HAWAII IRON WORKERS HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION
January 1, 2017

HAWAII IRON WORKERS HEALTH AND WELFARE TRUST FUND

94-497 Ukee Street
Waipahu, Hawaii 96797
(800) 581-8225

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EMPLOYER IDENTIFICATION NUMBER

99-0166475

January 1, 2017

TO: ALL ELIGIBLE EMPLOYEES AND THEIR FAMILIES

It is our pleasure to provide you with this most recent update of your Plan booklet which describes the eligibility rules and benefits provided for you and your family through the Plan. If you are not certain of your eligibility status under this Plan, please contact the Trust Fund Office.

The booklet furnishes a brief description of most of the benefits to which you and your family are entitled and the procedures that should be followed when making a claim. Booklets describing medical benefits available through the various health care providers are available at the Trust Fund Office. Any questions you may have concerning the Plan should be directed to the Trust Fund Office, where the staff will be happy to assist you.

The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. Participants will be notified of any Plan changes.

Sincerely,

BOARD OF TRUSTEES

This group health plan believes **the Kaiser plan is a "grandfathered health plan"** under the Patient Protection and Affordable Care Act (the 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 800-581-8225.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SPANISH LANGUAGE ASSISTANCE

Este documento contiene una breve descripción sobre sus derechos de beneficios del plan, en Ingles. Si usted tiene dificultad en comprender cualquier parte de este documento, por favor de ponerse en contactó con *la Administrative Office* a la dirección y teléfono en el (Quick Reference Chart) de este documento.

COORDINATION OF BENEFITS WITH MEDICARE

To comply with federal Medicare coordination of benefit regulations, you must promptly furnish to the Trust Fund Office the Social Security Number (SSN) of your Eligible Dependents for which you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

Failure to provide the SSN or complete the CMS model form (form is available from the Trust Fund Office) means that claims for eligible individuals cannot be processed for the affected individuals.

TABLE OF CONTENTS

QUICK REFERENCE CHART

Information Needed	Whom to Contact
Trust Fund Office • Eligibility for Coverage • Plan Benefit Information • Medicare Part D Notice of Creditable Coverage • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification	**Ironworkers Trust Fund** 94-497 Ukee Street Waipahu, HI 96797 Phone: (800) 581-8225
PPO Network • Medical Network Provider Directory • Additions/Deletions of Participating Providers • Finding a Center of Excellence for covered transplant • Precertification of Admissions and Medical Services • Appeals of UM decisions • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy	**HMAA (Hawaii Medical Assurance Association)** 737 Bishop Street, Suite 1200 Honolulu, HI 96813 Web Site: www.hmaa.com Before you visit your doctor or receive other healthcare services, please verify whether your provider is participating with HMAA through one of the following: • Ask your provider's office • View the provider directory at hmaa.com • Download the HMAA iPhone application • Contact Customer Service Center at 941-4622, toll-free at 888-941-4622, or via e-mail at CustomerService@hmaa.com To locate a provider on the Mainland, call PHCS toll-free at 1-888-721-7427 or visit www.multiplan.com Please note: there are no benefits available for certain transplants if services are not precertified by HMAA and performed at a Center of Excellence
Claims Processor • Claim Forms (Medical) • Medical Claims And Appeals • Prescription Drug Information	**HWMG (Hawaii Western Management Group, Inc)** 737 Bishop Street, Suite 1200 Honolulu, Hawaii 96813 Web Site: www.hwmg.org Phone: (808) 591-0088 Toll-Free: (800) 621-6998 Fax: (808) 591-0463

QUICK REFERENCE CHART

Information Needed	Whom to Contact
Akamai Advantage Medical Plan • 65C Plus Medical Plan	**HMSA (Hawaii Medical Service Association)** P.O. Box 860 Honolulu, HI 96808 808-948-6111 www.hmsa.com
Dental Plan • Dental Network Provider Directory • Dental Claims and Appeals	**HDS (Hawaii Dental Service)** **Send Written Correspondence to:** Hawaii Dental Service Attn: Customer Service 700 Bishop Street, Suite 700 Honolulu, HI 96813-4196 Phone from Oahu: 529-9248 Toll Free: 800-232-2533, extension 248 Web Site: www.hawaiidentalservice.com **E-mail: HDSCustomerService@HawaiiDentalService.com** **Visit 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 • Obtain claims information • Have their plan benefits faxed or mailed to them; simply by following prompts on the phone
Health Maintenance Organization (HMO) • Medical and Prescription Drug coverage • Vision • Kaiser Senior Advantage • Claim Forms (Medical) • Medical Claims and Appeals • Eligibility for Coverage • Plan Benefit Information • Prescription Drug Information • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy	**Kaiser Foundation Health Plan, Inc** Customer Service 808-432-5055 Neighbor islands only 1-800-966-5955 www.kaiserpermanente.org

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Life Insurance, Accidental Death and Dismemberment	**Pacific Guardian Life Insurance Company** 1440 Kapiolani Boulevard Honolulu, HI 96814 Phone (808) 955-2236
Weekly Loss of Time (Disability) • Disability Claims and Appeals • Not available for Non-Bargaining Employees	**Pacific Guardian Life Insurance Company** 1440 Kapiolani Boulevard Honolulu, HI 96814 Phone (808) 955-2236
Vision Plan • Vision Claims and Appeals	**VSP (Vision Service Plan)** 800-877-7195 www.vsp.com
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**Trust Fund Administrator (for COBRA and eligibility issues)** 94-497 Ukee Street Waipahu, HI 96797 Phone: (808) 671-8225 **HMAA (Hawaii Medical Assurance Association) for medical claims** 737 Bishop Street, Suite 1200 Honolulu, HI 96813 Phone: (808) 941-4622 or (888) 941-4622 Web Site: www.hmaa.com

SUMMARY OF ELIGIBILITY RULES

Active Iron Workers

Initial Eligibility

If you work as an Iron Worker for Contributing Employers who have made contributions to the Fund on your behalf, you are eligible for coverage under the following conditions:

Medical, Dental and Vision Benefits	The first day of the second calendar month following a period of seven consecutive calendar months or less in which you worked 240 hours.
Life Insurance Coverage	The first day of active full-time employment

For example, if you work a total of at least 240 hours between January 1 and March 31, you will be eligible for full benefits on May 1.

If you believe that you have worked the required hours but did not receive notification from the Fund Office that you have become eligible, it may be that your employer's contributions may be late. Just bring your stubs into the Fund Office and the Fund will grant you the hours shown on your pay stubs to establish your eligibility. However, if the Fund does not later actually receive the required contributions, your eligibility will terminate.

If you are a new member previously not covered under this Fund, you may have your benefits begin on the first day of active full-time employment by making payment of the required contribution to the Fund by the 5th of each month for a maximum of seven months. Active full-time employment means that you are working at least 120 hours per month in covered employment. You must complete an enrollment card and submit it to the Trust Fund Office in order to receive benefits.

Continuation of Eligibility

Hours you work for Contributing Employers will be credited to your "reserve account." Once you attain initial eligibility by working the required 240 hours, within a 7-month period, 120 hours of work credit will be deducted from your reserve account for each month of coverage and you will continue to remain eligible as long as your reserve account contains at least 120 hours of work credit.

You will be allowed to accumulate up to a maximum of 840 hours in your account after the deduction of 120 hours for the current month's eligibility.

In order to curb unauthorized use of medical coverage by persons who are not eligible under this Plan, all participants will be required to complete an annual questionnaire as a condition for continuation of eligibility. **IF YOU FAIL TO TIMELY RETURN THIS QUESTIONNAIRE, YOUR MEDICAL INSURANCE BENEFITS WILL BE TERMINATED.** The Trust Fund may investigate discrepancies between its current records of eligible persons as compared with the questionnaire

Weekly Loss of Time

To qualify for weekly loss of time benefits, you must meet all statutory Temporary Disability Insurance (TDI) requirements.

Hawaii Prepaid Health Care Act

If you do not meet the eligibility requirements of this Fund and you are an employee of a Contributing Employer, you may become eligible for basic medical benefit coverage mandated by the Hawaii Prepaid Health Care Act, on the first of the month following four consecutive weeks in which you worked at least 20 hours each week. Verification of employment and a completed enrollment card must be submitted to the Trust Fund Office.

You and your dependents will be eligible only for basic medical benefits through HMAA. You will not be covered for dental, vision, prescription drug or any other benefits. Coverage is provided for you at no charge; however, self-payment is required for dependent coverage.

Dependents of Eligible Employees

Eligibility

Family members eligible for medical, dental, vision and life insurance coverage are:

- Your legal spouse; and
- Your natural children, stepchildren, adopted children and children who are required to be covered as the result of a QMCSO or under legal guardianship if they are younger than age 26. Adopted children become eligible upon placement for adoption. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. The Trust Fund Office requires a copy of your Marriage Certificate and a copy of the Birth Certificates for your dependent children.

Furthermore, an unmarried child of any age who is unable to earn a living because of a mental or physical disability is also considered an eligible dependent, provided the child was both disabled and eligible as a dependent under the Plan prior to age 26, and is solely dependent upon the employee for support and is declared as a dependent for federal income tax purposes. If proof of the child's mental or physical disability is filed with the Plan Office within 90 days after the Plan's limiting age, the child will remain eligible for hospital-medical and dental benefits as long as you are eligible and the child remains incapable of self-support. Proof of dependency must be furnished to the Plan as may be required from time to time.

The following individuals are **not eligible** for coverage under the Plan: foster child, a spouse of a Dependent Child (e.g. employee/retiree's son-in-law or daughter-in-law) or a child of a Dependent Child (e.g. employee/retiree's grandchild).

Enrollment Cards

Every employee working for a Contributing Employer must complete an enrollment card. Blank enrollment cards are available at the Trust Fund Office. It is important that the Trust Fund Office has a completed enrollment card with a copy of the necessary documents (e.g. marriage certificate, dependent birth certificates, etc.). Otherwise there will be a delay in coverage for you and your family members. All documents must be provided within 30 days of the beginning of coverage.

After you have filed an enrollment card with the Trust Fund Office, upon establishing initial eligibility, you will receive either an HMAA Membership Card or a Kaiser Plan Identification Card, whichever is appropriate.

Each employee must notify the Trust Fund Office in writing promptly when any change occurs in family status due to marriage, birth of a child, death or divorce. A new Enrollment Card must be completed and mailed to the Trust Fund Office as soon as possible, with a copy of the necessary documents (e.g. marriage certificate, dependent birth certificates, etc.) You should also notify the Trust Fund Office in writing if you should change your home address.

- Your new spouse and eligible stepchildren become eligible upon your marriage, and will be covered provided they are enrolled within 30 days of your marriage.
- Your natural children become eligible on birth, and will be covered provided they are enrolled within 30 days of their birth.
- Your adopted children become eligible upon placement for adoption, and will be covered upon enrollment.

- Your other children become eligible when they meet all of the requirements for being a dependent, and will be covered upon enrollment.

Beneficiary Card for Life Insurance

Every employee working for a Contributing Employer should complete a Beneficiary Designation card for the life insurance benefit. Blank Beneficiary Designation cards are available at the Trust Fund Office.

If you wish to change your beneficiary, a new Beneficiary Designation card must be completed and mailed to the Trust Fund Office.

Qualified Medical Child Support Orders (QMCSOs)

To the extent required by law, the Plan will comply with the provisions of any Qualified Medical Child Support Order, including a National Medical Support Notice.

