Guide to Benefits

Health Plan Hawaii Plus

Health Maintenance Organization

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hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

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CHAPTER 1

This Chapter Covers

About this Guide to Benefits

Your HMO Program

Your coverage provides you with medical benefits for treatment of an illness or injury, prevention of illness and injury, and promotion of good health. The Health Plan Hawaii Member Handbook provides further information about this plan including Member's Rights and Responsibilities, Well-Being Services and preventive health services. In the event the Handbook differs from this Guide to Benefits, the Guide takes precedence. You can get a copy of the Handbook by calling your nearest Customer Service office listed on the back cover of this Guide or visit our web site at www.hmsa.com.

HMSA's Pharmacy and Therapeutics Advisory Committee, composed of practicing physicians and pharmacists from the community, meet quarterly to assess drugs, including new drugs, for inclusion in HMSA's plans. Drugs that meet the Committee's standards for safety, efficacy, ease of use, and value are included in various plan formularies. For more details on coverage under this plan, see *Chapter 4: Description of Benefits* and *Chapter 6: Services Not Covered*.

Terminology

The terms You and Your mean you and your dependents eligible for this coverage. We, Us, and Our refer to HMSA.

The term ***Health Plan Hawaii (HPH)*** means the HMSA plan that provides or arranges for benefits specified in this Guide to Benefits.

The term ***Provider*** means a physician or other practitioner recognized by us who provides you with health care services. Your provider may also be the place where you get services, such as a hospital or extended care facility. Also, your provider may be a supplier of health care products, such as a home or durable medical equipment supplier.

The term ***Health Center*** means a specified group of providers in the Health Plan Hawaii network that you designate as your primary center of care. Your designated health center is made up of your PCP and other providers.

The term ***Network*** means all providers represented in all health centers that have contracted with HMSA to care for Health Plan Hawaii members.

The term ***Primary Care Provider (PCP)*** means the provider you choose within your health center to act as your personal health care manager.

Chapter 1: Important Information

Definitions

Throughout this Guide, terms appear in ***Bold Italics*** the first time they are defined. Terms are also defined in *Chapter 11: Glossary.*

Questions

If you have any questions, please call us. More details about plan benefits will be provided free of charge. We list our phone numbers on the back cover of this Guide.

Accessing Care

Your Member Card

You must present your member card whenever you get services. It identifies you as a Health Plan Hawaii member. If you misplace or lose your card, call Customer Service so that a new card can be sent to you. Our phone numbers are listed on the back cover of this Guide.

Please note: For drugs benefits covered under your medical plan, you must present your member card at network pharmacies. If you do not present your card or if you use a non-network pharmacy, both of the following statements are true:

- You must pay in full at the time you fill the prescription.
- You are responsible for any difference between the eligible charge and the actual charge.

Your PCP

Benefits are available only for care you receive from or arranged by your PCP except for care for emergency services, annual vision exams, Online Care, breast pumps, covered immunizations, mental health and substance abuse services, and clinics located at pharmacies in Hawaii and approved by HMSA. To find a clinic near you go to www.hmsa.com. For more details on these services see *Chapter 4: Description of Benefits*.

You do not need a referral from your PCP to obtain access to obstetrical or gynecological care from a health care professional in your health center who specializes in obstetrics or gynecology. You may receive an annual gynecological exam from any Health Plan Hawaii participating gynecologist or nurse midwife without a referral.

Health Center and PCP

Health Center

Your health center is the group of providers from which all of your services are received. Your health center may be an actual clinic of providers or a group of providers who practice at various locations. Your health center is very important for two reasons:

- Your PCP works within your designated health center; and
- If your condition requires the skills of a specialist, your PCP will arrange for you to get care from a specialty provider within the health center.

PCP

Your PCP will act as your health manager. He or she will do all of the following:

- Advise you on personal health issues.
- Diagnose and treat medical problems.
- Coordinate and monitor any care you may require from appropriate specialists.
- Keep your medical records up-to-date.

Your PCP is the first point of contact whenever you require medical assistance. Maintaining an ongoing relationship with your PCP will help ensure that you are receiving optimal care.

Please check with your PCP for specific information about the requirements for receiving services at your health center.

Your Health Team

Choosing Your Health Team

Your health care team is made up of you and both of the following:

- Your designated health center
- Your designated PCP

To address individual health care needs, you and each covered dependent may choose his or her own PCP and health center within the Health Plan Hawaii Network.

When choosing a PCP and health center, you should consider the following information:

- Do you already have a Provider that you want to remain with? Read through the ***Health Plan Hawaii Directory of Health Centers and Providers*** to determine whether your current Provider is available as a PCP.
- Decide what type of Primary Care Provider specialty fits your needs (family practice, general practice, OB/GYN, internal medicine or pediatrics). For example, you may designate a pediatrician as the Primary Care Provider for your child.
- Select a health center that fits your needs (health centers are in different locations and may offer different providers and specialties).
- Consider your personal preferences (a male or female Provider, cultural issues and languages spoken).
- Call the Provider's office for more details (what are the office hours, what hospital can the Provider practice at, what is their experience with certain diseases).
- You may select any Primary Care Provider within the Health Plan Hawaii Network (the PCP you choose must be in your selected health center or you will be reassigned to the health center where your PCP works).

The Directory of Health Centers and Providers lists the names of each health center and the PCPs and other providers that belong to that health center. Copies of the directory are available by contacting Customer Service. Our phone numbers are listed on the back cover of this Guide.

Certain hospitals may leave HMSA's network of Providers but will remain available to you as if they were network Providers through the current term of your employer's agreement with HMSA. During this time you will continue to pay network hospital copayments and enjoy other in-network benefits even if the hospital leaves the network as to some or all HMSA plans. Network benefits will be available to you through the most current term of your employer's agreement with HMSA but no longer than 12 months from the time the hospital leaves the network.

Please note: To provide you with the best care possible, the total number of patients a PCP can care for is limited. If the PCP you select cannot accept new patients without adversely affecting the availability or quality of services provided, you will need to select someone else.

Changing Your Health Team

Your Primary Care Provider is responsible for providing and arranging all your medical care. Having a continuous relationship with your Primary Care Provider allows you the best possible care. If you need to change your Primary Care Provider, please call your nearest Customer Service office listed on the back cover of this Guide or visit our website at www.hmsa.com, or write Customer Service at:

Customer Service Department
Health Plan Hawaii
P.O. Box 860
Honolulu, Hawaii 96808-0860

If the request is received between the 1st and the 5th of the month, you may choose either the first of the current month or the 1st of the following month as the effective date. If the requested change is between the 6th – 31st, the earliest effective date is the first of the following month. You will get a new member card indicating the name of your new Primary Care Provider.

HMSA will review your request to change to a different health center on a case-by-case basis. We may postpone your request if:

- You are an inpatient in a hospital, an extended care facility or other medical institution at the time of your request;
- The change could have an adverse affect on the quality of your healthcare;
- You are an organ transplant candidate; or
- You have an unstable, acute medical condition for which you are receiving active medical care.

When We Must Assign a New PCP

If your Primary Care Provider's agreement with HMSA ends, we will notify you of the need to select a new Primary Care Provider from your health center. If you do not make a selection, you will be assigned a new Primary Care Provider. Your access to care will not be interrupted during the transition period.

Referrals

The Referral Process

When your PCP determines that your condition requires the services of a specialist or facility, he or she will refer you to an appropriate specialty physician or facility.

The referral process is as follows:

- First, your PCP will look for a physician or facility within your designated health center to treat you.
- If a specialty physician or facility is not available within your health center, your PCP will refer you to a physician or facility within the Health Plan Hawaii network of providers.
- If a specialty physician or facility is not available within your Health Plan Hawaii network of providers, your PCP will refer you to an HMSA participating physician or facility.

When you go to a specialty physician's office or a facility, you should do both of the following:

- Present your member card.
- Inform the physician or nurse that you have been referred by your PCP.

In rare circumstances, your PCP may need to refer you to a nonparticipating or out-of-state physician or facility. This should happen only when:

- a nonparticipating or out-of-state facility required to treat your condition is not available within the Health Plan Hawaii network or HMSA participating providers, or
- you are diagnosed with a condition or disease requiring specialty care, and a specialist within the Health Plan Hawaii network or HMSA participating providers who can provide the health care services for your condition or disease is either not available or access to these providers require unreasonable travel or delay.

Your PCP must submit an administrative review request to HMSA for authorization prior to services being rendered by a nonparticipating or out-of-state physician or facility. If authorization is received and approved prior to you getting services, HMSA will make payment using the nonparticipating or out-of-state provider's actual charge as the eligible charge and you will be responsible for the copayment/ coinsurance amount(s).If authorization is not received prior to receiving these services, you are responsible for the cost of the medical services.

