Mail Order Generic or Preferred Brand Diabetic Supplies	You no copayment per 90-day supply	Not a benefit
Mail Order Generic or Preferred Brand Diabetic Drugs and Insulin	You owe a copayment of $7.00 per 90-day supply	Not a benefit

- The total maximum benefit paid by the Plan is $500 per calendar year for combined services of either participating or non-participating chiropractic and acupuncture providers.
- The Plan pays 50% of the Eligible Charge for the first set of X-rays ordered by a participating Chiropractor. You are responsible for the balance of the Eligible Charge for the first set of X-rays and the full charge for any subsequent X-rays. The Plan does not cover X-rays ordered by non-participating chiropractors.

PRESCRIPTION DRUG PLAN BENEFITS (UHA DRUG PLAN Q)

PRESCRIPTION DRUG TYPE	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Member copayments for prescription drugs will not count toward the Annual Deductible or the Maximum Annual Copayment		
Generic	You owe a copayment of $7.00 per 30-day supply or 20% of the Eligible Charge if the Eligible Charge is over $150	You owe any charges that exceed 70% of the Eligible Charge
Preferred Brand Name	You owe a copayment of $15.00 per 30-day supply or 20% of the Eligible Charge if the Eligible Charge is over $150	You owe any charges that exceed 70% of the Eligible Charge
Non-Preferred Brand Name	You owe a copayment of $30.00 per 30-day supply or 20% of the Eligible Charge if the Eligible Charge is over $150	You owe any charges that exceed 70% of the Eligible Charge
Mail Order Generic	You owe a copayment of $7.00 per 90-day supply or 20% of the Eligible Charge if the Eligible Charge for a 30-day supply is over $150	Not a benefit

OTHER MEDICAL SERVICES	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
Orthotics *(Prior Authorization required)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges
Physical, Occupational and Speech Therapy *(Prior Authorization required)*	You owe a copayment of $12 per visit	You owe a copayment of $12 per visit and any difference between actual and Eligible Charges
Prosthetics *(Prior Authorization required when cost exceeds $500)*	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met	You owe a copayment of 20% of Eligible Charges after the Annual Deductible has been met and any difference between actual and Eligible Charges

OTHER MEDICAL SERVICES SPECIAL NOTES

Ambulance

- Ambulance (ground and intra-island or inter-island air) services to the nearest adequate hospital to treat your illness or injury are covered when all of the following apply:
  - Services to treat your illness or injury are not available in the hospital or skilled nursing facility where you are an inpatient or in the emergency department where you are initially seen;
  - Transportation begins at the place where an injury or illness occurred or first required emergency care;
  - Transportation ends at the nearest facility equipped to furnish emergency treatment;
  - Transportation is for emergency treatment under circumstances where emergency room services would be covered (See Hospital Services benefits section);
  - Transportation takes you to the nearest facility equipped to furnish emergency treatment.
- Air ambulance benefits are limited to inter-island and intra-island transportation within the State of Hawaii.

Appliances and Durable Medical Equipment

- Coverage is provided for appliances and durable medical equipment prescribed by your physician. Examples include: hearing aids; oxygen and rental of equipment for its administration; rental of wheelchair and hospital-type bed; and charges for use of an artificial kidney machine, pulmonary resuscitator, and similar special mechanical equipment. Prior Authorization is required when the purchase cost is more than $500 and the rental cost is greater than $100 per month.

- Replacement appliances and equipment will be covered only when ordered by your physician and when, in the opinion of UHA, the original appliance or equipment can no longer be used or repaired. UHA reserves the right to cover repair rather than replacement if it is the more cost-effective option.
- Benefits for Hearing Aids are limited to one device per ear every 5 years.
- Benefit payment for the rental of appliances and medical equipment is limited to the amount it would cost to purchase the appliance or equipment.

Evaluations for Hearing Aids

- Evaluations for hearing aids are covered only when you receive the evaluation in the office of a physician or audiologist.

Growth Hormone Therapy

- Prior Authorization is required for Growth Hormone Therapy. Benefits are limited to replacement therapy for eligible persons up to age 18 for treatment of:
  - 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 transplantation
  - AIDS-wasting or cachexia without evidence of suspected or overt malignancy and where other modes of nutritional supplements (e.g., hyperalimentation, enteral therapy) have been tried
  - Short stature due to growth hormone deficiency
  - Neonatal hypoglycemia secondary to growth hormone deficiency
  - Prader-Willi syndrome

Orthotics

- Coverage is provided for Orthotics when prescribed by your physician.
- Foot orthotics are not covered except for certain diabetic conditions.

Physical and Occupational Therapy

- Coverage is provided for Physical and Occupational Therapy when all of the following are true:
  - The therapy is ordered by a physician under an individual treatment plan;
  - The therapy is for restoration of musculoskeletal function that was lost or impaired by injury or illness;
  - The therapy can be reasonably expected to improve the patient's condition through short term care;
  - The therapy is provided by a registered physical therapist.
- Prior Authorization is required for services after the first 48 units (1 unit equals 15 minutes) or 12 sessions.
- Services of a registered occupational therapist are covered if the services could also be performed by a registered physical therapist. Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living. Occupational therapy supplies are not covered.
- Long term maintenance therapy and group exercise programs are not covered.

Prosthetics

- Coverage for Prosthetics is provided but only when prescribed by your physician. Examples include artificial limbs and eyes. Prior Authorization is required when the cost is more than $500.
- Vision appliances are covered subject to limitations for certain medical conditions such as following cataract surgery.