For more information or for a copy of the Plan's procedures regarding QMCSOs, at no charge, contact the Trust Fund Office.

Special Enrollment Rights

This Trust Fund automatically covers all eligible active participants who complete their enrollment card without self-payment. Therefore, active participants are usually not affected by the following information. Retirees who obtain other employment, or have working spouses, and have access to health benefits from the alternative employer should be aware of this federal regulation.

If you acquire a new dependent through marriage, birth, adoption, or placement for adoption, you may take that opportunity to enroll yourself and your other dependents, if you declined to do so when initially eligible. To do so, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you declined coverage when initially eligible because you had coverage elsewhere and you have now lost that other coverage or employer contributions to such coverage, you may enroll in the Plan if you request enrollment within 30 days after the other coverage or employer contributions ends **if** that other coverage terminated because of:

- loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was **"exhausted;"** or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- the other plan ceasing to offer coverage to a group of similarly situated individuals; or
- the loss of dependent status under the other plan's terms; or
- the termination of a benefit package option under the other plan, unless substitute coverage offered.

In addition, you and your dependents may also enroll in this Plan if you (or your eligible dependents):

- have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your dependents) **lose eligibility for that coverage**. However, you

must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends; or

- become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **60 days** after you (or your dependents) are determined to be eligible for such premium assistance.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements as are available to similarly-situated employees.

Termination of your Eligibility

Your coverage ends on the last day of the month during which you fail to maintain at least 120 hours in your reserve account after deducting 120 hours for the current month's eligibility. However, if you are inducted into military service (other than a temporary tour of duty not exceeding 30 days) your coverage will end on the date of your induction. You should notify the Trust Fund Office in writing of your induction into military service as soon as possible.

For a newly hired employee of a Contributing Employer, who has not worked a period of seven consecutive calendar months during which he worked at least 240 hours for Contributing Employers, Life Insurance will terminate on the last day of employment.

Termination of your Dependent's Coverage

Your dependent's coverage ends:

- On the date your coverage ends; or
- At the end of the month after the date he or she no longer qualifies as a dependent, as defined in the Plan.

In addition, your spouse's eligibility will terminate on the date of a divorce or legal separation from you (the employee).

The Trust Fund Office must be notified in writing of any changes regarding dependent eligibility. You will be responsible for any benefit payments based on incorrect information about family members.

Retroactive Cancellation of Coverage

In accordance with the requirements in the Affordable Care Act, the plan will not retroactively cancel coverage **except** in cases of fraud or intentional misrepresentation of a material fact.

If your coverage is terminated for any of the above reasons, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.

If your coverage is terminated as contributions are not paid on time, the termination will be subject to the specific eligibility rules outlined above.

Reestablishing Eligibility

If your health coverage terminates, it will be reinstated on the first day of the second calendar month following:

- a period of seven consecutive calendar months or less in which you accumulated 240 hours in your reserve account if you have NOT made continuous self-payments from your date of termination; or

- a period of 12 consecutive calendar months or less in which you accumulated 240 hours in your reserve account, PROVIDED YOU MADE CONTINUOUS SELF-PAYMENTS FROM YOUR DATE OF TERMINATION.

If you do not qualify for reinstatement of eligibility as described above, you must qualify for eligibility by meeting the requirements for initial eligibility.

Continuation of Coverage While on Industrial Disability

If you are injured on the job while working for a Contributing Employer and are eligible to receive Workers' Compensation benefits for the injury, you may receive extended coverage for Health and Welfare benefits when your eligibility has run out under the Fund's Eligibility Rules by submitting the required forms to the Trust Fund Office.

If you are working for a Contributing Employer and are not eligible or have never established eligibility under the Fund's Eligibility Rules when the injury occurs, coverage will begin the first of the month following the injury.

Benefits will be extended for up to one year (12 months) for the same injury. Determination of whether or not an injury is to be considered the same or different injury and the initial proof of disability, will be based on receipt of the following:

- Employer's Report of Industrial Injury (WC-1);
- Presentation of a Workers' Compensation benefit check;
- Completed Workers' Compensation Disability Disclaimer Form; and
- Any other proof as may be required by the Trustees.

This extended coverage will cease on the earlier of the date:

- You again become eligible under the Fund's Eligibility Rules for working Iron Workers, or
- The one year (12 months) maximum has been reached.

If you are unable to work after the maximum period for extended benefits has been reached, and you are receiving Workers' Compensation, you may continue coverage for yourself and your dependents by making payments of the required contribution in accordance with the following self-payment rules. Once the Workers' Compensation claim has been settled, you may continue coverage by making the required contribution to the Fund for up to a maximum of 18 months. The contributions must be received by the 5th of the month immediately following loss of eligibility.

In order to verify continued eligibility to make self-payments for your medical, dental and life insurance due to your industrial injury, you are required to provide a photocopy of your Workers' Compensation check to the Trust Fund Office. The copy is due annually.

If you have any questions concerning your eligibility for coverage, you should contact the Trust Fund Office.

Please refer to the section of this booklet entitled "COBRA Continuation Coverage" for information regarding continuation of coverage under COBRA.

Effective September 1, 1992, in accordance with the Self-Pay Provisions of the Plan, a disabled employee whose eligibility for himself and his eligible dependents has been extended for an additional 12 months due to a disability which occurred on the job for which he is receiving benefits from Workers' Compensation, must obtain health care for himself and his eligible dependents within the State of Hawaii. Benefits obtained outside of the State of Hawaii during the 12-month extended period will not be covered under the Fund.

Non-Bargaining Unit Employees

Employees of Contributing Employers who are not covered by the collective bargaining agreement ("Non-Bargaining Unit Employees") have their eligibility determined in accordance with the Subscriber Agreement their employer has signed with the Plan. The basic terms and conditions of participation of such Non-Bargaining Unit Employees are described below.

Participation

Contributing Employers may enroll all of their full-time employees who are not participating in the Plan pursuant to a collective bargaining agreement ("non-contract employees") by signing a Subscription Agreement in a form approved by the Plan. Acceptance of a Subscription Agreement is within the discretion of the Board of Trustees. If a Contributing Employer enrolls any such non-bargaining unit employees, it must enroll all of its full-time non--bargaining unit employees, and agree in writing to:

- abide by the provisions of the Trust Agreement and plan,
- abide by the actions of the Trustees,
- waive its right to appoint an Employer Trustee, and
- make premium payments for each regular eligible employee in the manner and amounts as may be determined by the Trustees from time to time.

Your eligible dependents will be governed by the same rules applicable to Bargaining Unit employees' dependents.

Contributing Employers may cover their non-bargaining unit employees pursuant to these provisions in accordance with the following procedures:

- They must sign up within 90 days of first signing a collective bargaining agreement with the Union, or be barred thereafter from participating.
- If the Contributing Employer does not elect to participate in the Trust or, having so elected, later terminates his participation, he shall be barred thereafter from participation in the Trust with respect to his non-bargaining unit employees.

Monthly Contributions

In order to establish and maintain eligibility for Plan benefits, monthly contributions from the employer in a monthly amount set by the Trustees, must be received by the Trust Fund Office (Life Insurance, HMAA (Medical and prescription drug), Kaiser Permanente (Medical and prescription drug), HDS (Dental) and VSP (Vision)) no later than the 5th day of the month for which coverage is effective (e.g., by May 5 for May coverage).

Benefits will not be payable for any month for which contributions have not been received or for which any delinquent contributions are owed by an employer as required under its collective bargaining agreements.

Effective Date of Benefit Coverage

Benefit coverage shall be effective as of the first day of the month following 30 days of employment for which employer contributions are received by the Fund Office on your behalf. You shall continue to be eligible as long as you are regularly employed by the employer and premiums are paid on your behalf in accordance with the rules established by the Trustees.

Termination of Eligibility

Coverage for you and your dependents ends on the last day of the month following the month your employment with the employer is terminated.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act, 29 USC §2601 et seq. provides that if you work for an employer covered by that Act you are entitled by law to up to 12 weeks each year (in some cases, up to 26 weeks) unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a Spouse, child or parent who is seriously ill, any qualifying emergency arising out of the fact that the Employee's spouse, child or parent is a covered military member on covered active duty, or for your own illness. In general, the employers covered by FMLA are those who employ 50 or more employees for each working day during each of twenty or more calendar weeks in the current or preceding calendar year. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Employer.

Self-Payments

Bargaining Unit Employees have the choice of self-payment as described below, or COBRA continuation coverage as described beginning on page 16.

IT IS IMPORTANT TO NOTE THAT THE MAXIMUM DURATION OF COBRA CONTINUATION COVERAGE WILL BE REDUCED BY ANY MONTHS OF SELF-PAYMENT.

Active Employees

If you lose eligibility because you have less than the required 120 hours for eligibility in your reserve account, you may continue eligibility for yourself and your eligible dependents for a period not to exceed 18 months by making payment of the required contribution to the Fund by the 5th of the month immediately following loss of eligibility.

Disabled Employees

If you are unable to work because of a disability which occurred off the job, and which is certified by your attending physician in writing in a form acceptable to the Fund, you may continue eligibility for a maximum of 18 months, for yourself and your eligible dependents by making the required contribution to the Fund by the 5th of each month following loss of eligibility.

Widows

The widow of a previously eligible active employee may continue eligibility for medical, vision and dental benefits for herself and any eligible dependent children by making payment of the required contribution to the Fund by the 5th of each month following loss of eligibility. Life and Accidental Death and Dismemberment insurance and Weekly Loss of Time benefits are not available to widows. Upon remarriage, he or she will no longer be eligible to make self-contributions.

Important Information

If an active employee, disabled employee or widow elects not to make a self-contribution when first eligible or fails to make the monthly payment on time, he or she will not be permitted to make a self-contribution for:

- Prior month(s) of eligibility; or
- Future eligibility until the annual open enrollment period.

The required contribution for the above classes of "Self-Payment" will be set by the Trustees from time to time and will be sufficient to cover the costs of the benefits provided.

Non-Bargaining Unit Employees are not eligible to make self-payments except under the COBRA continuation rules described beginning on page 16.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

The following information applies to reservists, members of the National Guard and Participants who enlist in the uniformed services of the United States.

An active employee who enters military service shall be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Duty to Notify the Trust Fund Office

It is important that you advise the Trust Fund Office in writing that hours will not be reported for you because you have been called up for active military service or you have enlisted in the uniformed services. This will protect your status in the Plan after you are discharged.

Benefits During Service of Less Than 30 Days

If your service is for less than 30 days, your coverage will be continued under the Trust Fund, unless you do not have the required hours in your reserve account at the time of your departure for active duty. If you would have had sufficient hours except for your call-up to active duty, you should contact the Fund Office in writing to receive credit for the hours you served on active military duty. You will be credited with eight hours for each day of active duty service during these 30 days.

Service Greater than 30 Days

Should your service last for more than 31 days, your options for health insurance are as follows:

USERRA

If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the date the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage.

Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Trust Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Reserve account

When you enter military service, you become covered under the military medical plan (TRICARE) on the effective date of your orders for active duty. You may use your reserve account to continue the coverage of your dependents. However, if your duty period exceeds your reserve account eligibility, your dependents will no longer be covered unless they elect to self-pay under this section. If you use your reserve account to provide coverage for your dependents, you will no longer have any reserve account hours available when you return from active duty.

TRICARE:

Your dependents are also eligible for coverage under TRICARE. You should discuss the options available to your dependents with the personnel office for your unit, as their choices are different depending on whether your service is less than or greater than 179 days. This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan's benefits under USERRA or COBRA is the best choice. If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.