HMSA will respond to this request within a reasonable time appropriate to the medical circumstances of your case but not later than 15 days after receipt of the request. We may extend the time once for 15 days if we cannot respond to the request within the initial 15 days and it is due to circumstances beyond our control. If this happens, we will let your PCP know before the end of the initial 15 days why we are extending the time and the date we expect to render our decision. If we need more details, we will let your PCP know and provide him or her with at least 45 days to provide the information.

Authorization of Services

Benefits are available only for care you receive from or arranged by your PCP except for care for emergency services, annual vision exams, Online Care, breast pumps, covered immunizations, mental health and substance abuse services, and clinics located at pharmacies in Hawaii and approved by HMSA. To find a clinic near you go to www.hmsa.com. For more details on these services see *Chapter 4: Description of Benefits.*

You do not need prior authorization from us or from your PCP to obtain access to obstetrical or gynecological care from a health care professional in your health center who specializes in obstetrics or gynecology. Prior authorization may be required for certain services. For a list of participating health care professionals in your health center who specialize in obstetrics or gynecology, contact Customer Service. Our phone numbers are listed on the back cover of this Guide.

You may receive an annual gynecological exam from any Health Plan Hawaii participating gynecologist or nurse midwife without prior authorization from us or from your PCP.

If your PCP does not provide or arrange for your services, you are responsible for the cost of the medical services.

If the provider you are referred to asks you to return for more services, benefits are only available if both of the following are true:

- The provider you are referred to contacts your PCP; and
- Your PCP arranges for more services (that may include the submission of an administrative review to HMSA).

Referral Limitations

Benefits for referred care are limited to those covered services described in this Guide to Benefits. Should your provider recommend or perform services that are not covered or do not meet payment determination criteria, you are responsible for all charges related to the service. See the section *Questions We Ask When You Receive Care* later in this chapter.

Claim Filing and Copayments

Specialty physicians and facilities who provide care when you are referred by your PCP will forward all claims to us. We reserve the right to send benefit payments to you, to a provider, or if you have other coverage besides this plan, to the other carrier. You are responsible for your copayment. For a summary of your copayments, see *Chapter 3: Summary of Benefits and Your Payment Obligations*.

Referrals to Another Island

If your PCP refers you to a specialist on another island you may be eligible for inter-island transportation. Contact your PCP to make appropriate arrangements for your care. Your PCP will notify HMSA. Call your nearest HMSA office listed on the back cover of this Guide for more details.

Care While You are Away from Home

Medical Care Outside of Hawaii (BlueCard® Program)

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain healthcare services outside of Hawaii, the claims for those services may be processed through one of these Inter-Plan Arrangements.

When you receive Medical Care Outside of Hawaii, you will receive it from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. Our payment practices in both instances are described below.

We cover only limited medical services received outside your plan service area. As used in this section, "Medical Care Outside of Hawaii" includes emergency care and urgent care only (and specifically not follow-up care, routine care, and elective care) obtained outside the geographic area we serve. Any other services will not be covered as Medical Care Outside of Hawaii when processed through any Inter-Plan Arrangements, unless authorized by your PCP. This is described in more detail below.

- *For emergency and urgent care services outside of Hawaii*, benefits are available through the BlueCard program. You should follow these steps:
  - Carry your current member card for easy reference and access to service.
  - If you experience a Medical Emergency while traveling outside Hawaii, go to the nearest Emergency facility.
  - For urgent care, to find names and addresses of nearby providers, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard Access at 1-800-810-BLUE (2583). Call the provider to schedule an appointment.

When you arrive at the participating BlueCard provider, present your member card. You are responsible for paying the provider copayments for covered services. The provider will submit a claim for the services rendered.

Contact your PCP as soon as possible after receiving services so that he or she can update your file and assist/approve any added care you might require.

- *For non-emergency and non-urgent care services outside of Hawaii*, you must contact your PCP to make appropriate arrangements for your care.
- Your PCP must submit an administrative review request to HMSA for an authorization prior to services being rendered. If authorization is not received prior to you receiving these services, you are responsible for the cost of the medical services.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental benefits (except when paid as medical benefits), and those prescription drug benefits or vision benefits that may be administered by a third party contracted by us to provide the specific service or services.

BlueCard® Participating Providers

Under the BlueCard® Program, when you receive Medical Care Outside of Hawaii within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

The BlueCard Program enables you to obtain Medical Care Outside of Hawaii, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for Medical Care Outside of Hawaii provided to you, so there are no claim forms for you to fill out. You will be responsible for the copayment amount, as stated in *Chapter 1: Important Information; Chapter 3: Summary of Benefits and Your Payment Obligations,* and *Chapter 4: Description of Benefits.*

Emergency Care Services

If you experience a Medical Emergency while traveling outside of Hawaii, go to the nearest Emergency or Urgent Care facility.

Whenever you receive Medical Care Outside of Hawaii and the claim is processed through the BlueCard Program, the amount you pay for Medical Care Outside of Hawaii, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to HMSA.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, also take into account adjustments to correct for over – or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price HMSA uses for your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured/self-funded accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Medical Providers Outside Hawaii

When Medical Care Outside of Hawaii is provided by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered medical services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services, air ambulance, and certain non-emergent services provided by nonparticipating providers in participating facilities.

Exceptions

In certain situations, we may use other payment methods, such as billed covered charges we would make if the medical services had been obtained within our service area, or a special negotiated payment, to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for covered medical services as set forth in the Guide to Benefits.

Benefit payments for covered emergency services provided by nonparticipating providers are a "reasonable amount" as defined by federal law.

Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered medical services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services. If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global Core Service Center at 1-800-810-BLUE (1-800-810-2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your copayment amounts. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered medical services.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard Service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered medical services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered medical services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from HMSA, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (1-800-810-2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Care on Neighbor Islands

For trips to the Neighbor Islands, urgent care benefits are available by contacting the Customer Service office on the island you are visiting. Our phone numbers are listed on the back cover of this Guide. A customer service representative will arrange your appointment and advise you of your copayment responsibility. Benefits include one visit to a provider's office. Contact your PCP as soon as possible after receiving services so that he or she can update your file and provide or arrange any added care you might require.

Guest Membership Program

If you will be living away from your plan service area for longer than 90 days, benefits are available through the Guest Membership program within the U.S. You will need to prearrange care in the new service area through us. We will advise you of the HMO host plans that are available to you.

- For members who are away from home, Guest Membership privileges are available for up to 180 days. If your absence from Hawaii exceeds 180 days, you may renew your Guest Membership privileges for up to an additional six months.
- For dependents who are away from home, Guest Membership privileges must be renewed annually.

Process for Establishing Guest Membership

How to Enroll in the Guest Membership Program. To enroll in the Guest Membership Program, call the HPH Away from Home Care Coordinator before you leave your plan service area. For a list of phone numbers by island, see the back cover of this Guide. The coordinator will research if a HMO host plan is available in the area you will be visiting.

- If a provider is available, you will need to fill out an enrollment form. Enrollment information can be taken by phone or through the mail.
- Once the enrollment is completed, the HPH coordinator will forward the enrollment form to the Away from Home Care Coordinator in the service area you will be visiting.
- Once the HMO host plan processes your enrollment form, you will become a guest member of the HMO host plan while you are living in their service area. As a guest member, you are eligible for those benefits offered by the HMO host plan and must abide by the provisions of that plan. Your HPH plan benefits will not apply until you return to your HPH service area.
- When you arrive at your destination, call the Away from Home Care Coordinator of the HMO host plan. The coordinator will provide you with a list of Providers (from which you can select a PCP) and a description of the host plan's benefits.

Questions We Ask When You Receive Care

Is the Care Covered?

To get benefits, the care you get must be a covered treatment, service, or supply. See *Chapter 4: Description of Benefits* for a listing of covered treatments, services and supplies.

Does the Care Meet Payment Determination Criteria?

All care you get must meet all of the following Payment Determination Criteria:

- For the purpose of treating a medical condition.
- The most appropriate delivery or level of service, considering potential benefits and harms to the patient.
- Known to be effective in improving health outcomes; provided that:
  - Effectiveness is determined first by scientific evidence;
  - If no scientific evidence exists, then by professional standards of care; and
  - If no professional standards of care exists or if they exist but are outdated or contradictory, then by expert opinion; and
- Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

Services that are not known to be effective in improving health outcomes include, but are not limited to, services that are experimental or investigational.

Definitions of terms and more details on the application of this Payment Determination Criteria are contained in the Patient's Bill of Rights and Responsibilities, Hawaii Revised Statutes § 432E-1.4. The current language of this statutory provision will be provided upon request. Requests should be submitted to HMSA's Customer Service Department.

