ProService Hawaii
Health & Welfare Benefit Plans

As your health care Plan Administrator, we are providing this additional information about your plans in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). Please note that this document includes information pertaining to all of the health and welfare benefit plans provided by ProService Hawaii; however, some medical, vision, prescription drug, dental and/or chiropractic plan information (shaded in gray) may or may not apply to you depending on the health plan elections made by you and your worksite employer.

SUMMARY PLAN DESCRIPTION (SPD) FOR MEDICAL, VISION, PRESCRIPTION DRUG, DENTAL AND CHIROPRACTIC PLANS

Effective January 1, 2023

PROSERVICE HAWAII

ProService Hawaii is a Professional Employer Organization that provides employee administration services, including health and welfare benefits, to its client companies (your worksite employer) and their employees. In certain circumstances, subject to the terms of a co-employment arrangement, ProService is the co-employer of the client companies' worksite employees.

INSURANCE CARRIERS OF HEALTH & WELFARE PROGRAMS

The following table lists the carriers ProService has contracted to provide your health and welfare benefits subject to your eligibility for the benefits.

CARRIER	PLAN	DOCUMENT CONTAINING DESCRIPTION OF BENEFITS
Medical		
HMSA	Preferred Provider Plan (PPO)	HMSA Preferred Provider Plan 2010 Guide to Benefits
HMSA	Preferred Provider Plan (PPO)	HMSA Preferred Provider Plan – A Guide to Benefits
HMSA	CompMed (PPO)	HMSA CompMed Guide to Benefits
HMSA	Health Plan Hawaii Plus (HMO)	HMSA's Health Plan Hawaii Plus Guide to Benefits
Kaiser	Kaiser 320 (HMO)	Kaiser Benefits Summary
Kaiser	Kaiser 220 (HMO)	Kaiser Benefits Summary
Vision		
HMSA	HMSA Vision	HMSA Vision Plan Certificate
Kaiser	Kaiser Optical	Kaiser Benefits Summary
Prescription Drug		
HMSA	HMSA Prescription Drug	HMSA Prescription Drug Plan Certificate
Kaiser	Kaiser Prescription Drug	Kaiser Benefits Summary
Dental		
Hawaii Dental Service	HDS	Summary of Dental Benefits
HMSA	HMSA	Summary of Dental Benefits
Complementary Care		
Kaiser	Chiropractic Plan	Kaiser Benefits Summary
HMSA	Acupuncture-Massage	Acupuncture-Massage Plan Certificate
Kaiser	Acupuncture-Massage	Kaiser Benefits Summary

ProService Hawaii is the Plan Administrator of the above plans. This Summary Plan Description (SPD) is intended to be reviewed by participants of the above plans, and/or those entitled, under applicable law, to review this SPD.

YOUR BENEFITS UNDER THE PLAN

For details on your benefit coverage, please refer to the above described documents, as amended ("Booklets") and/or the *Evidence of Coverage (EOC)* provided by the carrier in whose plan you are enrolled.

ELIGIBILITY FOR PLAN PARTICIPATION

In accordance with the Hawaii Prepaid Health Care Act, if you work twenty (20) hours a week for four (4) consecutive weeks, you are eligible to receive medical benefits under a medical plan(s), selected by your worksite employer. You may also voluntarily enroll in other health and benefit plans (vision, prescription drug, dental and complementary care, if your worksite employer offers a complementary care plan), and/or enroll your dependents (spouse, dependent children) in your chosen plan.

LIMITATIONS ON BENEFITS

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. The services and supplies must be provided, prescribed, authorized, or directed by the plan physician. You must receive the services and supplies at a plan facility or skilled nursing facility inside the plan's service area, except where specifically noted to the contrary in the *Evidence of Coverage.*

BENEFIT CLAIMS AND APPEALS PROCEDURE

For details on the benefit claims and appeals adjudication procedures, please refer to the *Evidence of Coverage (EOC)* provided by the carrier in whose plan you are enrolled.

PRE-EXISTING CONDITIONS LIMITATIONS AND SPECIAL ENROLLMENT PERIODS

The federal law (The Health Insurance Portability and Accountability Act of 1996, known as "HIPAA") limits the circumstances under which a group health plan may exclude coverage for medical conditions present before an individual is enrolled. Since this plan is governed by the law, the following rules apply:

1. **Certifications or other Evidence of Prior Coverage.** The primary method by which new enrollees (employees or dependents) will provide evidence of their prior health coverage is through a certificate provided by the prior employer or plan. However, if you do not have a certificate of prior coverage, you may provide other evidence of such coverage, such as health insurance ID card, pay stubs showing withholding for medical coverage, explanations of benefits, a certificate of coverage under a group policy, or any other relevant documents that evidence periods of health coverage. You must also sign a statement attesting that you had coverage for the period at issue, and you must cooperate with us in verifying your prior coverage, including authorizing us to obtain evidence of coverage from your prior employer(s) or plan(s).