Spousal coverage:

If your spouse works and his or her employer offers health benefits for which your dependents would be eligible if they were enrolled and your spouse paid any required amount, your spouse should talk to his or her employer's personnel representative. Loss of your coverage would entitle your dependents to special enrollment rights under another plan. Your spouse must enroll within 30 days of termination of your coverage under the Hawaii Iron Workers Health and Welfare Trust Fund.

COBRA

You may elect to cover your dependents under the Hawaii Iron Workers Health and Welfare Trust Fund Plan by completing a COBRA enrollment form and paying the premium in a timely manner. If you elect COBRA, your dependents will still be eligible for TRICARE, but the Hawaii Iron Workers Health and Welfare Trust Fund Plan will be the primary payer. You could also obtain any services that are not covered by TRICARE that this Plan does cover. By electing COBRA, you will preserve your reserve account until your discharge. However, you would not be eligible for the life insurance offered by the Plan.

After Your Discharge

You must also notify the Trust Fund Office in writing within the time period required under USERRA after your discharge.

After your discharge, if you did not use your reserve account to continue coverage for your dependents, your reserve account will be immediately re-instated. Even if you did use your reserve account, you will not have to re-qualify for initial eligibility. Your coverage will be re-instated the month following the month you have worked the required number of hours. Your employer is not required to report your hours until the 20th of the month after the work month. Therefore, if you need immediate re-instatement of your coverage, you must provide the Trust Fund Office with evidence of the hours you have worked. For example, you could submit a copy of your pay stub.

Retired Iron Workers

Please note that the Retiree coverage is <u>not</u> subject to the requirements of the Patient Protection and Affordable Care Act. Therefore, covered Dependent Children will only be eligible for coverage up to age 19 (or age 24 if a fulltime student or subject to one of the additional conditions for extended eligibility discussed below). Note: Michelle's Law (29 USC § 1185c) applies to students who are on leave of absence from school for medical reasons.

Eligible Retirees

To be considered eligible for health benefits, a Retired Iron Worker must:

- Be properly enrolled in the Plan as outlined under "Enrollment";
- Have been awarded a pension (see paragraph below titled "Self-Payments Retirees and Dependents for an explanation of the pro rata pension) from the Hawaii Reinforcing Iron Workers Pension Trust Fund or Hawaii Structural Iron Workers Pension Trust Fund; and
- Contribute monthly self-payments in a timely manner as outlined under "Self-Payments".

Enrollment by Retirees

Enrollment in one of the retiree plans (see "Medical Plan Options for Retirees") is not automatic. When you retire, you must submit properly completed enrollment forms along with documentation on your dependent spouse to the Trust Fund Office.

Self-Payments Retirees and Dependents

If you are a retired employee who is receiving a pension (other than a pro rata pensioner with less than 75% pension credits) from the Hawaii Reinforcing Iron Workers Pension Trust Fund or Hawaii Structural Iron Workers Pension Trust Fund, you may continue eligibility for yourself and your eligible dependents by making the required contribution to the Fund by the 5th of each month following loss of eligibility.

A retired employee as defined above will pay the full premium rates for the life, accidental death and dismemberment, vision and dental coverage, but will be allowed a credit, as determined by the Board of Trustees, toward his monthly medical (and vision) payment. Under certain circumstances, you may be eligible for assistance with the payment of the required contributions.

- Post-1994 retirees receive the sum of the $25 basic benefit plus $575 (maximum benefit of $600) per month towards medical coverage.
- Pre-1994 retirees will receive a maximum benefit of $375 per month towards medical coverage.

In all cases (Post-1994 and Pre-1994), the subsidy amount will always be the lesser of: the actual cost of eligible health coverage or the maximum monthly benefit available under the Plan. Only the cost of eligible benefits provided through the Hawaii Iron Workers Health and Welfare Trust Fund are eligible for the subsidy.

A retired employee has the option to self-pay for the life, accidental death and dismemberment, and dental benefits only, and discontinue coverage for the medical benefit. Such an election may be made only during the Fund's annual open enrollment period beginning December 15th and ending on January 15th with an effective date of February 1st. During subsequent open enrollment periods, you may once again elect to be covered for medical benefits by making the necessary self-payments.

If you wish to make a change in your benefits, you should contact the Trust Fund Office.

Widows

The widow of a retiree, except a retiree under a pro-rata pension, may continue eligibility for medical, vision and dental benefits for herself and any eligible dependent children by making payment of the required contribution to the Fund by the 5th of each month following loss of eligibility. Life and Accidental Death and Dismemberment insurance is not available to widows. Upon remarriage, she will no longer be eligible to make self-pay contributions.

Important Information

If a retiree or widow elects not to make a self-contribution when first eligible, he or she will not be permitted to make a self-contribution for:

- Prior month(s) of eligibility; or
- Future eligibility until the annual open enrollment period.

The required contribution for the above classes of "self-payment" will be set by the Trustees from time to time and will be sufficient to cover the costs of the benefits provided.

Dependents of Covered Retirees

Eligibility

Family members eligible for coverage are your legal spouse and your unmarried children younger than age 19. Adopted children become eligible upon placement for adoption. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. Unmarried stepchildren and children under legal guardianship (as specified in a court order) under age 19 are eligible if they reside with you in a regular parent-child relationship, are entirely supported by you and are declared by you on your income tax returns for federal income tax purposes, and proof of dependency is furnished to the Trust Fund Office as may be required. The Trust Fund Office requires a copy of your Marriage Certificate and a copy of the Birth Certificates for your dependent children.

Dependent children between the ages of 19 through 24 who are full-time students will also be covered for medical, dental, vision and life insurance benefits. To secure such coverage, you must submit to the Trust Fund Office a student certification form (available at the Trust Fund Office) with the name and birth date of the dependent student and the name of the school or university he or she is attending. This student certification must be done annually.

If the Plan receives a written certification from a child's treating physician that (1) the child is suffering from a serious illness or injury, and (2) a leave of absence (or other change in enrollment) from a postsecondary institution is Medically Necessary, and if the loss of student status would result in a loss of health coverage under the Plan, the Plan will extend the child's coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the Medically Necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (i) one year later, or (ii) the date on which coverage would otherwise terminate under the terms of the Plan (for example, when the child reaches the Plan's limiting age).

Furthermore, an unmarried child of any age who is unable to earn a living because of a mental or physical disability is also considered an eligible dependent, provided the child was both disabled and eligible as a dependent under the Plan prior to age 19 (24 if a full-time student), and is solely dependent upon the employee for support and is declared as a dependent for federal income tax purposes. If proof of the child's mental or physical disability is filed with the Plan Office within 90 days after the Plan's limiting age, the child will remain eligible for hospital-medical and dental benefits as long as you are eligible and the child remains incapable of self-support. Proof of dependency must be furnished to the Plan as may be required from time to time.

No Vesting

Benefits for retirees are not vested and may be changed, amended or terminated at any time at the Board's discretion.

Coverage Options

The following chart outlines the coverage options available for each Employee, Dependent and Retiree.

	HMAA (Medical and Drug)	Kaiser (Medical and Drug)	HMSA 65+	Kaiser Senior Advantage	HDS Dental	VSP Vision	Pacific Guardian (Life Insurance) [1]	Pacific Guardian (AD&D)	Pacific Guardian (Weekly Loss of Time)
Bargained Employees	X	X			X	X	X	X	X
Eligible Dependents of Bargained employees	X	X			X	X	X	X	
Non-Bargained Employees	X	X			X	X	X	X	X
Eligible Dependents of Non-Bargained Employees	X	X			X	X	X	X	
Non-Medicare eligible Retirees	X	X			X	X	X	X	
Dependents of Non-Medicare Eligible Retirees	X	X			X	X	X	X	
Medicare Eligible Retirees			X	X	X	X	X	X	
Dependents of Medicare Eligible Retirees	X (if Dependents not eligible for Medicare)	X (if Dependents not eligible for Medicare)	X	X	X	X	X	X	
Non-Medicare eligible Retired Employee with a Medicare eligible spouse [2]	X	X			X	X	X	X	
Medicare eligible Active Employee with a Non-Medicare eligible spouse [3]	X	X			X	X	X	X	

1. Dependent Life Insurance is attached to the Employee or Retiree coverage. Dependents are not eligible to elect this coverage on their own.
2. If a Non-Medicare Retired Employee is enrolled in HMAA with a Medicare spouse, the only option for the Medicare spouse is HMSA Akamai Advantage 65+. If a Non-Medicare Retired Employee is enrolled in Kaiser with a Medicare eligible spouse, Kaiser Senior Advantage is THE ONLY OPTION for the Medicare eligible spouse.
3. If a Medicare eligible Active Employee is enrolled in HMAA with a Non-Medicare spouse, the only option for the Medicare eligible employee is HMAA. If a Medicare eligible Retired Employee is enrolled in Kaiser with a Non-Medicare spouse, Kaiser Senior advantage is THE ONLY OPTION for the Medicare eligible Retired Employee.

COBRA CONTINUATION COVERAGE RULES

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

Qualifying Events

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you may continue health care coverage under certain circumstances called "qualifying events" for you and your eligible dependents past the date coverage would normally end. Health care benefits will be identical to the benefits the Plan provides to you at the time your coverage terminated. You and your eligible Dependent(s) will be required to pay the full cost of the coverage in order to continue it. The Life Insurance Benefit, Accidental Death and Dismemberment (AD&D) Benefit, and the Weekly Loss of Time Benefit cannot be continued under COBRA rules.

IT IS IMPORTANT TO NOTE THAT THE MAXIMUM DURATION OF COBRA CONTINUATION COVERAGE (WHETHER 18, 29, OR 36 MONTHS) WILL BE REDUCED BY ANY MONTHS OF CONTINUED COVERAGE EXTENDED UNDER THE SELF-PAYMENT PROVISIONS DESCRIBED ON PAGE 12.

Circumstances under which health care coverage can be continued and the duration of continuation coverage are outlined in the following chart:

Qualifying Event Causing Health Care Coverage to End	**DURATION OF COBRA FOR QUALIFIED BENEFICIARIES[1]**		
	Employee	**Spouse**	**Dependent Child(ren)**
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months
Retiree coverage is terminated or coverage is substantially reduced within one year before or after the employer files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Retiree: for Life	Varies[2]	Varies[2]

1: When a covered employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered Spouse and dependent children who are Qualified

Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

2: Employer's bankruptcy under Title 11 of the US Code may trigger COBRA coverage for certain retirees and their related Qualified Beneficiaries such as COBRA coverage for the life of the retiree. The retiree's Spouse and dependent children are entitled to COBRA for the life of the retiree and if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the Qualifying Event occurs, but the retiree's surviving Spouse is alive and covered by the group health plan, then that surviving Spouse is entitled to coverage for life.

If you or one of your eligible Dependents is determined by the Social Security Administration to be totally disabled at any time before or during the first 60 days of COBRA continuation coverage, COBRA coverage may continue for up to 29 months. Proof of eligibility for Social Security disability benefits is required within 60 days after the date of the Social Security determination and prior to the expiration of the initial 18 months of COBRA coverage, to qualify for continuation of the additional 11 months of coverage. In addition, if a second qualifying event other than an event as described in (1) or (2) occurs within the first 18-month period, COBRA coverage for the affected Dependent(s) may be extended for up to a maximum of 36 months from the date of the first qualifying event.