The fact that a physician may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets Payment Determination Criteria, even if it is listed as a covered service.

Except for BlueCard participating and BlueCard PPO providers, participating providers may not bill or collect charges for services or supplies that do not meet HMSA's Payment Determination Criteria unless a written acknowledgement of financial responsibility, specific to the service, is obtained from you or your legal representative prior to the time services are rendered.

Participating providers may, however, bill you for services or supplies that are excluded from coverage without getting a written acknowledgement of financial responsibility from you or your representative. See *Chapter 6: Services Not Covered*.

More than one procedure, service, or supply may be appropriate to diagnose and treat your condition. In that case, we reserve the right to approve only the least costly treatment, service, or supply.

You may ask your physician to contact us to decide if the services you need meet our Payment Determination Criteria or are excluded from coverage before you get the care.

Is the Care Consistent with HMSA's Medical Policies?

To be covered, the care you get must be consistent with the provider's scope of practice, state licensure requirements, and HMSA's medical policies. These are policies drafted by HMSA Medical Directors, many of whom are practicing physicians, with community physicians and nationally recognized authorities. Each policy provides detailed coverage criteria for when a specific service, drug, or supply meets payment determination criteria. If you have questions about the policies or would like a copy of a policy related to your care, please call us at one of the phone numbers on the back cover of this Guide.

Did You Receive Care from Your PCP?

Benefits are available only for care you receive from or arranged by your PCP except for care for emergency services, annual vision exams, Online Care, breast pumps, covered immunizations, mental health and substance abuse services, and clinics located at pharmacies in Hawaii and approved by HMSA. To find a clinic near you go to www.hmsa.com. For more details on these services see *Chapter 4: Description of Benefits*.

You do not need a referral from your PCP to obtain access to obstetrical or gynecological care from a health care professional in your health center who specializes in obstetrics or gynecology. You may receive an annual gynecological exam from any Health Plan Hawaii participating gynecologist or nurse midwife without a referral.

Is the Service or Supply Subject to a Benefit Maximum?

Benefit Maximum is the maximum benefit amount allowed for a covered service or supply. A coverage maximum may limit the duration or the number of visits. For details about benefit maximums, read *Chapter 2: Payment Information* and *Chapter 4: Description of Benefits.*

Is the Service or Supply Subject to Precertification?

Certain services require our prior approval. For services subject to approval, read *Chapter 5: Precertification.*

Did You Receive Care from a Provider Recognized by Us?

To determine if a provider is recognized, we look at many factors including licensure, professional history, and type of practice. All HPH network providers and some non-network providers are recognized. To find out if your provider is a network provider, refer to your Directory of Health Centers and Providers. If you need a copy, call us and we will send one to you or visit www.hmsa.com. To find out if a non-network provider is recognized, call us at one of the phone numbers on the back cover of this Guide.

Did a Recognized Provider Order the Care?

All covered treatment, services, and supplies must be ordered by a recognized provider practicing within the scope of his or her license.

Chapter 1: Important Information

What You Can do to Maintain Good Health

Practice Good Health Habits

Staying healthy is the best way to control your health care costs. Take care of yourself all year long. See your provider early. Don't let a minor health problem become a major one. Take advantage of your preventive care benefits.

Routine and Preventive Services

Detecting conditions early is important. That's why HMSA is committed to providing you with benefits for routine and preventive health services. Many serious disorders can be prevented by healthier lifestyles, immunizations, and early detection and treatment. Routine and preventive care should always be performed by your PCP. PCP means the provider you choose within your health center to act as your personal health care manager.

Be a Wise Consumer

You should make informed decisions about your health care. Be an active partner in your care. Talk with your provider and ask questions. Understand the treatment program and any risks, benefits, and options related to it.

Take time to read and understand your ***Report to Member***. This report shows how we applied benefits. Review your report and let us know if there are any inaccuracies.

You may get copies of your Report to Member online through My Account on hmsa.com or by mail upon request.

Interpreting this Guide

Agreement

The Agreement between HMSA and you is made up of all of the following:

- This Guide to Benefits.
- Any riders and/or amendments.
- The enrollment form submitted to us.
- The agreement between us and your employer or group sponsor.

Our Rights to Interpret this Document

We will interpret the provisions of the Agreement and will determine all questions that arise under it. We have the administrative discretion:

- To determine if you meet our written eligibility requirements.
- To determine the amount and type of benefits payable to you or your dependents according to the terms of this Agreement.
- To interpret the provisions of this Agreement as needed to determine benefits, including decisions on medical necessity.

Our determinations and interpretations, and our decisions on these matters are subject to *de novo* review by an impartial reviewer as provided in this Guide to Benefits or as allowed by law. If you do not agree with our interpretation or determination, you may appeal. See *Chapter 8: Dispute Resolution.*

No oral statement of any person shall modify or otherwise affect the benefits, limits and exclusions of this Guide to Benefits, convey or void any coverage, or increase or reduce any benefits under this Agreement.

CHAPTER 2

This Chapter Covers

Eligible Charge

Definition

For most medical services, except for emergency and air ambulance services provided by nonparticipating providers, and certain services provided by nonparticipating providers in participating facilities, the ***Eligible Charge*** is the lower of either the provider's *actual* charge or the amount we establish as the *maximum allowable fee*. HMSA's payment, and your copayment, are based on the eligible charge. Exception: For services from participating facilities, HMSA's payment is based on the maximum allowable fee and your copayment is based on the lower of the actual charge or the *maximum allowable fee*.

The base amount on which your copayment is calculated for emergency and air ambulance services from nonparticipating providers, as well as certain non-emergent services provided by nonparticipating providers in participating facilities, is calculated in accord with federal law.

Exception: For nonparticipating services included in the No Surprises Act of 2021 you will not have to pay the difference between the actual charge and the *maximum allowable fee*, but your cost-share may be different based on the requirements of the law. Please check HMSA.com for details.

Please note: If you get a noncovered service, you are responsible for the entire amount charged by your provider.

Copayment

Definition

A *copayment* applies to most covered services. It is either a fixed percentage of the eligible charge or a fixed dollar amount. Exception: For services provided at a participating facility, your copayment is based on the lower of the facility's actual charge or the *maximum allowable fee*. You owe a copayment even if the facility's actual charge is less than the *maximum allowable fee*.

Except as otherwise stated in this Guide:

- When you get multiple services from the same provider on the same day, you owe one fixed dollar copayment if fixed dollar copayments are applicable to the services you get. However, if the eligible charge for the service or supply you receive is less than the fixed dollar copayment amount listed in chapter 3, your actual copayment is the eligible charge and you may owe more than one copayment. The total copayment amount will not exceed the fixed dollar copayment amount listed in chapter 3 for the service or supply you receive.
- You owe all copayments that are a percentage of eligible charge if eligible charge percentage copayments are applicable to the services you get.

• If you get some services with fixed dollar copayments and some with copayments that are a percentage of eligible charge, you owe one fixed dollar copayment and all copayments based on a percentage of eligible charge. For services with fixed dollar copayments, if the eligible charge for such services is less than the fixed dollar copayment amount listed in chapter 3, your actual copayment is the eligible charge and you may owe more than one copayment. However, your copayment amount will not exceed the fixed dollar copayment amount listed in chapter 3 for the service or supply you receive.

If you get services from more than one provider on the same day, more than one copayment may apply.

Amount

See *Chapter 3: Summary of Benefits and Your Payment Obligations.*

Annual Copayment Maximum

Definition

The ***Annual Copayment Maximum*** is the maximum copayment amounts you pay in a calendar year. Once you meet the copayment maximum you are no longer responsible for copayment amounts unless otherwise noted.

Amount

$2,500 per person or

$7,500 (maximum) per family

When You Pay More

The following amounts do not apply toward meeting the copayment maximum. You are responsible for these amounts even after you have met the copayment maximum.

• Payments for services subject to a maximum once you reach the maximum. See *Benefit Maximum* later in this chapter.
• Payments for noncovered services.
• Any amounts you owe in addition to your copayment for covered services.

Maximum Allowable Fee

Definition

The ***Maximum Allowable Fee*** is the maximum dollar amount HMSA will pay for a covered service, supply, or treatment.