Speech Therapy

- Prior Authorization is required for Speech Therapy services. Coverage is provided when all of the following are true:
  - The therapy is ordered by a physician under an individual treatment plan;
  - The therapy is necessary to restore speech or hearing function which was lost or impaired by injury or illness;
  - The therapy can be reasonably expected to improve the patient's condition through short term care;
  - The therapy is provided by a speech therapist holding a Certificate of Clinical Competence from the American Speech and Hearing Association.
- Long term maintenance programs are not covered.
- Speech Therapy for a child with developmental learning disabilities or developmental delay is not covered.

COMPLEMENTARY ALTERNATIVE MEDICINE

COMPLEMENTARY ALTERNATIVE MEDICINE	PARTICIPATING PROVIDER	NONPARTICIPATING PROVIDER
COMPLEMENTARY ALTERNATIVE MEDICINE Services provided by licensed chiropractors or acupuncturists limited to neuromusculoskeletal conditions		
Office Visits	You owe a copayment of $10 per visit	You owe any difference between the actual charge and the Plan's payment of up to $20 per visit
First set of X-rays	You owe a copayment of 50% of Eligible Charges	Not a benefit

COMPLEMENTARY ALTERNATIVE MEDICINE SPECIAL NOTES

- Benefits are limited to treatment of conditions of the neuromusculoskeletal system by licensed chiropractors and acupuncturists.

LOCAL 665 I.A.T.S.E. ANNUITY FUND
LOCAL 665 I.A.T.S.E. HEALTH & WELFARE TRUST FUND
c/o GROUP PLAN ADMINISTRATORS, INC.
222 South Vineyard Street, PH4
Honolulu, Hawaii 96813
Telephone: (808) 523-9411 • Fax: (808) 533-6789

DATE: February 2012

TO: All Participants

FROM: Board of Trustees

RE: Local 665 IATSE Health & Welfare Fund

At their meeting on January 10, 2012, the Board of Trustees approved an increase to the Fund's monthly subsidy for employee benefits from **$100 TO $150 PER ELIGIBLE EMPLOYEE EFFECTIVE MARCH 1, 2012** as shown below.

Currently, all Employer Contributions that are received by the Fund on your behalf are credited to your Bank Reserve. Each month, $459.76 (UHA) or $571.21 (Kaiser) is deducted from your Bank Reserve for your eligibility. All Employer Contributions that are not needed for your current eligibility are credited to your Bank Reserve to be used for future eligibility. The maximum Bank Reserve is $2,900.00.

The current cost to provide benefits to participants of the Fund with the increased Subsidy are as follows:

	UHA	Kaiser
Benefits (Medical, Drug, Vision, Dental, Life Insurance)	**$ 559.76**	**$ 671.21**
LESS SUBSIDY	**($150.00)**	**($150.00)**
Total Monthly Cost	**$409.76**	**$521.21**

Effective with the December 2011 work month for coverage in the month of March 2012, the Fund's Subsidy will be increased to $150.00 per eligible Employee per month. In order for you to be eligible for benefits in any given month, the amount of Employer Contributions received on your behalf plus your Bank Reserve must be equal to or greater than the net premium cost for the plan you selected after deducting the Fund's Subsidy of $150.00.

For your information, the following examples are an explanation of how this $150 Subsidy will work:

Example 1: You earned $400.00 in Employer Contributions for work in December 2011 and you have a Bank Reserve of $2,9000.00. You selected the UHA package which costs $559.76. After applying the $150.00 Fund Subsidy, the net premium cost is $409.76.

Your Beginning Bank Reserve		$2,900.00
Add: Employer Contributions	$400.00	
Cost of UHA package	$559.76	
Less: Fund Subsidy	($150.00)	
Net Premium Cost	$409.76	
Deduction from your Bank Reserve		$ 9.76
Your Ending Bank Reserve		$2,890.24

Example 2: You did not earn any Employer Contributions for work in December 2011, however, you have a Bank Reserve of $1,500.00. You selected the Kaiser package which costs $671.21. After applying the $150.00 Fund Subsidy, the net premium cost is $521.21. Since you did not earn any Employer Contributions, $521.21 will be deducted from your Bank Reserve and you will be eligible for benefits in March 2012.

Your Beginning Bank Reserve		$1,500.00
Add: Employer Contributions	$0.00	
Cost of Kaiser package	$671.21	
Less: Fund Subsidy	($150.00)	
Net Premium Cost	$521.21	
Deduction from your Bank Reserve		$ 521.21
Your Ending Bank Reserve		$978.79

Example 3: You earned $50.00 in Employer Contributions for work in December 2011, and you have a Bank Reserve of $200.00. You selected the UHA package which costs $559.76. After applying the $150.00 Fund Subsidy, the net premium cost is $409.76. Since the amount of Employer Contributions you earned and your Beginning Bank Reserve are insufficient to cover the net premium cost, you will not be eligible for benefits in March 2012. However, if you were eligible for benefits in February 2012, you may continue your coverage under either the Self-Payment or COBRA programs. The $50.00 you earned for work in December 2011 will be added to your Bank Reserve.

Your Beginning Bank Reserve		$ 200.00
Add: Employer Contributions	$50.00	
Cost of UHA package	$559.76	
Less: Fund Subsidy	($150.00)	
Net Premium Cost	$409.76	
Addition to your Bank Reserve		$ 50.00
Your Ending Bank Reserve		$ 250.00

Should have any questions on the new Eligibility Rule change or need assistance with your coverage, please contact the Trust Fund Office at (808) 523-9411 (Joy or Darren) or for Neighbor Islands, call toll free at (877)523-9411.