Extended COBRA Coverage If A Second Qualifying Event Occurs

If, during an 18-month period of COBRA Continuation Coverage resulting from insufficient work hours, you die, divorce your spouse or if a covered child ceases to be a Dependent child under the Plan, the maximum COBRA coverage period for the affected Spouse and/or child is extended to 36 months from the date of the first Qualifying Event. This extended period of COBRA coverage is not available to anyone who became the Participant's Spouse after the first Qualifying Event. However, this extended period of COBRA coverage is available to any children born to, adopted by, or placed for adoption with the Participant during the 18-month period of COBRA coverage. It is the responsibility of you or your spouse or child to notify Fund Office that a second qualifying event has occurred.

NOTE: Because dependent coverage under the plan is not terminated when the Employee becomes eligible for Medicare, Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and dependents who are Qualified Beneficiaries.

Notification

When one of these situations occurs, the Fund Office upon notification will give you or your eligible Dependents all the details regarding continuation coverage, including the cost. It is your responsibility, however, to inform the Fund Office, in writing, of a divorce or legal separation or of a child losing eligible Dependent status under the Plan**. If you do not notify the Fund Office in writing within 60 days of a divorce or legal separation or a child losing eligible Dependent status, you will lose the right to elect continuation coverage.**

You are encouraged to inform the Fund Office in writing of any qualifying event. The written notice should be sent to the Fund Office whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents or any other information that is requested.

You will have 60 days from the date you would have lost coverage due to the qualifying event or, if later, 60 days from the date you receive the COBRA election notice to respond if you wish to elect coverage. If you reject this continuation coverage, your lawful spouse and Dependent children will be given the opportunity to elect coverage independently from you.

The Fund Office will notify you of the cost of continuation coverage when it notifies you of your right to this coverage. You have a maximum of 45 days from the date you mail your election form to the Fund Office in which to submit your first payment. If you wait until the end of the election period, payment for each full month passed since the date active

coverage terminated must be included with the first payment. The health care providers will send you billing notices, and payment should be made directly to the providers.

Notice of Unavailability of COBRA Coverage

In the event the Fund is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Fund Office an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Qualified Beneficiaries

Under the law, only "qualified beneficiaries" are entitled to COBRA continuation coverage. A qualified beneficiary is any individual who was covered under the Plan on the day before the COBRA qualifying event by virtue of being on that day an employee (you), the spouse of an employee or retiree, or the Dependent child of an employee or retiree.

Retirees, please note: When you retired, you (the Employee) were offered a choice between electing a temporary continuation of their group health coverage ("COBRA Continuation Coverage") or electing Retiree health coverage. As you elected the Fund's Retiree health coverage, you will have no further COBRA continuation rights. However, your covered Spouse or dependent child may experience a COBRA Qualifying Event as described in this section.

A child who becomes a Dependent child by birth, adoption, or placement for adoption with you during a period of COBRA continuation coverage is also a qualified beneficiary and will have the same COBRA rights as a spouse or children who were covered by the Plan before the qualifying event that triggered the COBRA continuation coverage.

A spouse who becomes your spouse during a period of COBRA continuation coverage, in contrast, is not a qualified beneficiary (in other words, is not eligible for the spousal options described), but you may add such a spouse to your coverage during the period you remain eligible for COBRA continuation coverage.

You may add newly acquired eligible Dependents while covered under COBRA by notifying the Fund Office in writing within 30 days after acquiring the new eligible Dependent. In addition, if you have eligible Dependents who declined COBRA continuation coverage after the qualifying event because they had coverage elsewhere and that other coverage is lost (due to exhaustion of continuation coverage under that plan, ineligibility for the coverage, or the employer's ceasing to make contributions for the coverage), you may add those Dependents for the balance of your COBRA period, provided you do so within 30 days of the loss of the other coverage. Adding Dependents may increase the amount of the premium you are required to pay.

Termination of COBRA Continuation Coverage

Coverage under COBRA will terminate before the end of the maximum period allowed under any one of the following circumstances:

- failure to make the monthly payment on time;
- the date you or a Dependent become covered under another group health plan (which does not limit or exclude any pre-existing condition you or your Dependent might have). Such pre-existing condition exclusions will become prohibited beginning with the plan year in 2014;
- the date you or a Dependent become entitled to Medicare.
- the date your covered former spouse remarries and becomes covered by a group health care plan or program;
- the date the Plan is terminated. However, if the Plan is replaced, coverage may be continued under the new Plan; or

- for Non-Bargaining Unit Employees, the date their employer no longer provides coverage under this Plan to any Non-Bargaining Unit Employees.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate coverage or conversion coverage. The notice will be provided as soon as practicable after the Fund Office determines that COBRA coverage will terminate early.

Types of Benefits

Any person electing COBRA continuation shall have the option of electing either:

- **Core Benefits**: medical coverage (including hospital, and prescription drug benefits).
- **Core plus Non-Core Benefits**: medical coverage (including hospital, and prescription drug benefits), dental and vision benefits.

Paying for COBRA Coverage

COBRA Continuation Coverage is available only at your own expense. If you or your Dependents elect to continue coverage, the full cost, plus a 2% administrative charge, will be charged (in the case of an extension due to disability, it is the full cost plus 50%).

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay the first premium due starting with the date COBRA coverage was elected. If this first payment is not made when due, COBRA coverage will not take effect. After the first payment, subsequent payments are due on the first day of each month. There will be a grace period of 30 days to pay the monthly premium payments. If payment of the amount due is not made by the end of the applicable grace period, your COBRA coverage will terminate.

If you make a payment later than the first day of the coverage month to which it applies, but before the end of the grace period for that month, your benefits under the plan will be suspended as of the first day of the coverage month and then retroactively reinstated (going back to the first day of the coverage month) when the payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Conversion Coverage

After your continuation coverage under COBRA terminates, you can apply for conversion to individual coverage if that is provided for under the Plan's contracts at that time. Contact HMAA or Kaiser for information on conversion and the applicable deadlines. Note that COBRA continuation coverage is not the same as conversion coverage. Conversion coverage provides you with an individual policy of health insurance handled directly between you and an HMO or insurance company. Unlike COBRA continuation coverage, conversion coverage does not guarantee coverage identical to your group health plan and requires you to pay your premiums directly to the HMO or insurance company at individual rates.

CHOICE OF MEDICAL AND DENTAL PLAN

Medical Plan Options

You have the option of selecting one of the following medical plans which include prescription drug benefits:

PPO - HMAA (Hawaii Medical Assurance Association)

The benefits provided through HMAA are described in PPO booklet. You may select a doctor and/or hospital of your choice. However, use of participating providers and hospitals may result in lower out-of-pocket expenses, as they have agreed to provide services at special negotiated rates.

You have the option of obtaining services from either participating providers or non-participating providers. You can benefit financially by utilizing preferred providers, resulting in lower coinsurance percentages, lower deductibles, and less out-of-pocket expense for most services.

No medical examination is required for medical benefits. Eligible individuals and their eligible dependents will be covered regardless of their physical condition.

The contact information for HMAA can be located on the Quick Reference Chart at the beginning of this booklet.

HMO - Kaiser Foundation Health Plan, Inc

An HMO is an organization which has entered into a contract with certain hospitals and physicians. It differs from traditional fee-for-service plans in that you are limited to the choice of physicians and hospitals. In an HMO you must select a physician from among those employed by or under contract to the HMO. However, covered services and supplies are provided by the HMO facilities either at no cost to you or with minimal copayments. Further, there are no claim forms to file.

Except for certain medical emergencies or authorized referrals, you are NOT ALLOWED to go to other physicians or hospitals (not affiliated with Kaiser). If you do, neither the Fund nor Kaiser will be responsible for the charges you incur.

The contact information for Kaiser can be located on the Quick Reference Chart at the beginning of this booklet.

For eligible Retirees only

Effective for retirements on and after June 1, 2010, if both you and your spouse are over age 65 when you retire, you may enroll in either Kaiser Senior Advantage Plan or the Akamai Advantage offered by Hawaii Medical Service Association (HMSA). HMSA's Akamai Advantage plan and the Kaiser Senior Advantage Plan are available only to retirees who have Medicare Part A and Part B and pay Medicare premiums. Generally, you must live within the state of Hawaii to be covered. However, there is limited coverage available outside the state of Hawaii. Contact Kaiser or HMSA with any questions you may have on available coverage.

Effective for retirements on and after June 1, 2010, if you are under age 65 when you retire, you (and any covered spouse or dependent(s)) can stay on the HMAA Plan until you reach age 65. At that time, you will be required to enroll in either the HMSA Akamai Advantage Plan or Kaiser Senior Advantage. If your spouse is under age 65 when you retire and you are 65+, your covered spouse can stay on the HMAA Plan until your spouse turns 65 years old and is eligible for Medicare Part A and Part B, pay Medicare premiums and live within the state of Hawaii.

If you are enrolled in HMSA's Akamai Advantage Plan, you should receive all of your care from HMSA Akamai Advantage contracted providers. The current listing of contracted

doctors is available by contacting HMSA. If you use a provider who is not contracted with HMSA to provide services to Medicare enrollees, you will need to submit your claim to and pay the portion of charges not covered by Medicare. Likewise, if you are enrolled in Kaiser Senior Advantage, you will be required to receive all of your care from Kaiser providers at a Kaiser facility (except for emergency situations).

Changing Plans – Open Enrollment

You may change plans during the Fund's periodic open enrollment as determined by the Board of Trustees. This period is currently from December 15th to January 15th, with an effective date of February 1. At that time, you can contact the Fund Office and all the information you will need to make a choice will be sent to you. Once you have made a selection, you cannot change medical plans until the next open enrollment period unless there is a special enrollment opportunity, as described on page 7.

Dental Plan – Hawaii Dental Service (HDS)

You may elect to cover yourself and your eligible Dependents under the Hawaii Dental Service (HDS) Dental Plan. You have the option of obtaining services from either participating or non-participating providers. You can benefit financially by utilizing participating providers, resulting in lower out-of-pocket expenses.

MEDICAL BENEFITS

Be sure to see the materials from HMAA, HMSA or Kaiser for information on such matters as:

- how your plan works
- any deductibles you have to meet
- what services and supplies are covered
- what your share of the costs is
- any maximum benefits, limits on visits or services, or exclusions from coverage
- what providers you can use (please see the HMAA, HMSA or Kaiser website listed on the Quick Reference Chart for a list of network providers). If you are not able to access the internet listing, please contact the insurance company directly for assistance.
- how to change your Primary or personal care Physician if you're in an HMO
- pre-authorization requirements
- what you should do in an emergency or if you become ill or injured while traveling
- what walk-in and mail order service you have for prescription drugs
- how your plan handles your private medical information
- how benefits are handled if you have other coverage or you're eligible for Workers' Compensation or payments from another party
- procedures for appealing claims or care decisions
- any arbitration provisions

If you do not find the information you are looking for, contact HMAA, HMSA or Kaiser.

Special Provisions Regarding Women's Health Care

All the medical plan choices comply with federal laws that guarantee certain rights to women:

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, the doctor), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Under the Women's Health and Cancer Rights Act of 1998, all plans that cover mastectomies are also required to cover related reconstructive surgery. Available reconstructive surgery must include both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of mastectomy, including lymphedemas. These services are elective and are chosen by the patient in consultation with the attending physician. They are subject to a plan's usual deductible and copayment provisions.