These are examples of some of the methods we use to determine the Maximum Allowable Fee:

• For most services, supplies, or procedures, we consider:
  – Increases in the cost of medical and non-medical services in Hawaii over the last year.
  – The relative difficulty of the service compared to other services.
  – Changes in technology.
  – Payment for the service under federal, state, and other private insurance programs.
• For *some facility-billed services*, we use a per case, per treatment, or per day fee (per diem) rather than an itemized amount (fee for service). This does not include practitioner-billed facility services. For non-network hospitals, our maximum allowable fee for all-inclusive daily rates established by the hospital will never exceed more than if the hospital had charged separately for services.
• For *services billed by BlueCard PPO and participating providers outside of Hawaii*, we use the lower of the provider's actual charge or the negotiated price passed on to us by the on-site Blue Cross and/or Blue Shield Plan. For more details on HMSA's payment practices under the BlueCard Program, see *Care While You are Away from Home* in *Chapter 1: Important Information.*
• For *drugs and supplies*, we use nationally recognized pricing sources and other relevant information. The allowable fee includes a dispensing fee. Any discounts or rebates that we get will not reduce the charges that your copayments are based on. We apply discounts and rebates to reduce drugs and supplies coverage rates.

Benefit Maximum

Definition

A ***Benefit Maximum*** is a limit that applies to a specified covered service or supply. A service or supply may be limited by duration or number of visits. The maximum may apply per service or calendar year.

Where to Look for Limitations

See *Chapter 4: Description of Benefits.*

CHAPTER 3

This Chapter Covers

Benefit and Payment Chart

About this Chart

This benefit and payment chart:

- Is a summary of covered services and supplies. **It is not a complete description of benefits. For coverage criteria, other limitations of covered services, and excluded services, be sure to read *Chapter 1: Important Information, Chapter 4: Description of Benefits,* and *Chapter 6: Services Not Covered.***
- Gives you the page number where you can find more details about the service or supply.
- Tells you what the copayment percentage or fixed dollar amount is for covered services and supplies.

***Please note*:** Special limits may apply to a service or supply listed in this benefit and payment chart. Please read the benefit details on the page referenced.

Remember, benefits are available only for care you receive from or arranged by your PCP except for care for emergency services, annual vision exams, Online Care, breast pumps, covered immunizations, mental health and substance abuse services, and clinics located at pharmacies in Hawaii and approved by HMSA. To find a clinic near you go to www.hmsa.com. For more details on these services see *Chapter 4: Description of Benefits*.

You do not need a referral from your PCP to obtain access to obstetrical or gynecological care from a health care professional in your health center who specializes in obstetrics or gynecology. You may receive an annual gynecological exam from any Health Plan Hawaii participating gynecologist or nurse midwife without a referral.

Chapter 3: Summary of Benefits and Your Payment Obligations

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
Routine and Preventive		
Annual Preventive Health Evaluation (preventive visit)	26	None
Diabetes Prevention Program	26	None when received from a provider that meets the requirements of the Diabetes Prevention Program as described in *Chapter 4: Description of Benefits* under *Special Benefits – Routine and Preventive*
Disease Management and Preventive Services Programs	26	None
Preventive Health Services	26	None
Prostate Specific Antigen (PSA) Screening Test	27	None
Vision Exam	27	$20
Well-Being Services	27	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.
Well-Child Care (through age twenty-one)	27	None
Online Care		
Online Care	28	None
Telehealth		
Telehealth	28	Your copayment amounts vary depending on the type of services or supply you receive. See copayment amounts listed in this chart for the service or supply you receive.
Physician Visits		
Away from Home Care	28	$20 for out of network urgent care in Hawaii $20 for urgent care from a BlueCard provider outside Hawaii Host plan copayments apply for services from BlueCard providers outside Hawaii if you are enrolled in the Guest Membership Program Please see *Chapter 1: Important Information* under *Care While You are Away From Home* for more information
Emergency Room	28	None
Extended Care Facility	29	10% of eligible charge
Home	29	$20
Inpatient Hospital	29	10% of eligible charge
Office	29	$20
Outpatient Hospital	29	$20
Surgical Center	29	$20

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
Testing, Laboratory and Radiology		
Allergy Testing	29	10% of eligible charge (office visit) 10% of eligible charge (hospital outpatient) 10% of eligible charge (hospital inpatient)
Diagnostic Testing	29	20% of eligible charge (office visit) 20% of eligible charge (hospital outpatient) 10% of eligible charge (hospital inpatient)
Evaluations for the Use of Hearing Aids	29	$20 (office visit)
Genetic Testing and Counseling	29	20% of eligible charge (office visit) 20% of eligible charge (hospital outpatient) 10% of eligible charge (hospital inpatient)
Laboratory and Pathology	29	$10 (office visit) $10 (hospital outpatient) 10% of eligible charge (hospital inpatient)
Radiology - General	29	$10 (office visit) $10 (hospital outpatient) 10% of eligible charge (hospital inpatient)
Radiology - Other	30	20% of eligible charge (outpatient) 10% of eligible charge (inpatient)
Surgery		
Anesthesia	30	$20 (outpatient professional charges) 10% of eligible charge (inpatient professional charges)
Assistant Surgeon Services	30	$20 (outpatient professional charges) 10% of eligible charge (inpatient professional charges)
Bariatric Surgery	30	$20 (outpatient professional charges) 10% of eligible charge (inpatient professional charges)
Oral Surgery	30	$20 (outpatient professional charges) 10% of eligible charge (inpatient professional charges)
Surgical Procedures	31	10% of eligible charge (outpatient surgical center) $20 (outpatient professional charges) 10% of eligible charge (hospital operating room) 10% of eligible charge (inpatient professional charges)
Tubal Ligation	31	None (outpatient professional charges) None (inpatient professional charges)
Maternity		
Artificial Insemination	31	$20
In Vitro Fertilization	31	20% of eligible charge
Maternity Care – Routine Prenatal Visits, Delivery and One Postpartum Visit	32	10% of eligible charge
Pregnancy Termination	32	$20 (outpatient) 10% of eligible charge (inpatient)

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
Hospital and Facility Services		
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	32	10% of eligible charge
Hospital Ancillary Services	32	10% of eligible charge
Hospital Room and Board	33	10% of eligible charge (You may owe amounts in addition to your copayment. Please see *Chapter 4: Description of Benefits* under *Hospital and Facility Services – Hospital Room and Board* for more information.)
Outpatient Facility	33	10% of eligible charge
Private Duty Nursing	33	50% of eligible charge
Emergency Services		
Emergency Room Facility Services	33	$100
Rehabilitation Therapy Services		
Dr. Ornish's Program for Reversing Heart Disease (TM)	35	$20 when received from a provider that meets the requirements of the Dr. Ornish Program described in *Chapter 4: Description of Benefits* under *Rehabilitation Therapy Services*.
Physical and Occupational Therapy	35	$20 (office visit) $20 (hospital outpatient) 10% of eligible charge (hospital inpatient)
Pulmonary Rehabilitation	36	$20 (outpatient) 10% of eligible charge (inpatient)
Speech Therapy Services	36	$20 (outpatient) 10% of eligible charge (inpatient)
Home Health Care and Hospice		
Home Health Care	36	None
Hospice Services	37	None
Supportive Care	37	None
Chemotherapy and Radiation Therapy		
Chemotherapy – Infusion/Injections	37	10% of eligible charge (outpatient) 10% of eligible charge (hospital inpatient)
Radiation Therapy	37	20% of eligible charge (outpatient) 10% of eligible charge (inpatient)
Miscellaneous Medical Treatments		
Advance Care Planning	38	None
Ambulance (air)	38	20% of eligible charge
Ambulance (ground)	38	20% of eligible charge

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
Blood and Blood Products	38	None
Breast Pump	38	None
Contraceptive IUD	39	None
Contraceptive Implants	39	None
Contraceptive Injectables	39	None
Dialysis and Supplies	39	10% of eligible charge (hospital outpatient) 10% of eligible charge (hospital inpatient)
Durable Medical Equipment and Supplies	39	20% of eligible charge
Gender Identity Services	39	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.
Growth Hormone Therapy	40	10% of eligible charge (office visit) 10% of eligible charge (hospital outpatient) 10% of eligible charge (hospital inpatient)
Implanted Internal Items/Implants – Outpatient	40	None
Inhalation Therapy	40	$20 (office visit) $20 (hospital outpatient) 10% of eligible charge (hospital inpatient)
Injections – Other than Self-Administered	40	10% of eligible charge (office visit) 10% of eligible charge (hospital outpatient) 10% of eligible charge (hospital inpatient)
Injections – Self Administered	40	None
Medical Foods	40	20% of eligible charge
Medical Nutrition Therapy	40	None
Orthodontic Services to Treat Orofacial Anomalies	41	None (You may owe amounts in addition to your copayment. Please see *Chapter 4: Description of Benefits* under *Miscellaneous Medical Treatments – Orthodontic Services to Treat Orofacial Anomalies* for more information.)
Orthotics and External Prosthetics	41	20% of eligible charge
Outpatient IV Therapy	41	None
Vision and Hearing Appliances	41	20% of eligible charge
Behavioral Health – Mental Health and Substance Abuse		
Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us	42	None

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
Hospital/Facility Charges	42	None (hospital outpatient) 10% of eligible charge (hospital inpatient) (You may owe amounts in addition to your copayment. Please see *Chapter 4: Description of Benefits* under *Behavioral Health – Mental Health and Substance Abuse* for more information.)
Physician Visits	42	$20 (office visit) $20 (hospital outpatient) 10% of eligible charge (hospital inpatient)
Psychological Testing	42	None (office visit) None (hospital outpatient) 10% of eligible charge (hospital inpatient)
Organ and Tissue Transplants		
Organ and Tissue Transplants	43	$20 (office visit) 10% of eligible charge (outpatient surgical center) $20 (outpatient professional charges) 10% of eligible charge (hospital operating room) 10% of eligible charge (inpatient professional charges)
Organ Donations	44	$20 (office visit) 10% of eligible charge (outpatient surgical center) $20 (outpatient professional charges) 10% of eligible charge (hospital operating room) 10% of eligible charge (inpatient professional charges)
Case Management Services		
Case Management Services	44	Your copayment amounts vary depending on the type of service. See copayment amounts listed in this chart for the service you receive.