   The plan administrator will notify you in writing, after review of your certification or other documentation, whether a pre-existing condition exclusion applies to you or a dependent. If a pre-existing limitation will apply, you will be notified of the basis for such determination, including the source and substance of any information which was relied on; a written explanation of any appeal procedures established by the plan or issuer; and a reasonable opportunity to submit additional evidence of credible coverage, if you disagree with that determination.

   A. If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage or you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. This special rule applies if you or your dependents lose the other coverage due to termination of employment, change in employment status, termination of the other plan's coverage, cessation of the employer's contribution toward coverage, exhaustion of COBRA coverage, death of a spouse, divorce, or legal separation.

   B. Even if you do not meet the 31-day requirement, the plan must allow you to enroll if you did not initially sign a written waiver of coverage stating that the reason you were waiving coverage was because you had other coverage and acknowledging that such waiver may cause you (and your dependents) to be treated as a late enrollee if you subsequently request enrollment.

   C. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you are eligible for coverage but do not enroll, your dependent cannot enroll.

   D. If a court of competent jurisdiction orders coverage of a spouse or minor child, that individual may be enrolled mid-year if the request for enrollment is made to the employer within (31) days of the court order.

BENEFITS DURING FAMILY AND MEDICAL LEAVE

If you are on a leave of absence approved by your employer and your leave is protected under the federal Family and Medical Leave Act (FMLA), you may continue medical benefits during such leave of absence. Contact the ProService Hawaii HR Service Center for details on eligibility for, and terms and conditions of, an approved leave of absence.

While you are on FMLA leave, your worksite employer will continue to pay the company share of the health insurance premium (for individual or dependent coverage) up to a maximum of 12 weeks within a 12-month period. Please refer to your employee handbook or your company policy for further details. Benefits that are not continued during FMLA leave will be reinstated, with no waiting period or pre-existing condition limitation, when you return from FMLA leave. Any share of medical premiums which you had paid for before starting FMLA leave must be paid for by you during the leave.

Contact the ProService Hawaii HR Service Center or refer to your employee handbook for additional information on the family/medical leave policy or if you want to request leave under this statute. You may also have certain rights under other state family leave laws.

CONTINUING BENEFITS DURING MILITARY LEAVE

If you go on active duty in the U.S. armed forces, you will cease to be covered under the regular group health plan as of the end of the month in which you enter active military service. However, you have the following rights to continue coverage:

1. If your military leave period is for 31 days or less, you have the right to continue medical coverage for yourself and dependents who were covered under our group medical plan for up to 31 days, at a cost of not more than the cost for a similarly situated active employee.

2. If the military leave period is for 31 days or more, you have the right to elect COBRA-like continuation coverage for yourself and your dependents who were covered under the group medical plan. [See the "COBRA – GENERAL NOTICE" section in your Confirmation of Health Care Coverage packet for details on your COBRA rights.]

COBRA CONTINUATION RIGHTS

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that may allow plan participants to continue medical coverage under specified circumstances where such group coverage would otherwise be lost. COBRA does not apply to any employer that normally employed fewer than twenty (20) employees on a typical business day during the preceding calendar year. If you qualify for COBRA, you or your covered dependents must apply for and pay the required premium before the deadline for payment in order to continue coverage. COBRA coverage can be extended for 18, 29, or 36 months, depending on the particular "qualifying event" that gave rise to COBRA. [See the "COBRA – GENERAL NOTICE" section in your Confirmation of Health Care Coverage packet for details on your COBRA rights.]

MATERNITY MINIMUM STAY PROVISIONS

The Newborns' and Mothers' Health Protection Act generally prohibits group health plans and health insurance issuers offering group insurance coverage from:

- restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or
- requiring that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

When a person insured for benefits under any of the above referenced health plans who has had a mastectomy (at any time) decides to have breast reconstruction, based on consultation between the attending physician and the patient, the following benefits will be subject to the same coinsurance and deductibles, which apply to other Plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications in all stages of mastectomy, including lymphedema.

If you have any questions about your benefits, please call the number on your ID card or contact your worksite employer or the Plan Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee. A Qualified Medical Child Support Order (QMCSO) may require medical coverage for an employee's child who is not otherwise covered. When the company, as plan sponsor, receives a QMCSO, we must promptly notify the employee and the child that the order has been received and what procedures we will use to determine if the order is "qualified." If we determine the order is qualified and the employee must provide coverage for his/her child pursuant to the QMCSO, we will deduct from the employee's paycheck the amount necessary to pay for such coverage. We will notify the affected employee once we determine whether or not the order is qualified. Participants and beneficiaries can obtain a copy of the procedures governing QMCSO determinations from the Plan Administrator without charge.

STATEMENT OF ERISA RIGHTS

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

1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The 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 make available to each participant a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, 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. If your claim for a welfare benefit is denied or ignored in whole or in part you have the 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 materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. 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).