PROVISIONS THAT APPLY ONLY TO HMAA PARTICIPANTS

HMAA Patient Protection Rights

As a Non-grandfathered plan under the Affordable Care Act, certain provisions apply only to HMAA Participants. These provisions do not apply to

PCP Designation

HMAA does not require the selection or designation of a primary care provider (PCP). You have the ability to visit any PPO or Non-PPO healthcare provider; however, payment may be less when you use a Non-PPO provider.

Access to Ob/Gyn Provider

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Nondiscrimination in Health Care

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Fund will not discriminate with respect to participation under the Fund or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. The Fund is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

External Review

In compliance with the Affordable Care Act (ACA), you may be offered the opportunity to seek further external review, by an Independent Review Organization ("IRO"), if you have an appeal related to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time. Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal. An External Review is performed by an Independent Review Organization ("IRO") and would be at no cost to you. For more information on External Review rights, contact HMAA.

External review is not available for any other types of denials including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this external review process does not pertain to life and accidental death and dismemberment (AD&D) claims and disability claims (including applications for extended benefits during a job-related disability). See the materials from HMAA for possible External Review rights on those benefits.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Please note that this Life Insurance coverage is <u>not</u> subject to the requirements of Health Care Reform. However, the Board of Trustees has decided to allow coverage of Dependent Children up to age 26 even though it is not required to do so.

Life Insurance Benefits for Employees

Group Life Insurance will be paid in full to your beneficiary in the event of your death from any cause, according to the following schedule:

Active Employees under age 65	$50,000
Active Employees age 65 to 70	$25,000
Active Employees age 70 and older	$12,500
Retired Employees under age 70	$5,000
Retired Employees age 70 and older	$2,500

Insurance During Total Disability

If, as an active employee eligible under the Plan, you become totally disabled before age 60, your Group Life Insurance can be continued without cost to you during the disability period. In order to continue your coverage you must notify the Fund Office promptly, in writing, of your total disability and advise them that you want to apply to have your Life Insurance extended so that the required forms can be sent to you for completion.

The Life Insurance Benefit provisions require that the necessary forms and proof that your total disability has continued for at least six months, must be received by the Life Insurance Company within twelve months from the date on which your disability began. You must meet this time requirement in order to qualify. Receipt of notice or proof of total disability by the Fund Office is not sufficient. You will be required to submit evidence of your continuing disability periodically.

Your Beneficiary

You may name anyone you wish as your beneficiary and you may change your beneficiary at any time by filling out the proper form and sending it to the Fund Office. If you do not designate a beneficiary or if your beneficiary does not outlive you, the amount of the insurance will be payable as follows:

1. to your spouse, if living; if not,
2. in equal shares to your then living children, if any; if none,
3. in equal shares to your father and mother, if living; if not,
4. in equal shares to your brother(s) and sister(s), if any; if none,
5. to your estate.

If the beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, no payment will be made until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. This provision does not prevent the Life Insurance Company from making payment to or for the benefit of a minor beneficiary in accordance with applicable state law.

If any benefits under this provision are to be paid to your estate, the Life Insurance Company may pay an amount not greater than $1,000 to any person they deem to be entitled

to such funds. Any and all payments made by the Life Insurance Company shall fully discharge them in the amount of such payment.

How to Continue Your Life Insurance If You Lose Eligibility

If you cease to be eligible for the Group Life Insurance (for reasons other than termination of the Group Policy), you may convert all or part of your Group Life Insurance, without medical examination, to a personal individual life insurance policy. To do this, you must submit an application to the Life Insurance Company and pay the first month's premium within the 31-day period following the date that you ceased to be eligible for the Group Life Insurance. If you die during this 31-day period, the Life Insurance Company will pay the amount that could have been converted, whether or not you had applied for an individual policy.

You may elect to convert coverage to a Whole Life Insurance policy. The individual policy will be made effective at the end of the 31-day period and the premiums will be the same as those customarily charged at conversion.

Life Insurance for Dependents

The Dependents Life Insurance will be paid in full in the event of death at any time or place or from any cause. Upon receipt of proof of death of an insured dependent, the applicable amount of life insurance shown below will be paid to you or the designated beneficiary.

Spouse $1,000

Children

14 days through age 5 months..... $500

6 months through age 26..... $1,000

Conversion Privilege

If your dependent's insurance terminates because your insurance is terminated for any reason except for non-payment of premium or termination or amendment of this policy, your dependents insurance may be converted to a Whole Life Insurance Policy without evidence of insurability.

Application and payment of the first premium for the individual policy must be made within thirty-one days after termination of eligibility. The premium for the individual policy will be at the Company's customary rate for the form and amount and will be determined by the age of the dependent on the policy issue date. The amount of life insurance under the policy will not be in excess of the amount the dependent had in force under this policy at the date of termination.

If your dependent's insurance terminates because of termination or amendment of this policy, conversion will be available as stated above provided that the dependent has been insured for Dependent Life Insurance under this policy for at least five years on the date of such termination. The amount of life insurance for the insured dependent spouse or child under the individual policy will not exceed the amount of insurance the dependent spouse or child was covered for under the Group Policy, less any amount the dependent is or becomes eligible for under any group policy issued or reinstated by this or any other insurance carrier within thirty-one days after termination.

Any individual policy issued will become effective on the thirty-first day following the termination of Dependents Life Insurance under this policy provided that all premium payments are made, and the required conditions for conversion are fulfilled. If the insured spouse or child dies during the thirty-one day conversion period, the amount of insurance the dependent could convert will be payable whether or not application for an individual policy or the first premium payment has been made.

Payment of Benefits

Any insurance payable due to the death of an insured dependent will be paid to you, if living. If not living, payment will be made to your estate.

If a child or children is the first surviving class of beneficiaries, the Company must have a signed affidavit by one child stating that the persons in that class of beneficiaries are the sole surviving members of such class. If the beneficiary is a minor or otherwise not capable of giving a valid release for any payment due, payment may be made to the legally appointed guardian of the property of the beneficiary.

Terminal Illness Accelerated Death Benefit

If you are an Active Employee under age 64 and are terminally ill, you may request an accelerated death benefit. The benefit is 50% of your $50,000 life insurance benefit, or $25,000. The remaining life insurance benefit would be payable to your beneficiary at the time of your death. You may contact the Fund Office or the Life Insurance Company for additional information.

Accidental Death and Dismemberment Benefits

Your Accidental Death and Dismemberment Insurance will be paid for any of the following losses as the result of an accident, on or off the job. The injury must be sustained while you are insured and the loss must occur within 365 days after such injury. Payment will be made regardless of any other benefits you may receive.

Loss of Life	**(Paid to your beneficiary, in addition to your Life Insurance)**
Active employees under age 65	$50,000
Active employees age 65 to 70	$25,000
Active employees age 70 and over	$12,500
Retired employees under age 70	$5,000
Retired employees age 70 and over	$2,500
Loss of:	The full amount indicated
Both hands,	above for the Loss of Life
Both feet,	(Paid to you)
Sight of both eyes,	
One hand and one foot,	
One hand and sight of one eye, or	
One foot and sight of one eye	
Loss of:	One-half the amount
One hand,	indicated above for
One foot, or	Loss of Life
Sight of one eye	(Paid to you)

The loss of hands and feet means the loss of their use by severance at or above the wrist or ankle and the loss of sight means the total and irrevocable loss of sight.

The payment for all losses caused by any one accident may not be more than the full amount of your insurance, but the benefits paid on account of one loss will not prevent further payment for losses resulting from subsequent accidents.

The Accidental Death and Dismemberment Insurance does not cover any loss that occurs more than 365 days after the accident, nor any loss resulting from:

- Intentionally self-inflicted injury;
- Suicide or attempted suicide whether, in either case, sane or insane;
- Disease or mental infirmity or the medical or surgical treatment or diagnosis for such disease or infirmity;
- Ptomaines or bacterial infections, except pus-forming infections resulting from an injury not excluded by these exclusions;
- Any declared or undeclared insurrection or act of war;
- Travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft;
- The Insured's being under the influence of any drug, except those prescribed by a physician, including alcohol, narcotics, hallucinogens and gas or fumes, which are taken or inhaled voluntarily; or
- Voluntary poisoning.

WEEKLY LOSS OF TIME BENEFIT

For Active Employees Only

If you become disabled, as certified by a physician, while covered under the Plan as a result of non-occupational accident or sickness, and are unable to perform any and every duty of your regular work, you will be paid the following weekly benefit for up to 26 weeks in any one benefit year.

First Week of Disability

- No benefits payable until the 8th day of disability.

Second through Twenty-Seventh Week of Disability

- 70% of your average weekly wage, up to a maximum of 120% of the maximum weekly Hawaii Temporary Disability Insurance Statutory Benefit starting with the second week of disability for up to 26 weeks during each disability period.

Other Eligibility Requirements

- You must have been employed immediately before the date you suffered your injury or illness or, if you were separated from your job, your injury or illness must have occurred within 2 weeks from your separation date.
- In the 52 weeks preceding your first day of disability, there must have been at least 14 weeks when you were in Hawaii employment and were paid for 20 hours or more per week and earned wages of at least $400 per week (the weeks do not have to be consecutive or with only one employer).

Benefits are not payable for any disability:

- While the employee is receiving compensation under the State Unemployment Insurance Plans, or any Workers' Compensation or Occupational Subrogation Rights disease law.
- If an Employee may receive indemnity payments for wage loss under the Workers' Compensation law of the State of Hawaii, or under any applicable employers' liability law of the State of Hawaii, or may recover damages from a third person who is responsible for the sickness or accident causing the disability; the insurer shall be subrogated to, and have a lien upon, the rights of the Employee against the third party to the extent that damages include wage loss during the period disability benefits were received in the amount of such benefits.

Non-Bargaining Unit Employees

Non-Bargaining Unit Employees are not eligible for the Weekly Loss of Time benefit.

DENTAL BENEFITS

Provided through Hawaii Dental Service (HDS)

Please note that this fully insured dental coverage is not subject to the requirements of Health Care Reform. Therefore, the calendar year and lifetime maximums will apply to all Plan Participants. However, the Board of Trustees has decided to allow coverage of Dependent Children up to age 26 even though it is not required to do so.

After you meet the initial eligibility requirements under the Fund, you and your dependents will automatically be covered under the dental plan available through HDS (Hawaii Dental Service).

Important Facts about HDS Dental Plan

How To Use Your Plan

This section provides a brief outline of your plan benefits and is for information only. The Group Plan Agreement between Hawaii Iron Workers Health and Welfare Trust Fund and HDS contains a complete description of benefits and all the terms and conditions of membership. You may review this Group Plan Agreement during regular business hours at the Trust Fund Office.

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 partner with HDS by limiting their fees 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.HawaiiDentalService.com or call the HDS Customer Service department at the telephone number listed on the Quick Reference Chart at the beginning of this SPD.

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 292,000 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.HawaiiDentalService.com and click on "Members/Find a Participating Dentist." Click on the link at the bottom of the page to search for a Mainland dentist. Select "Delta Dental Premier" as your plan type. 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 membership 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 membership card.

HDS's payment will be based upon the Delta Dental dentist's agreed upon fee for his/her state. Your Patient Share will be the difference between the Delta Dental dentist's agreed upon fee 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 that the non-participating dentist actually charges and the amount paid by HDS in accordance with your plan.

- 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 Benefit (EOB) report.

Whether you visit a participating or non-participating dentist, please be sure to let your dentist know that you have an HDS plan and discuss your financial obligations with your dentist before you receive treatment. All dental claims must be filed within 12 months of the date of service for HDS claims payment.