Drugs and Supplies

Copayments for ***Drugs and Supplies*** are listed below. This plan covers drugs and supplies only when approved by the FDA, prescribed by your Provider, and if you do not have an HMSA drug plan or your drug plan does not cover the drugs listed in the chart below. See *Chapter 4: Description of Benefits* for more details.

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
Autism Spectrum Disorders Drugs		***If you have an HMSA drug plan with benefits for drugs to treat autism spectrum disorders, the HMSA drug plan benefits will apply and not the benefits of this plan.***
Autism Spectrum Disorders Drugs	44	**Network Pharmacy** None for Generic drugs None for Preferred Formulary drugs None for Non-Preferred Formulary drugs **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 100% of the eligible charge **Contracted Mail Order Pharmacy** None for Generic drugs None for Preferred Formulary drugs None for Non-Preferred Formulary drugs
Chemotherapy – Oral Drugs		***If you have an HMSA drug plan with benefits for oral chemotherapy drugs, the HMSA drug plan benefits will apply and not the benefits of this plan.***
Chemotherapy – Oral	44	**Network Pharmacy** None **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 100% of the eligible charge **Contracted Mail Order Pharmacy** None
Contraceptives		***If you have an HMSA drug plan with benefits for contraceptives, the HMSA drug plan benefits will apply and not the benefits of this plan.***
Contraceptive Diaphragms/Cervical Caps	44	**Network Pharmacy** None **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 50% of the eligible charge **Contracted Mail Order Pharmacy** None
Contraceptives Oral	44	***If you have an HMSA drug plan with benefits for oral contraceptives, the HMSA drug plan benefits will apply and not the benefits of this plan.*** **Network Pharmacy** None for Generic drugs 50% of eligible charge for Preferred Formulary drugs 50% of eligible charge for Non-Preferred Formulary drugs

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
		Non-Network Pharmacy You owe the entire charge and HMSA reimburses you 50% of the eligible charge **Contracted Mail Order Pharmacy** None for Generic drugs 50% of eligible charge for Preferred Formulary drugs 50% of eligible charge for Non-Preferred Formulary drugs
Contraceptives - Other Methods	44	***If you have an HMSA drug plan with benefits for other contraceptive methods, the HMSA drug plan benefits will apply and not the benefits of this plan.*** **Network Pharmacy** None for Generic drugs 50% of eligible charge for Preferred Formulary drugs 50% of eligible charge for Non-Preferred Formulary drugs **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 50% of the eligible charge **Contracted Mail Order Pharmacy** None for Generic drugs 50% of eligible charge for Preferred Formulary drugs 50% of eligible charge for Non-Preferred Formulary drugs
Contraceptives - Over-The-Counter	44	***If you have an HMSA drug plan with benefits for over-the-counter contraceptives, the HMSA drug plan benefits will apply and not the benefits of this plan.*** **Network Pharmacy** None **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 50% of the eligible charge **Contracted Mail Order Pharmacy** None
Diabetic Drugs, Supplies, and Insulin		***If you have an HMSA drug plan with benefits for diabetic drugs, supplies, and insulin, the HMSA drug plan benefits will apply and not the benefits of this plan.***
Diabetic Drugs	44	**Network Pharmacy** 20% of eligible charge for Generic drugs 20% of eligible charge for Preferred Formulary drugs 30% of eligible charge for Non-Preferred Formulary drugs **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 100% of the remaining eligible charge after deducting: 20% of eligible charge for Generic drugs 20% of eligible charge for Preferred Formulary drugs 30% of eligible charge for Non-Preferred Formulary drugs

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
		Contracted Mail Order Pharmacy 20% of eligible charge for Generic drugs 20% of eligible charge for Preferred Formulary drugs 30% of eligible charge for Non-Preferred Formulary drugs
Diabetic Supplies	44	**Network Pharmacy** 50% of eligible charge **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 50% of the eligible charge **Contracted Mail Order Pharmacy** 50% of eligible charge
Insulin	44	**Network Pharmacy** 20% of eligible charge for Generic drugs 20% of eligible charge for Preferred Formulary drugs 30% of eligible charge for Non-Preferred Formulary drugs **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 100% of the remaining eligible charge after deducting: 20% of eligible charge for Generic drugs 20% of eligible charge for Preferred Formulary drugs 30% of eligible charge for Non-Preferred Formulary drugs **Contracted Mail Order Pharmacy** 20% of eligible charge for Generic drugs 20% of eligible charge for Preferred Formulary drugs 30% of eligible charge for Non-Preferred Formulary drugs
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs		***If you have an HMSA drug plan with benefits for U.S. Preventive Services Task Force recommended drugs, the HMSA drug plan benefits will apply and not the benefits of this plan.***
USPSTF Recommended Drugs	44	**Network Pharmacy** None **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 80% of the eligible charge **Contracted Mail Order Pharmacy** None

CHAPTER 4

This Chapter Covers

Chapter 4: Description of Benefits describes covered services. Benefits are available only for care you receive from or arranged by your PCP except for care for emergency services, annual vision exams, Online Care, breast pumps, covered immunizations, mental health and substance abuse services, and clinics located at pharmacies in Hawaii and approved by HMSA. To find a clinic near you go to www.hmsa.com. You do not need a referral from your PCP to obtain access to obstetrical or gynecological care from a health care professional in your health center who specializes in obstetrics or gynecology. You may get an annual gynecological exam from any Health Plan Hawaii participating gynecologist or nurse midwife without a referral. For more details on these exceptions, refer to the benefit descriptions for each of these services in this chapter. Be sure to read *Chapter 1: Important Information*. All information within *Chapter 1: Important Information* applies to accessing the services described in this chapter. This chapter is divided into the following categories:

Be Sure to Also Read:
- Chapter 1: Important Information
- Chapter 3: Summary of Benefits and Your Payment Obligations

About this Chapter

Your health care coverage provides benefits for procedures, services or supplies that are listed in this chapter. You will note that some of the benefits have limitations. These limitations describe criteria, circumstances or conditions that are necessary for a procedure, service or supply to be a covered benefit. These limitations may also describe circumstances or conditions when a procedure, service or supply is not a covered benefit. These limitations and benefits should be read with *Chapter 6: Services Not Covered,* in order to identify all items excluded from coverage.

Additional Coverage Mandated by Law

As may be required by law, including without limitation in response to State and/or Federal emergency declarations, this plan may provide expanded benefits and coverage policies not described in this Guide. Up-to-date information related to such circumstances, including emergency declarations, will be posted on our website at www.hmsa.com.

Continuity of Care

You may be eligible for continuity of care if you are a continuing care patient receiving a course of treatment from a Health Plan Hawaii Network provider and one of the following occurs:

- the contractual relationship between the Health Plan Hawaii Network provider and HMSA is terminated;
- benefits provided under your plan with respect to the Health Plan Hawaii Network provider are terminated because of a change in the terms of the participation of such Health Plan Hawaii Network provider in such plan; or
- you are under a group health plan and the contract between such group health plan and HMSA is terminated.

With respect to the above occurrences, the term "terminated" does not include a termination of a contract for failure to meet applicable quality standards or for fraud.

For more details, see *Chapter 10: General Provisions, Continuity of Care*.

Non-Assignment of Benefits

Benefits for covered services described in this Guide cannot be transferred or assigned to anyone. Any attempt to assign this coverage or rights to payment will be void.

Routine and Preventive

Annual Preventive Health Evaluation (preventive visit)

Covered, for one annual preventive health evaluation for members who are 22 and older when received from their primary care provider, including an assessment of any other preventive screenings you might need. See *Preventive Health Services* for other screenings covered by this plan.