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 (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SUMMARY PLAN INFORMATION

NAMES OF PLANS:	**MEDICAL & VISION:** HMSA Preferred Provider Plan 2010 HMSA Preferred Provider Plan - A HMSA CompMed Plan - A Health Plan Hawaii Plus Vision DU / Vision DV Kaiser 320 Kaiser 220 **DENTAL:** HDS Preventive Care HDS Preventive Care Plus HMSA V14/L55 HMSA V15/L55 **PRESCRIPTION DRUG:** HMSA Prescription Drug Kaiser Prescription Drug **COMPLEMENTARY CARE:** Kaiser Chiropractic Plan $20/20 HMSA Acupuncture-Massage Plan $20/12 Kaiser Acupuncture-Massage Plan $20/20
PLAN SPONSOR:	ProService Hawaii 6600 Kalanianaole Hwy., Suite 200 Honolulu, Hawaii 96825
PLAN ADMINISTRATOR:	ProService Hawaii 6600 Kalanianaole Hwy., Suite 200 Honolulu, Hawaii 96825
AGENT FOR SERVICE OF LEGAL PROCESS:	ProService Hawaii 6600 Kalanianaole Hwy., Suite 200 Honolulu, Hawaii 96825 Phone: (808)394-8878

	Service of legal process may be made upon the Plan Administrator.
EMPLOYER IDENTIFICATION NUMBER FOR PROSERVICE HAWAII:	61-1582293
TYPE OF PLANS:	Medical, Dental, Vision, Drug, Complementary Care
END OF PLAN YEAR:	January 1, 2023 (start) – December 31, 2023 (end)
TYPE OF ADMINISTRATION:	Insurer Administration
HEALTH INSURANCE ISSUERS: *Except when otherwise indicated, these benefits are guaranteed under a contract and/or policy of insurance issued by the issuer. Administrative services are provided by these issuers who are the claims administrators and coordinators.*	**MEDICAL & VISION:** Hawaii Medical Service Association (HMSA) 818 Keeaumoku Street Honolulu, HI 96808 Kaiser Foundation Health Plan, Inc. - Hawaii 711 Kapiolani Blvd., Suite 400 Honolulu, HI 96813 **DENTAL:** Hawaii Dental Services (HDS) 900 Fort Street Mall, Suite 1900 Honolulu, Hawaii 96813-3705 Hawaii Medical Service Association (HMSA) 818 Keeaumoku Street Honolulu, HI 96808 **PRESCRIPTION DRUG:** Hawaii Medical Service Association (HMSA) 818 Keeaumoku Street Honolulu, HI 96808 Kaiser Foundation Health Plan, Inc. - Hawaii 711 Kapiolani Blvd., Suite 400 Honolulu, HI 96813 **COMPLEMENTARY CARE:** Hawaii Medical Service Association (HMSA) 818 Keeaumoku Street Honolulu, HI 96808 Kaiser Foundation Health Plan, Inc. - Hawaii 711 Kapiolani Blvd., Suite 400 Honolulu, HI 96813
PLAN CONTRIBUTIONS:	**The Worksite Employer and the employees provide contributions necessary to fund the Plan.** The Worksite Employer shall contribute the difference between the amount employees contribute and the premiums for the group insurance coverage. Any experience credits or refunds under a group insurance contract shall be applied first to reimburse the Employer for its contributions, unless otherwise provided in that group insurance contract or required by applicable law. Voluntary coverages are entirely paid by employees.
LOSS OF BENEFITS:	Circumstances under which you may be disqualified from the plan, ineligible for benefits, or have benefits denied, forfeited, suspended are outlined in the termination of coverage section of the booklets. If you decide to decline coverage because you have medical coverage elsewhere, you must sign a State of Hawaii Department of Labor waiver form HC-5 when you become eligible and each calendar year thereafter. If you later enroll, you must do so at least one week prior to the end of the month for coverage to begin on the 1st of the following month.

LOSS OF BENEFITS (cont'd)	**In the event an employee is hospitalized or prevented by sickness from working, the employer, under the Hawaii Prepaid Health Care Act, is required to continue the employee's medical coverage for a period not to exceed three months by contributing in the same manner as prior to his/her inability to work.**
PROCEDURE FOR AMENDING THE PLAN:	The Employer reserves the right to discontinue or change the plan at any time, subject to any applicable legal requirements for prior notice.
CLAIMS PROCEDURE:	You may obtain claim forms and other information from your medical provider upon request and free of charge. If you need help contacting the medical provider, please contact the ProService HR Service Center or contact: **MEDICAL & VISION** HMSA: (808) 948-6111; Maui (808) 871-6295 Kaiser: (808) 432-5955; Maui (808) 243-6600 **DENTAL** Hawaii Dental Service: (800) 232-2533 HMSA: (808) 948-6111; Maui (808) 871-6295 **PRESCRIPTION DRUG** HMSA: (808) 948-6111; Maui (808) 871-6295 Kaiser: (808) 432-5955; Maui (808) 243-6600 **COMPLEMENTARY CARE** HMSA: (808) 948-6111; Maui (808) 871-6295 Kaiser: (808) 432-5955; Maui (808) 243-6600

If your claim is denied in whole or in part, you will receive a written notice of the denial. The notice will explain the reason for the denial and the review procedures. You may request a review of the denied claim. The request must be submitted, in writing, within 60 days after you receive the notice. Specify your reasons for requesting the review of the denied claim. For additional details, including where to submit your request, refer to your certificate booklet.