Helping You Manage Your Costs

HDS participating dentists agree to limit their fees and charge you at the agreed upon fee even after you reach your annual plan maximum. 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.

Covered Benefits

The following is a very brief summary of your benefits. For a full description of your available dental benefits, contact HDS.

Summary of Benefits	HDS Covers
Plan Maximum (per person per calendar year)	**None**
Diagnostic (including exam twice a year and x-rays)	100%
Preventive Care (including cleanings, fluoride, sealants, space maintainers)	
Restorative Care (fillings, crowns and gold restorations)	**85%**
Endodontics (including root canals)	**85%**

Summary of Benefits	HDS Covers
Periodontics	
Prosthodontics (bridges, dentures)	85%
Implants – HDS will recognize endosteal implants as an alternate benefit to a 3-unit bridge, under the prosthodontic benefit.	85%, Maximum $2,500 per calendar year
Oral Surgery	85%

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 (included in some plans; see Summary of Dental Benefits).
- Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to a patient by a dentist.
- All transportation costs such as airline, taxi cab, rental car and public transportation are not covered.

Questions on Your Claims

If you have any questions or concerns about your dental claims, please call the Customer Service department at 529-9248 on Oahu or toll-free at 1-800-232-2533 extension 248.

If you are not satisfied with the plan benefit determination, a request for reconsideration may be sent to the Manager of Customer Service within one year of the date of service. A copy of HDS's claims appeal process may be obtained from Customer Service.

Additional Information

For additional information regarding your HDS benefits, please visit HDS online at *www.HawaiiDentalService.com*. You will be able to access your HDS information 24/7. Following are directions on how to access your online account and a summary of the information that is available to you.

VISION CARE BENEFITS

Provided through Vision Service Plan (VSP)

Please note that this vision coverage is <u>not</u> subject to the requirements of Health Care Reform. Therefore, the calendar year and lifetime maximums will apply to <u>all</u> Plan Participants. However, the Board of Trustees has decided to allow coverage of Dependent Children up to age 26 even though it is not required to do so.

Vision Care Benefits are available to you and your dependents for regular vision examinations and lenses and frames when necessary for proper visual function or correction. These benefits are provided by Vision Service Plan (VSP). It is important that you refer to the VSP brochure prior to obtaining services.

Services and Material Provided Through VSP:

Vision Examination

After a $10 copayment, a comprehensive examination of the visual functions is provided once every 12 months, including the prescription of corrective eyewear where indicated.

Lenses and Frames

Where the vision examination indicates that new lenses or frames or both are necessary for proper visual health, they will be supplied after a $25 copayment for materials, together with such professional services as are necessary, which shall include, but not be limited to:

- prescribing and ordering proper lenses;
- assisting in the selection of a frame;
- verifying the accuracy of the finished lenses;
- proper fitting and adjustment of the spectacles.

Materials

Certain materials such as oversize frames are cosmetic in nature and not necessary for visual health. You will be responsible for the extra costs.

- Lenses - available once each 12 months; and
- Frames - available once each 24 months.

Contact Lenses

<u>Elective</u>

When you choose contact lenses in lieu of lenses and frames, VSP will apply an allowance of $120 in-network ($105 out-of-network) to the cost of the lenses and professional services associated with the dispensing of contact lenses: The $25 copayment for materials does not apply to elective contact lenses.

<u>Necessary</u>

Contact lenses are furnished under the Vision Service Plan in lieu of lenses and frames, when the doctor secures prior approval for the following conditions:

- following cataract surgery;
- to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- certain conditions of anisometropia; and

- keratoconus.

For information on the prior approval process and appeals of decisions on requests for prior approval, see your Evidence of Coverage from VSP.

Contact lenses once furnished under the plan can only be replaced with prior authorization by VSP, but in no event more frequently than every twelve (12) months.

For Non-VSP Doctor Service

If you choose to receive vision care services and materials from a doctor or dispensing optician who is not a participating member of the VSP network you will be reimbursed in accordance with the following schedule:

Professional Fees	
Vision Examinations, up to	$ 45
Materials	
Single Vision Lenses, up to	$ 45
Bifocal Lenses, up to	$ 65
Trifocal Lenses, up to	$ 85
Lenticular Lenses, up to	$125
Frames, up to	$ 47
Contact Lenses	
When determined by VSP to be necessary, up to	$210
Elective, up to	$105

To find a doctor that participates in the VSP network, log on at www.vsp.com or call VSP at 1-800-877-7195.

Exclusions

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

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses.
- Two pair of glasses in lieu of bifocals.
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Any eye examination or any corrective eye wear that is required by an employer as a condition of employment.

ENROLL FOR MEDICARE RETIREES OVER AGE 65

If you are retired and you (or your dependent) are approaching age 65 and have not filed an application or established eligibility for a monthly Social Security benefit, you should be aware that you are not automatically enrolled in Medicare. In order to avoid any loss of protection, you (or your dependent) should enroll for Parts A and B of the Federal Medicare program during the seven-month period of initial eligibility (three months prior to the month of your eligibility and three months thereafter). This should be done at the nearest Social Security office.

Failure to enroll during your initial eligibility period means you cannot enroll until the Medicare open enrollment period in the following calendar year. This Plan will not pay for charges that Medicare would have paid but for your failure to enroll.

Once you have enrolled for Medicare, you must assign your Medicare benefits to either Kaiser or HMSA and receive all of your care from Kaiser or HMSA's Medicare contracted doctors and other health care providers. The Plan does not pay for care that is not covered under the Kaiser Senior Advantage or HMSA Akamai Advantage Plan.

MEDICAID RECIPIENTS

The following rules will apply with respect to any Employee, or dependent, who is eligible for Medicaid benefits:

- Benefits payments under the Plan will be made in accordance with any assignment of rights made by or on behalf of the Employee, or dependent, to the extent that the assignment is required by a state Medicaid program.
- In enrolling any Employee, or dependent, under the Plan, or in determining or making any benefit payments to or on behalf of any Employee, or dependent, the Plan will not take into account the fact that the individual is eligible for or provided medical assistance under a state Medicaid program.
- To the extent that a state Medicaid program has made payments that the Plan is legally responsible for, the Plan's benefit payments will be made in accordance with any state law, provided that the state has acquired the individual's rights with respect to those benefit payments.

GENERAL INFORMATION HOW TO FILE A CLAIM

For Life Insurance and Accidental Death and Dismemberment Benefits

A certified copy of the death certificate showing the deceased's Social Security number should be sent to the Trust Fund Office. If death is the result of an accident and Accidental Death Benefits are being claimed, include a copy of any newspaper clippings and/or official report with the details of the accident. The benefit check will be forwarded to your beneficiary in the event of your death.

For Weekly Loss of Time Benefits

Claim forms are available at the Trust Fund Office. You should complete Part A of the Claim Form. Your employer should complete Part C and your physician should complete Part D of the form and mail it to the Trust Fund Office. The completed Claim Form should be filed no later than 30 days after you become sick or disabled.

If you file a claim beyond 30 days, attach a statement explaining why you were unable to file earlier. After you file your claim, the Fund's insurance carrier will notify you if you are eligible for benefits.

For HMAA Benefits

Here are some instructions to help you file a claim with HMAA. A claim is a form requesting payment of benefits for services covered by this Plan. You or the provider who performed the service must fill out an HMAA approved claim form and send it to HWMG so that payment can be made for covered services. HWMG can pay benefits only after your claim is received. Please note: all Participating Providers will file your claims directly with HWMG.

If you have already paid a provider for services covered by this Plan, you can file a claim with HWMG. HWMG will then reimburse you the amount of your Plan benefits for those covered services.

Any claim sent or brought to HWMG more than one year after the date you received the services will not be eligible for payment.

How to File Medical Claims (including prescription drugs)

When you receive covered services in Hawaii:

- Present your HMAA membership card to the provider;
- Be sure the provider and HMAA have your correct mailing address; and
- Ask the provider to file an HMAA claim for you. Please note: all Participating Providers will file your claims directly with HMWG.
- Participants in Akamai Advantage do not need to file any claims.
- Present your HMAA membership card to the provider who dispenses your drugs.

For mail order prescription drug claims:

Benefits for mail order prescription drugs, supplies, and insulin are **only** available through contracted providers. Call HMAA at the number listed on the Quick Reference Chart at the beginning of this SPD for a list of contracted providers. If you receive mail order prescription drugs and supplies from a non-participating provider, no benefits will be paid.

Services From a Non-HMAA Provider

Because HMAA has no agreements with non-participating providers and facilities, you will be responsible for the difference between the entire billed amount and the payment made by HWMG. As a result, your out-of-pocket expenses will be substantially higher. This includes the use of a non-participating provider or facility in emergency care situations.

Out-of-State Claims (HMAA)

For Participating Providers outside Hawaii: This program provides access to medical services on the U.S. Mainland by participating with the PHCS Healthy Directions and MultiPlan Complementary Networks. This enables members to obtain medical services from Participating providers while traveling outside our service area (which is the state of Hawaii).

The out-of-area contract may require copayments that are based on the provider's billed charges rather than on the discounted price the plan actually pays the provider. This may result in a higher copayment for certain out-of-area claims.

Hospital Inpatient Services from a Participating Blue Cross and Blue Shield Provider

When you receive covered hospital inpatient services from a Participating Blue Cross and Blue Shield Provider outside Hawaii, you may:

- present your HMAA membership to the Participating Blue Cross and Blue Shield Provider;
- be sure the Participating Blue Cross and Blue Shield Provider has your correct mailing address, and
- ask the Participating Blue Cross and Blue Shield Provider to file a claim for you.

Participating Blue Cross and Blue Shield Providers will file out-of-state claims for hospital inpatient services for you. However, you are responsible for making sure the claims are filed.

Hospital Inpatient Services From Other Providers and All Outpatient Services

When you receive covered outpatient services or hospital inpatient services from a non-Blue Cross and Blue Shield provider outside Hawaii, you may:

- send to HMAA an HMAA approved claim form that has been completed and signed by the provider; or
- send HMAA a copy of the itemized bill or receipt. Be sure to write your HMAA membership number on the bill.

For out-of-state urgent care or emergency care (Health Care Hawaii Plus), contact HMAA for details.

How to File a Dental Claim with HDS

An HDS Participating Dentist will file your claims for you.

If you choose to have services performed by a dentist who is not an HDS or Delta Dental participating dentist, 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 the address listed on the Quick Reference Chart at the beginning of this SPD.

For Kaiser Foundation Health Plan

(Medical and Prescription Drug)

When you need services at Kaiser clinics or at Kaiser Hospitals

- Present your Kaiser I.D. card.
- Make sure the address in your medical file is correct.
- There is no need to file any claims.

- If you have no I.D. card you can still obtain services. A temporary card will be issued for your use that day by the clinic receptionist or Membership Service office at the Hospital or Clinic.
- If you are visiting a clinic or the hospital for the first time, make sure that you tell the receptionist or Membership Service office.

When you receive services at non-Kaiser facilities for emergencies

- Only costs for emergency care will be covered.
- Present your Kaiser I.D. card or if you don't have one tell the medical personnel that you are a Kaiser member.
- This is the only time you will need to file a claim. Make sure the attending physician or hospital completes the form.
- If there is no form available, you may file a claim by sending your name or the patient's name and medical record number, paid receipt(s), medical documentation, and a written statement describing the sequence of events to the address below within 90 days (or as soon as reasonably possible) after services were received for the out-of-plan emergency or out-of-area urgent care:

For more information about how to use the Kaiser Health Plan refer to The Kaiser Brochure.