Please note: Similar services for members under age 22 are covered as set forth in other sections of this chapter. See *Well-Child Care.*

Diabetes Prevention Program

The Diabetes Prevention Program is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Covered in accord with HMSA's Diabetes Prevention Program policy available at www.hmsa.com.

For more information on the program and how to find a provider, please visit our Diabetes Prevention Program page at https://hmsa.com/well-being/diabetes-prevention/.

Please note: Coverage is limited to one program per lifetime. If you receive benefits for this program under an HMSA plan, you will not be eligible for benefits for the program under any other HMSA plan.

Disease Management and Preventive Services Programs

Covered, for programs available through HMSA's Health and Well-Being services for members with:

- asthma,
- diabetes,
- cardiovascular disease,
- chronic obstructive pulmonary disease (COPD),
- behavioral health conditions (mental health and substance abuse), and
- normal and at-risk pregnancies.

The programs offer services to help you and your physician manage your care and make informed health choices.

You may be automatically enrolled in some of these programs or referred by your physician. HMSA reserves the right to, at any time, add other programs or to end programs. Call your nearest HMSA office listed on the back cover of this Guide for more details.

Preventive Health Services

Covered in accord with HMSA's medical policy for preventive health. Preventive health services include, but are not limited to the following recommendations or guidelines:

- Screenings and counseling services with a grade A or B recommendations by the U.S. Preventive Services Task Force (USPSTF).

• Bright Futures Recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA).
• Preventive care and screening for women supported by HRSA guidelines.
• Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices (ACIP).

Please note: USPSTF, HRSA, and ACIP recommendations may change. If you need more details about these recommended screenings, including a current list of recommendations please visit our website at www.hmsa.com or call us at one of the phone numbers listed on the back of this Guide.

Coverage may include (but is not limited to):
• Periodic evaluations such as well-woman visits
• Immunizations
• Cancer screenings such as mammograms, pap smears or colonoscopy
• Preventive counseling and screening for diabetes or depression
• Screening for HIV, syphilis, gonorrhea and chlamydia

Covered for the following screenings:
• anemia and lead screening for children
• colorectal cancer screening
• fecal occult blood test
• lipid evaluation
• newborn metabolic screening
• cervical cancer screening
• osteoporosis screening
• diabetes screening.

***Please note*:** Certain services must have precertification. See *Chapter 5: Precertification.*

Prostate Specific Antigen (PSA) Screening Test

Covered. For diagnostic PSA tests, see later in this chapter under *Testing, Laboratory, and Radiology*.

Vision Exam

Covered. Your HMO medical plan provides benefits for one routine vision exam per calendar year. A referral from your PCP is not necessary. You may get services from any provider who participates in the HMO vision network. However, follow-up care or care unrelated to the routine vision exam must be received from or arranged by your PCP.

Your plan does not provide benefits for vision exams by non-network vision providers. Copies of the HMO Vision Network directory are available by contacting Customer Service. Our phone numbers are listed on the back cover of this Guide.

Well-Being Services

HMSA offers a variety of well-being tools, programs and services to take care of you and your family. Visit hmsa.com/wellbeing to find the latest benefits available to our members.

Well-Child Care (through age twenty-one)

Covered. Well-Child Care means routine and preventive care for children through age twenty-one. Well-Child Care includes:
• office visits for history,
• physical exams,
• sensory screenings,
• developmental/behavioral assessments,
• anticipatory guidance,
• laboratory tests, and
• immunizations as identified on the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care and in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP).

Online Care

Online Care

Covered, when provided by HMSA Online Care at www.hmsa.com. You must be at least 18 years old. A member who is a dependent minor is covered when accompanied by an adult member. Initial base conversations as well as conversation extensions are covered for all provider types available on HMSA Online Care.

Please note: Sessions and eligibility are subject to the Online Care Consumer User Agreement.

Telehealth

Telehealth

Covered, in accord with Hawaii law and HMSA's medical policy for "Telehealth Services" which can be found at www.hmsa.com. Telehealth is the use of telecommunications services to transmit medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis when the parties are separated by distance. Telecommunications services, include:

- Store and forward technologies.
- Remote monitoring.
- Live consultation.
- Mobile health.

In addition, services provided via telecommunications must be otherwise covered and not excluded by this plan. Your benefit will vary depending on the type of service you receive through telehealth. For instance, if you receive a physician visit through telehealth, the physician visit benefit will apply. See copayment amounts for the service you receive through telehealth in *Chapter 3: Summary of Benefits and Your Payment Obligations*.

"Telecommunications" is defined as the integrated electronic transfer of medical data, including but not limited to real time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange.

Standard phone contacts, facsimile transmissions, or email texts, in combination or by itself, are not covered.

Physician Visits

Away from Home Care

Covered, for physician visits while you are away from home according to the Away From Home Care Program. Guidelines are explained in *Chapter 1: Important Information* in the section *Care While You are Away from Home*.

Emergency Room - Physician Visits

Covered, but only to stabilize a medical condition which is accompanied by acute symptoms of sufficient severity (including severe pain) that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

- Serious risk to the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child).
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Examples of an emergency include:

- chest pain or other heart attack signs,
- poisoning,
- loss of consciousness,
- convulsions or seizures,
- broken back or neck,
- heavy bleeding,
- sudden weakness on one side,
- severe pain,
- breathing problems,
- drug overdose,

	• severe allergic reaction, • severe burns, and • broken bones. Examples of non-emergencies are: • colds, • flu, • earaches, • sore throats, and • using the emergency room for your convenience or during normal physician office hours for medical conditions that can be treated in a physician's office. If you need emergency services, call 911 or go to the nearest emergency room for care. Pre-authorization or a referral from your PCP is not needed. ***Please note:*** If you are admitted to the hospital as an inpatient after a visit to the emergency room, hospital inpatient benefits apply and not emergency services benefits.
Extended Care Facility Physician Visits	Covered, when you are in an extended care facility, including physician consultations and visits by a specialty physician.
Home Physician Visits	Covered, including physician consultations and visits by a specialty physician.
Inpatient Hospital Physician Visits	Covered, when you are inpatient at a hospital including physician consultations and visits by a specialty physician. Newborn care is covered in accord with the time periods specified later in the chapter under *Maternity and Newborn Length of Stay*.
Office Physician Visits	Covered, at a physician's office including physician consultations and visits by a specialty physician. ***Please note:*** A copayment will not be applied to outpatient miscarriage services.
Outpatient Hospital Physician Visits	Covered, when you are outpatient at a hospital including physician consultations and visits by a specialty physician.
Surgical Center Physician Visits	Covered, when you are in a surgical center, including physician consultations and visits by a specialty physician.

Testing, Laboratory, and Radiology

Allergy Testing	Covered.
Diagnostic Testing	Covered, for tests to diagnose an illness or injury. Some examples of diagnostic testing include: • Electroencephalograms (EEG). • Electrocardiograms (EKG or ECG).
Evaluations for the Use of Hearing Aids	Covered.
Genetic Testing and Counseling	Covered, but only if you meet HMSA's criteria. Call us for more details. Our phone number is listed on the back cover of this Guide. ***Please note*:** Certain services must have precertification. See *Chapter 5: Precertification.* Other services identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations are described under *Routine and Preventive.*
Laboratory Tests	Covered. Some examples of lab tests include: • Urinalysis • Blood tests • Throat cultures
Radiology - General	Covered. Some examples of general radiology include: • Diagnostic mammography.

• X-rays.

Please note: Some radiological procedures must have precertification. See *Chapter 5: Precertification.*

Radiology - Other

Covered. Some examples of other radiology include:
- Computerized Tomography Scan (CT Scan).
- Interventional radiology.
- MRI.
- Nuclear Medicine.
- Ultrasound.

Please note: Some radiological procedures must have precertification. See *Chapter 5: Precertification.*

Surgery

Certain surgical procedures must have precertification from HMSA. See *Chapter 5: Precertification*.

Anesthesia

Covered, as required by the attending provider and when appropriate for your condition. Services include:
- General anesthesia.
- Regional anesthesia.
- Monitored anesthesia when you meet HMSA's high-risk criteria.

Please note: Anesthesia for dental services are covered in accord with HMSA's medical policy on "Deep Sedation and General Anesthesia for Dental Services" which can be found at www.hmsa.com. The medical policy provides detailed coverage criteria for when services meet HMSA's payment determination criteria.

Assistant Surgeon Services

Covered, when:
- The complexity of the surgery requires an assistant; and
- The facility does not have a resident or training program; or
- The facility has a resident or training program, but a resident or intern on staff is not available to assist the surgeon.

Bariatric Surgery

Covered, but only if you meet HMSA's criteria and when:
- The facility is located in the state of Hawaii, has a contract with HMSA to perform bariatric surgery and has a comprehensive weight management program; or
- The facility is an approved Blue Distinction Center for bariatric surgery with an agreement for continuity of care in the state where the member primarily resides.