For Vision Benefits Through Vision Service Plan

Steps for using a VSP provider are as follows:

- Call any VSP participating doctor to make an appointment (you do not need to obtain a benefit form from VSP first). Identify yourself as a VSP member and provide your Social Security number and the name of the group plan ("Hawaii Iron Workers Health and Welfare Trust Fund").
- If you need assistance locating a VSP participating doctor, call VSP at the number listed at the front of this SPD or log on to the VSP website at www.vsp.com and use the "Find a doctor" feature.
- After you have scheduled an appointment, the VSP participating doctor will contact VSP to verify your eligibility and plan coverage.
- When you go for your visit, pay the doctor the applicable copayment(s) and charges for any costs not covered (for example, any amount beyond the Plan allowance for the frame you select or charges for options that are cosmetic in nature). VSP will pay the doctor directly for the balance of the charges.

If you use a non-VSP provider, you will need to pay the doctor in full at the time of your visit, then request reimbursement of the applicable amounts in accordance with the Schedule of Allowances, appearing on page 36, subject to the applicable copayment(s). Reimbursement benefits are not assignable.

CLAIMS DECISIONS AND APPEALS

Please refer to your fully insured plan document(s) or Evidence of Coverage for a complete explanation of your claim appeal rights under ERISA for medical, dental, weekly loss of time and life insurance and accidental death and dismemberment. These materials, outlining the claims and appeals procedures for each of these plans are furnished automatically, without charge, as separate documents.

A review of **eligibility status** for any claim denied in whole may be submitted to the Fund Office.

The following rules apply when the Fund Office denies a claims **as to basic eligibility under the Plan** due to a determination of lack of eligibility. The following eligibility issues are examples of the type of appeal that the Fund Office reviews:

- whether your Employer has made sufficient contributions on your behalf; and
- if your COBRA premium has not been received within the required time period.

Within 30 days of receipt of an eligibility dispute, the Fund Office will grant or deny your eligibility claim. If the Fund Office requires additional information, they will (within 30 days) advise you what additional information is required, why it is required and issue a decision within 30 days of receipt of the requested information.

If your claim for eligibility is denied, the Fund Office's notice of denial will include: (1) the specific reason for the denial; (2) specific reference to the provisions of this plan on which the denial is based; (3) any additional information that might change the decision of the Fund Office; (4) the procedures you must follow to have your claim for eligibility reviewed by the Board of Trustees.

Should the Fund Office fail to take any action on your claim of basic eligibility within 30 days of the Fund Office's receipt of your claim of basic eligibility, you may treat your claim as denied and seek review by the Board of Trustees under the following review procedures.

Review procedures

You may appeal a denial of initial eligibility or continuing eligibility within 180 days of the date you received the denial notice. To appeal, write to the Fund Office and state the reasons why you believe you were incorrectly determined to be ineligible, including any additional documentation to support your claim. You also may submit questions or comments you think are appropriate and you may review all relevant documents, including those related to how the Trustees dealt with comparable eligibility issues in the past.

The Trustees typically meet quarterly. If your appeal is received by the Fund Office at least 30 days in advance of a regularly scheduled meeting, your appeal will be considered by the Trustees at the next regularly scheduled meeting. To the extent permitted by federal regulations, consideration of your appeal may be put over to the next meeting of the Board if additional information is required. You will be notified in writing of any need for additional information.

When the Board makes a final determination on your appeal, you will be advised in writing of the determination by the Fund Office within five days of the decision.

Under a federal law known as ERISA, a participant or beneficiary whose claims for benefits has been denied, may file suit against the Plan pursuant to ERISA Section 502(a). However, prior to filing such a suit, the appeal process described above must be pursued and exhausted. Thus, following any denial of eligibility, if you disagree it is important you file a timely appeal. In all cases, your appeal must be filed no later than 180 days after you receive the initial eligibility denial. If you do not file an appeal within the required time frame, you will have failed to exhaust your appeal rights.

If is important to understand that all benefits provided under the Fund are provided through HMO contracts and contracts of insurance. Thus, even if the Trustees eventually agree with your eligibility claim, benefits can be paid for a retroactive period only if the HMO and/or insurer agrees to accept retroactive premiums for retroactive coverage. Accordingly, it is in your best interest to promptly file all appeals related to eligibility.

The rules related to eligibility in no fashion replace the claims and appeal rules set forth in the Evidence of Coverage or Certificate of Coverage you receive from the insurance company when you enroll for health benefits. The Board of Trustees only deals with basic eligibility issues.

Should you have any questions related to these rules, do not hesitate to contact the Fund Office.

Using an Authorized Representative

An authorized representative may submit a claim (or later an appeal) for you if you are unable to complete it Yourself and have previously designated the individual to act on Your behalf. A form can be obtained from the Trust Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on Your behalf.

Statement on HIPAA's Privacy Rules

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like the Hawaii Ironworkers Health and Welfare Trust Fund protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Notice of Privacy Practices, which you have received from Plan's insurance underwriters, Kaiser, HMAA, HDS, HMSA and VSP. This statement is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Fund Office and the Board of Trustees do not use or receive any medical information about plan participants from Kaiser, HMAA, HDS, HMSA or VSP. However, the Fund Office maintains other information that is protected by the HIPAA Privacy regulations, for example, your address, social security number and Kaiser, HMAA, HDS or HMSA account number. The Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health Plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the sponsored by the Hawaii Ironworkers.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy rule. You will receive a separate notice from Kaiser, HMAA, HDS and VSP as the Plan's Business Associates. Those notices will describe your HIPAA privacy rights with respect to benefits provided by the insurers.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated. These rights are described in detail in the Notices of Privacy Practices you have received from Kaiser, HMAA, HDS, HMSA and VSP.

This Plan also maintains a Notice of Privacy Practices which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, or if you have questions about the privacy of your health information, please contact the Privacy Officer the Fund Office. If you wish to file a complaint about a privacy issue, please contact the Privacy Officer at the Fund Office.

TERMINATED EMPLOYEE SUPPLEMENTAL MEDICAL ACCOUNT

Eligibility

If you work as an Ironworker for Contributing Employers who have made contributions to the Account in the Hawaii Ironworkers Health and Welfare Trust Fund (the "Fund") on your behalf, or if you are a Union employee permitted to participate in the Account, you are eligible for coverage under the following conditions:

- Your employment is terminated or your hours are reduced to a level that causes you to lose active employee health benefits under the Fund.
- You remain available for employment and maintain membership in the Union.
- You have no remaining reserve account hours that may be used to pay health insurance continuation premiums and you are not eligible for the Fund's Retiree Supplemental Medical Account.
- You remain eligible for coverage under the health insurance plan in which you participated at the time of your termination or reduction in hours.
- You complete at least one year of credited service.

Benefits

The Account will pay 100% of the premiums for up to 18 months of medical insurance coverage under the insurance plan in which you were participating at the time of your termination or reduction in hours. If your coverage ends before the 18th month because you are rehired by a Contributing Employer or the Union, your hours are increased, or you otherwise cease to be eligible under the preceding section, you will again receive benefits from the Account when you again become eligible, until you have used up your lifetime maximum of 18 months of benefits.

Making a Claim

If you believe that you are eligible for benefits from the Account, file a claim with the Trust Fund Office. The forms may be obtained from the Trust Fund Office.

Plan Benefits Are Not Guaranteed

The Trustees reserve the right to change or discontinue (i) the types and amounts of benefits under this Account and (ii) the eligibility rules, including those rules providing extended or accumulated eligibility even if the extended eligibility has already been accumulated.

The nature and amount of benefits are always subject to the actual terms of the Rules and Regulations of the Account as they exist at the time the claim occurs.

In addition, retiree benefits are not vested and may be changed, amended or terminated at the Board's discretion.

LONG TERM CARE INSURANCE

The basic benefit provides up to **$2,000 per month for up to three years** for care in either a qualifying Long Term Care facility or Professional Home and Community Care. You may elect to pay a premium to cover your qualifying relatives, who are persons age 18 to 80 and are related to you as your spouse or your natural, adoptive or step children, parents, grandparents or siblings or the spouse of any of these individuals.

You will qualify for benefits if you or your qualifying relative are unable to perform two or more "activities of daily living" for a period of at least 90 days over two years (730 consecutive days) or if you suffer from a severe cognitive impairment (such as Alzheimer's Disease) which requires you to be under substantial supervision for your own safety.

Note that your caregiver cannot be your family member unless the caregiver is a regular employee of the licensed Adult Day Care Facility or the licensed Home Care provider through which you receive care.

You will receive a Certificate of Coverage that provides all of the requirements and restrictions that apply to the policy issued by the insurance company listed in the Quick Reference Chart at the beginning of this document. Call the Trust Fund Office with questions.

ACTIVE SUPPLEMENTAL MEDICAL ACCOUNT

Eligibility

If you are an Ironworker who has who terminates or incurs a reduction in hours (resulting in a loss of coverage) after completing at least one Year of Credited Service (as defined under Hawaii Reinforcing Ironworkers Pension Trust Fund, the Hawaii Structural Ironworkers Pension Trust Fund, or any successor qualified multiemployer pension plan between the Union and Individual Employers) for a Contributing Employer is eligible for the benefits outlined below.

- **Terminate** means a severance of employment with an Individual Employer or with the Union for any reason, including layoff, involuntary termination or voluntary termination (if the Employee remains available for employment and maintains membership in the Union).
- **Reduction in Hours** means reduction in the number of hours worked by an Employee resulting in the Employee's loss of coverage under the Fund's health benefits for active employees.

For purposes of this Active Supplemental Medical Account, an Employee is an Ironworker who is or was covered by a Collective Bargaining Agreement (CBA) or any other written contribution agreement between the Union and an individual Employer which requires contributions to the Account or an Employee of the Union permitted by the Union to receive benefits from the Account.

Amount of Benefits

Benefits are in the form of monthly premium payments made by the Account directly to the medical and/or vision plan(s) that you (and any covered Dependents) were participating in at the time of your termination or reduction in hours

Please note: No payments will be made for Medicare supplement plans or dental plans.

Timing of Benefits

Benefit payments will start in the first month in which the Employee:

- Has no remaining reserve account hours to use to pay premiums, and
- Is not eligible for a current premium payment under the Fund's Retiree Supplemental Medical Account.

Benefit payments will stop at the earliest to occur of the following events:

- The date payments under the account have been made for a total of eighteen (18) months (does not have to be 18 consecutive months),
- Your coverage under the Fund is reinstated because of reemployment or sufficient increase in hours,
- You become eligible for benefits under the Fund's Retiree Supplemental Medical Account, or
- You are not eligible for coverage under the insurance plan.

If you receive less than eighteen (18) months of premium payments, you may receive additional benefits if he again lose coverage due to termination or a reduction in hours. **However, the maximum lifetime aggregate benefits available for any Employee is eighteen (18) months of premium payments.**

Making a Claim

If you believe that you are eligible for benefits from the Account, please file a claim with the Trust Fund Office. The forms may be obtained from the Trust Fund Office.

Claim Denial

If a claim is denied (or partially denied), you will be given written notice of the denial within a reasonable period after the claim is received. The notice will give

- the specific reasons for the denial,
- a specific reference to the plan provision on which denial is based,
- a description of any additional material or information that may be needed as well as an explanation of why the material or information is necessary, and
- an explanation of the claims review procedure.