Oral Surgery

Covered, but only when the dentist performs surgery that could be performed by a physician or a dentist. Coverage is limited to:
- the removal of tumors and cysts;
- surgery to correct injuries;
- cutting and draining of cellulitis;
- cutting of sinuses, salivary glands, or ducts;
- reduction of dislocations and removal of jawbone joint; and
- major oral surgery for augmentation (building up) of the gum ridge.

Reconstructive Surgery

Covered, but only for corrective surgery required to restore, reconstruct, or correct:
- Any bodily function that was lost, impaired, or damaged as a result of an illness or injury.
- Developmental abnormalities when present from birth and that severely impair or impede normal, essential bodily functions.
- The breast on which a mastectomy was performed, and surgery for the reconstruction of the other breast to produce a symmetrical appearance (including prostheses). Treatment for complications of mastectomy and reconstruction, including lymphedema, is also covered.

Complications of a non-covered cosmetic reconstructive surgery are not covered, except treatment rendered by a Health Plan Hawaii Network physician for complications resulting from non-covered cosmetic services performed by a Health Plan Hawaii group plan.

Please note: Certain services require precertification. See *Chapter 5: Precertification.*

Surgical Procedures — Covered, for surgery including pre-and post-operative care.

Tubal Ligation — Covered, for surgery for a tubal ligation. Reversal of a tubal ligation is not covered.

Maternity

Artificial Insemination — Covered.

Coverage for other related services such as office visits, labs, and radiology are described in other sections of this Guide.

In Vitro Fertilization — Covered, when provided or arranged by your PCP. While you are enrolled or have been enrolled with HMSA (in either a group or individual plan), coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure ("IVF Benefit") per:

- HMO product (e.g., Health Plan Hawaii) or
- PPO product (e.g., Preferred Provider Plan/Comprehensive Medical Plan).

If you have exhausted the above benefits under prior coverage with HMSA, you will be entitled to a one-time additional single IVF Benefit under your group plan, but only if you did not ever receive an IVF Benefit under an HMSA plan with that group.

In vitro fertilization services are not covered when a surrogate is used. The in vitro procedures must be performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine's minimal standards for programs of in vitro fertilization.

If you have a male partner, you must meet all of the following criteria:

- You and your male partner have a five-year history of infertility or infertility is related to one or more of the following medical conditions:
  - Endometriosis;
  - Exposure in utero to diethylstilbestrol (DES);
  - Blockage or surgical removal of one or both fallopian tubes; or
  - Abnormal male factors contributing to the infertility.
- You and your male partner have been unable to attain a successful pregnancy through other covered infertility treatments.

If you do not have a male partner, you must meet the following criteria:

- You are not known to be otherwise infertile, and
- You have failed to achieve pregnancy following three cycles of physician directed, appropriately timed intrauterine insemination.

Please note: These services must have precertification. See *Chapter 5: Precertification*.

Please note: In vitro fertilization not provided or approved by your PCP is not a covered benefit and you are responsible for payment. In vitro fertilization services include those services constituting the complete in vitro fertilization and embryo transfer process. Benefits for services in connection with, but not included in the complete in vitro fertilization process, are covered elsewhere in this Guide.

***Please note*:** Exclusions or limitations that may relate to this benefit are described in *Chapter 6: Services Not Covered* in the section labeled *Fertility and Infertility*.

Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit

Covered, for:
- routine prenatal visits,
- delivery, and
- one postpartum visit.

Coverage for other maternity related services such as nursery care, labor room, hospital room and board, pregnancy termination, diagnostic tests, labs, and radiology are described in other sections of this Guide.

Maternity and Newborn Length of Stay

You have inpatient benefits for maternity as follows:
- 48 hours from time of delivery for a vaginal labor and delivery; or
- 96 hours from time of delivery for a cesarean labor and delivery.

All newborns are covered for services described earlier in this chapter for the first 48 or 96 hours. For a description of covered services see *Hospital Room and Board – Newborn Nursery Care* and *Physician Visits*. Newborns are covered after the first 48 or 96 hours if added to your coverage within 31 days of birth.

Newborns with congenital defects and birth abnormalities are covered for the first 31 days of birth even if not added to your coverage. These newborns are covered after 31 days of birth only if added to your coverage within 31 days of birth. See *Chapter 10: General Provisions* under *Eligibility for Coverage*.

Pregnancy Termination

Covered.

Hospital and Facility Services

Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)

Covered in accord with HMSA's medical policies. Information on our policies can be found at www.hmsa.com.

Room and board is covered, but only for semi-private rooms when all of the following are true:
- You are admitted by your PCP.
- Care is ordered and certified by your PCP.
- Care is for skilled nursing care, sub-acute care, or long-term acute care rendered in an extended care facility.
- Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care.
- The confinement is not for custodial care.

Benefit Limitation: Coverage for extended care facilities is limited to 120 days per calendar year.

Services and supplies are covered, including:
- routine surgical supplies,
- drugs,
- dressings,
- oxygen,
- antibiotics,
- blood transfusion services, and
- diagnostic and therapy services.

Please note: Services from out-of-state providers and from nonparticipating providers must have precertification. See *Chapter 5: Precertification.*

Hospital Ancillary Services

Covered. Examples of ancillary services include:
- anesthesia,
- antibiotics and other drugs chemotherapy and radiation therapy,
- hemodialysis,
- lab tests,
- oxygen,
- surgical supplies and
- X-rays.

Please note: Anesthesia for dental services are covered in accord with HMSA's medical policy on "Deep Sedation and General Anesthesia for Dental Services" which can be found at www.hmsa.com. The medical policy provides detailed coverage criteria for when services meet HMSA's payment determination criteria.

Hospital Room and Board

Covered. Your plan may include a copayment for hospital rooms. See *Chapter 3: Summary of Benefits and Your Payment Obligations*, under *Hospital and Facility Services*, to find out if you owe a copayment under this plan. Also, you may owe the difference between HMSA's payment and the hospital charge. See below for more information.

- Semi-Private Rooms. Your copayment (if any) is based on the facility's medical/surgical semi-private room rate.
- Private Rooms.
  - At Network Facilities:
    - If you are hospitalized in a network facility with private rooms only, your copayment (if any) is based on HMSA's maximum allowable fee for semi-private rooms.
    - If you are hospitalized in a network facility with semi-private and private rooms or a BlueCard facility, your copayment (if any) is based on the facility's medical/surgical semi-private room rate. Also, you owe the difference between the facility's charges for private and semi-private rooms. ***Exception:*** If you are hospitalized for conditions identified by HMSA as conditions that require a private room, your copayment (if any) is based on the facility's medical/surgical private room rate. You may call HMSA for a list of these conditions.
  - At Non-network Facilities:
    - If you are hospitalized in a non-network facility, your copayment (if any) is based on the facility's medical/surgical semi-private room rate. Also, you owe the difference between the facility's charges for private and semi-private rooms. ***Exception:*** If you are hospitalized for conditions identified by HMSA as conditions that require a private room, your copayment (if any) is based on the facility's medical/surgical private room rate. You may call HMSA for a list of these conditions.
- Intensive care or coronary units.
- Intermediate care units.
- Isolation units.
- Operating rooms.
- Newborn nursery care. Covered for the baby's nursery care after birth in accord with the time periods specified in this chapter under *Maternity and Newborn Length of Stay*.

If we inform you that you do not meet payment determination criteria for acute inpatient care, but you meet payment determination for skilled nursing, sub-acute, or long-term acute care, you must transfer to the first available extended care facility bed. If you do not transfer, you must pay all acute inpatient charges beginning on the day we informed you that you no longer meet acute inpatient payment determination criteria and an extended care facility bed became available.

***Please note*:** Services at nonparticipating and out-of-state post-acute facilities must be precertified. See *Chapter 5: Precertification*.

Outpatient Facility

Covered, including but not limited to observation room and labor room.

Please note: Certain rehabilitation services outside the State of Hawaii must have precertification. See *Chapter 5: Precertification.*

Private Duty Nursing

Covered, when:

- Care is ordered and certified by your PCP or attending physician.
- You are inpatient at a hospital; and
- Services are rendered by a duly licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.).

Emergency Services

Covered, but only to stabilize a medical condition that is accompanied by acute symptoms or sufficient severity (including severe pain), including room and ancillary charges, and physician visits, if a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

- Serious risk to the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child).

- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Examples of an emergency include:
- chest pain or other heart attack signs,
- poisoning,
- loss of consciousness,
- convulsions or seizures,
- broken back or neck,
- heavy bleeding,
- sudden weakness on one side,
- severe pain,
- breathing problems,
- drug overdose,
- severe allergic reaction,
- severe burns, and
- broken bones.