In the application and interpretation of any of the provisions of this Account, the decisions of the Trustees will be final and binding on all parties, including the Employees, Individual Employers, and the Union.

Plan Changes

The Board of Trustees reserve the right to change or discontinue (i) the types and amounts of benefits under this Account and (ii) the eligibility rules, including those rules providing extended or accumulated eligibility even if the extended eligibility has already been accumulated. If this Account is discontinued, any assets remaining (after providing for the expenses of the Account and for payment of any current premiums) will be distributed to the Fund to provide benefits to Fund participants.

The nature and amount of benefits are always subject to the actual terms of the Rules and Regulations of the Account as they exist at the time the claim occurs.

Plan Benefits Are Not Guaranteed

Benefits are not vested and may be changed, amended or terminated at the Board's discretion.

Please note: If any amendment results in the payment of some but less than 100% of the premium payment required for continuation of coverage, the Employee's failure to make the balance of the payment due will result in a termination of coverage.

RETIREE SUPPLEMENTAL MEDICAL ACCOUNT

Eligibility

If you are an Ironworker who works for a Contributing Employer who has made contributions to the Account in the Hawaii Ironworkers Health and Welfare Trust Fund (the "Fund") on your behalf, or for the Union, the Trust Fund Office or the Ironworkers Training Trust Funds and are permitted to participate in the Account, you are eligible for coverage if you terminate employment under the following conditions:

- you have accrued at least 5 years of credited service under the Hawaii Reinforcing Ironworkers Pension Trust Fund or the Hawaii Structural Ironworkers Pension Trust Fund (the "Pension Plan"); and
- you have been eligible for active employee medical insurance coverage under the Fund for at least 36 of the last 60 months immediately prior to retirement; and
- you are entitled to receive an immediate or deferred benefit under the Pension Plan.

Timing of Benefits

If you are eligible for a benefit after you retire, it will begin in the month you begin receiving Pension Plan payments (but after April 1, 2004, when the Account became effective) and end on the first of the following events:

- you die; or
- you cease to receive Pension Plan payments; or
- you fail to make a co-payment or become ineligible for insurance coverage for any other reason.

Amount of Benefits

Benefits are in the form of monthly premium payments made directly by the Account to your health insurance plan under the Fund. The amount of the monthly payment depends on your status at the time of retirement:

- If you are a Union officer who retires on or after January 1, 2003 (and had been a Union officer for at least 9 years), the payment will be 100% of your medical, dental and life insurance premiums.
- If you retire with at least 5 years of credited service under the Pension Plan after September 1, 1994, the payment will be the lesser of 100% of your insurance premiums or the sum of $600. Alternatively, if an eligible retired Employee elects not to obtain health insurance coverage under the Fund, the benefits available from the Account (up to $600) may be used to pay the premiums for life insurance and/or dental insurance provided under the Fund
- If you were a retired self-pay participant prior to August 12, 2009, the payment will be for medical insurance only (not dental) and will be the lesser of 100% of your medical insurance premium or the sum of $375.
- If you do not fall into either of the foregoing categories the payment will be a $25 "Basic Benefit" for medical insurance only (not dental).

Spousal Benefit

If you are married at the time of your death and had earned a benefit under the Pension Plan, your spouse will receive a benefit from the Account in the same monthly amount as you would have received had you lived (except that the $25 basic benefit described above will not apply), beginning in the month after you die and ending in the month in which the first of the following events occurs:

- your spouse dies; or

- your spouse remarries; or
- your spouse fails to make a co-payment or becomes ineligible for insurance coverage for any other reason.

Plan Changes

If you or your spouse changes to a different health insurance plan under contract with the Fund, your benefits will be changed to reflect the new plan's premiums.

Making a Claim

If you believe that you are eligible for benefits from the Account, file a claim with the Trust Fund Office. The forms may be obtained from the Trust Fund Office.

Plan Benefits Are Not Guaranteed

The Trustees reserve the right to change or discontinue (i) the types and amounts of benefits under this Account and (ii) the eligibility rules, including those rules providing extended or accumulated eligibility even if the extended eligibility has already been accumulated.

The nature and amount of benefits are always subject to the actual terms of the Rules and Regulations of the Account as they exist at the time the claim occurs.

In addition, retiree benefits are not vested and may be changed, amended or terminated at the Board's discretion.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The following information concerning the Benefit Trust Fund is being provided to you in accordance with federal government regulations:

Name of Plan

The name of the plan is the Hawaii Iron Workers Health and Welfare Trust Fund.

Plan Administrator/Plan Sponsor

The Board of Trustees is the Plan Administrator and/or the Plan Sponsor. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to governmental agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974.

The Board of Trustees have engaged the contract administrator named below to provide routine administrative services to the Plan:

Emily Morton
Hawaii Iron Workers
Health and Welfare Trust Fund
94-497 Ukee Street
Waipahu, Hawaii 96797

Plan Number

The plan number is 501

Employer Identification Number (EIN)

The Employer Identification Number issued to the Board of Trustees by the Internal Revenue Service is 99-0166475.

Type of Plan

This is a health and welfare plan providing life insurance, Accidental Death and Dismemberment, Weekly Loss of Time, Medical, Dental, and Vision benefits.

Agent for Service of Legal Process

The Board of Trustees has designated the following person as agent for service of legal process:

Emily Morton
Hawaii Iron Workers Health and Welfare Trust Fund
94-497 Ukee Street, Waipahu, Hawaii 96797

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

Names and Business Addresses of the Trustees

Employer Trustees

Mr. T. Kawika Chun
Mutual Welding Co., Ltd.
2846 Ualena Street
Honolulu, Hawaii 96819

Union Trustees

Mr. Clyde Eugenio
2325 Apapa Street
Pearl City, Hawaii 96782

Employer Trustees	Union Trustees
Mr. Douglas Ewart South Pacific Steel P.O. Box 700028 Kapolei, Hawaii 96709	Mr. Shon T.G.P. Moea'i Hawaii Iron Workers Trust Fund Office 94-497 Ukee Street Waipahu, Hawaii 96797
Mr. Edson Hoo Aloha Steel Corporation 850 Ahua Street Honolulu, Hawaii 96819	Mr. Lincoln Naiwi Hawaii Iron Workers Trust Fund Office 94-497 Ukee Street Waipahu, Hawaii 96797
Mr. Steven Togami Associated Steel Workers, Ltd. P.O. Box 488 Aiea, Hawaii 96701	Mr. Joseph O'Donnell Iron Workers Union Local 625 94-497 Ukee Street Waipahu, Hawaii 96797
Mr. John Watanabe S&M Welding Co., Ltd. 1320 Kalani Street, #202 Honolulu, Hawaii 96817	Mr. Bronson Paris Iron Workers Union Local 625 94-497 Ukee Street Waipahu, Hawaii 96797
Mr. Daniel Woo S&M Welding Co., Ltd. 1320 Kalani Street, #202 Honolulu, Hawaii 96817	Mr. Arnold Wong Iron Workers Stabilization Fund 94-497 Ukee Street Waipahu, Hawaii 96797

Collective Bargaining Agreements

The Plan is maintained pursuant to various collective bargaining agreements. Copies of any of the collective bargaining agreements may be obtained upon written request to the Fund Office and are available for examination at the Fund Office during regular office hours.

A copy of any of the collective bargaining agreement will also be available for inspection within 10 calendar days after written request at any of the Local Union Offices or at the office of any contributing employer to which at least 50 Plan participants report each day.

The Fund Office will provide, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the collective bargaining agreement and the employer's address.

Plan Year

The date of the end of the Fund's fiscal year is July 31.

Plan's Requirements for Eligibility and Benefits

The Plan's requirements with respect to eligibility for benefits are shown in the "Summary of Eligibility Rules," starting on page 4 of this benefit booklet.

Termination

Certain factors could interfere with payment of benefits from the Plan (result in your disqualification or ineligibility, denial of your claim, or loss, forfeiture, or suspension of benefits you might reasonably expect). Examples of such factors are listed below. See also any other sources of information that apply to you (i.e., the brochures from the insurance company listed on the Quick Reference Chart at the beginning of this document).

- Failure to follow your plan's requirements for obtaining pre-authorization. If you wish to receive the maximum benefits available, you must comply with any pre-authorization requirements your health care plans have.
- Failure to use contracting or network providers. You will not receive the highest level of coverage available for many health care services unless you use preferred/participating providers. If you are in an HMO plan and you use out-of-network providers, you will not receive any benefits (unless it's an emergency or you have an authorized referral).
- Provisions for coordination of health care benefits. If you or a dependent has other coverage for health care benefits, payment of benefits under this Plan's health care plans will be coordinated with payment of benefits under that other coverage.
- Provisions regarding payment from another source (third-party liability). If you are hurt or made ill by the action (or lack of action) of someone else and you receive damages or other compensation, your health care plans, the Fund, and Pacific Guardian Life will have the right to recover any payments they have made for the injury or illness. These provisions will also apply if you are injured in a motor vehicle accident for which you receive motor vehicle insurance payments.
- Failure to submit claims in a timely way. You should submit all claims within the times stated in your health care plan materials or this booklet.
- Failure to provide notice of changes in your family situation. You must contact the Trust Fund Office regarding any changes in your family status. You will be liable for benefit payments based on incorrect information about family members (for example, if you fail to notify the Trust Fund Office in writing that you have divorced or a child has ceased to be an eligible dependent).

Any factors affecting your receipt of benefits will depend on your particular situation. If you have questions, contact the Trust Fund Office, Member Services at your health care plans, or the insurance company.

Contribution Source

All contributions to the Plan are made by Employers in accordance with collective bargaining agreements in force with the union at fixed rates per hour. Self-payment may be required as described in this Summary Plan Description.

Type Of Funding

Benefits are fully insured and are provided through the organizations listed in the Quick Reference Chart at the beginning of this document. The complete terms of the benefits are included in the group insurance policies with each carrier.

Termination of Plan

The Board of Trustees may terminate the Plan pursuant to its authority under the Trust Agreement. If the Plan is terminated, its remaining assets will be used to continue to provide its benefits for so long as Plan assets permit, or else they will be transferred to a successor plan providing health care benefits. However, the Trustees would have the right to revise, reduce or otherwise adjust benefits in any reasonable manner in connection with such termination.

In no event will the termination of the Plan or Trust result in a reversion of any assets to a contributing employer.

Procedures to Follow for Filing a Claim

The procedure to be followed in order to receive benefits under each coverage is described in your terms of the benefits are included in the group insurance policies with each insurance carrier. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

Claims Review and Appeal Procedures

A review of eligibility status for any claim denied in whole may be submitted to the Administrator.

Statement of ERISA Rights

As a participant in the Hawaii Iron Workers Health and Welfare Trust 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 are entitled to the following rights:

Receive Information About Your Plan and Benefits

1. 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. These documents include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration).
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
3. 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 Coverage

1. Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health 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 it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. 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.

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 it 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 Plan 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 (after exhausting the applicable appeals procedures). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of 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 (EBSA) (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at (866) 444-EBSA (3272) or writing to the following address:

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 obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA brochure request line at 800-998-7542 or contacting the EBSA field office nearest you. You may also find answers to your plan questions and a list of EBSA field offices at the website www.dol.gov/ebsa.

Plan Benefits Are Not Guaranteed

The Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under this Plan and (2) the eligibility rules, including those rules providing extended or accumulated eligibility even if the extended eligibility has already been accumulated.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

In addition, retiree benefits are not vested and may be changed, amended or terminated at the Board's discretion.