Examples of non-emergencies are:
- colds,
- flu,
- earaches,
- sore throats, and
- using the emergency room for your convenience or during normal physician office hours for medical conditions that can be treated in a physician's office.

If you need emergency services, call 911 or go to the nearest emergency room for care. Pre-authorization or a referral from your PCP is not needed.

Please note: If you are admitted to the hospital after your condition is no longer emergent, hospital inpatient benefits will apply and not emergency services benefits.

You will not receive benefits if you use emergency services for any of these reasons:
- For your convenience.
- During normal office hours for medical conditions that are treatable in a physician's office.

Contacting Your PCP

If you are unable to contact your PCP before you get emergency services, you (or someone acting on your behalf) should contact your PCP to:
- Advise him or her of your condition; and
- Get instructions about follow-up care.

Please note: You should contact your PCP within 48 hours after the illness or injury or as soon as reasonably possible.

Emergencies Outside of Hawaii

For emergencies in another state or country, these guidelines apply:
- If the provider participates with the Blue Cross and/or Blue Shield plan in that state (or foreign country), the provider will file a claim for you. We will reimburse the provider directly. ***Please note***: Remember to show the provider your member identification card.
- If the provider does not participate with the Blue Cross and/or Blue Shield plan in that state (or foreign country), you are responsible for paying the provider directly and filing a claim with us. For more details on filing claims, see *Chapter 7: Filing Claims.*

Please note: If you have guest membership and require emergency services, the benefits of guest membership applies. See *Chapter 1: Important Information* in section *Care While You are Away from Home.*

How to Access Emergency Services

For emergencies you should do one of the following:
- If possible, you should first contact your PCP for direction and guidance on the emergency situation. Your PCP (or a Provider acting on his or her behalf) is available for such calls 24 hours a day.
- If your illness or injury is so life-threatening that contacting your PCP is not realistic, go immediately to the nearest emergency center for care.

Once at the emergency room, you (or someone acting on your behalf) should do all of the following:
- Present your member card.

• Ask the physician or hospital to forward a copy of your medical care record to your PCP. Your PCP will review the emergency care, arrange for any necessary follow-up care, update your medical records, and be kept informed of your health status. Please tell your PCP about any specific emergency instructions given to you.
• Request the physician or hospital to file a claim with us.

Rehabilitation Therapy Services

Dr. Ornish's Program for Reversing Heart Disease™

Covered in accord with HMSA's then current policy available at www.hmsa.com and when all of the following are true:
• Program services are provided by practitioners who contract with HMSA to provide program services, and
• Services are received in the State of Hawaii at an accredited Ornish Reversal Program.

Dr. Ornish's Program for Reversing Heart Disease™ is a comprehensive approach to cardiovascular disease management and overall well-being improvement that addresses modifiable risk factors under the supervision of a multidisciplinary team. It helps members with heart disease and related health issues to assess, track and manage their condition; and, improve key factors such as eating habits, stress management and physical activity. The program consists of eighteen 4 hour sessions which include:
• Supervised exercise
• Yoga and meditation
• Support group
• Experiential education session with group meal

Please note: Coverage is limited to one program per lifetime. If you get benefits for this program under an HMSA plan, you will not be eligible for benefits for the program under any other HMSA plan.

Physical and Occupational Therapy

Covered in accord with HMSA's medical policy for physical and occupational therapy. Changes to the policy may occur at any time during your plan year. Current medical policies can be found at www.hmsa.com. According to HMSA's current medical policies, therapy services are covered but only when all of the following are true:
• The diagnosis is established by a physician, physician's assistant or advanced practice registered nurse and the medical records document the need for skilled physical and/or occupational therapy.
• The therapy is ordered by a physician, physician's assistant or advanced practice registered nurse under an individual treatment plan.
• The therapy is from a qualified provider of physical or occupational therapy services. A qualified provider is one who is licensed appropriately, performs within the scope of his/her licensure and is recognized by HMSA.
• The therapy is necessary to achieve a specific diagnosis-related goal that will significantly improve neurological and/or musculoskeletal function due to a congenital anomaly, or to restore neurological and/or musculoskeletal function that was lost or impaired due to an illness, injury, or prior therapeutic intervention. (Significant is defined as a measurable and meaningful increase in the level of physical and functional abilities attained through short-term therapy as documented in the medical records).
• The therapy is short-term, generally not longer than 90 days, defined as the number of visits necessary to improve or restore neurological or musculoskeletal function required to perform normal activities of daily living, such as grooming, toileting, feeding, etc. Therapy beyond this is considered long-term and is not covered. Maintenance therapy, defined as activities that preserve present functional level and prevent regression, are not covered.
• The therapy does not duplicate services from another therapy or available through schools and/or government programs.
• The therapy is described as covered in HMSA's medical policies on physical and occupational therapy. Information on our policies can be found at www.hmsa.com.

Please note: Certain services must be precertified. See *Chapter 5: Precertification.*

Group exercise programs and group physical and occupational therapy exercise programs are not covered.

Pulmonary Rehabilitation

Pulmonary rehabilitation is a multidisciplinary approach to reducing symptoms and improving quality of life in patients with compromised lung function.

Benefits are not provided for maintenance programs.

Participants must meet HMSA's eligibility criteria and guidelines.

***Please note*:** These services must have precertification. See *Chapter 5: Precertification.*

Speech Therapy Services

Covered in accord with HMSA's medical policy for speech therapy. Changes to the policy may occur at any time during your plan year. Current medical policies can be found at www.hmsa.com. According to HMSA's current medical policy, speech therapy is covered to treat communication impairments and swallowing disorders but only when all of the following statements are true:

- The diagnosis is established by a physician, physician's assistant, or advanced practice registered nurse and the medical records document the need for skilled speech therapy services.
- The therapy is ordered by a physician, physician's assistant, or advanced practice registered nurse.
- The therapy is necessary to treat function lost or impaired by disease, trauma, congenital anomaly (structural malformation) or prior therapeutic intervention.
- The therapy is rendered by and requires the judgment and skills of a speech language pathologist certified as clinically competent (SLP CCC) by the American Speech–Language Hearing Association (ASHA).
- The therapy is provided on a one-to-one basis.
- The therapy is used to achieve significant, functional improvement through objective goals and measurements.
- The therapy and diagnosis are covered as described in HMSA's medical policies for speech therapy services. Information on our policies can be found at www.hmsa.com.
- The therapy is not for developmental delay/developmental learning disabilities.
- The therapy does not duplicate service from another therapy or available through schools and/or government programs.

Speech therapy services include:

- speech/language therapy,
- swallow/feeding therapy,
- aural rehabilitation therapy, and
- augmentative/alternative communication therapy.

***Please note**:* Certain services must have precertification. See *Chapter 5: Precertification.*

Home Health Care and Hospice Services

Home Health Care

Covered, when all of these statements are true:

- Services are prescribed in writing by a physician to treat an illness or injury when you are homebound. ***Homebound*** means that due to an illness or injury, you are unable to leave home, or if you do leave home, doing so requires a considerable and taxing effort.
- Part-time skilled health services are needed.
- Services are not more costly than alternate services that would be effective to diagnose and treat your condition.
- Without home health care, you would need inpatient hospital or extended care facility services.
- The attending physician must approve a plan of treatment for the Beneficiary. If you need home health care visits for more than 30 days, the physician must recertify that more visits are required and provide an ongoing plan of treatment at the end of each 30-day period of care.
- Visits must be from the Health Center or a qualified home health agency.

Benefit Limitation: Home health care is limited to 365 visits per illness or injury.

Hospice Services

Covered. A Hospice Program provides care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. We follow Medicare guidelines to determine benefits, level of care and eligibility for hospice services. Also, we cover:

- Residential hospice room and board expenses directly related to the hospice care being provided, and
- Hospice referral visits during which a patient is advised of hospice care options, regardless of whether the referred patient is later admitted to hospice care.

While under hospice care, the terminally ill patient is not eligible for benefits for the terminal condition except hospice services and attending physician office visits. The patient is eligible for all covered benefits unrelated to the terminal condition.

The attending physician must certify in writing that the patient is terminally ill and has a life expectancy of six months or less.

Supportive Care

Covered in accord with HMSA's then current Supportive Care policy available at www.hmsa.com.

Supportive Care is a comprehensive approach to care for members with a serious or advanced illness including:

- Stage 3 or 4 cancer,
- advanced Congestive Heart Failure (CHF),
- advanced Chronic Obstructive Pulmonary Disease (COPD), or
- any advanced illness that meets the requirements of the Supportive Care policy.

Members receive comfort-directed care, along with curative treatment from an interdisciplinary team of practitioners. Supportive Care is only available in Hawaii and when a member is referred by his or her physician.

Please note:

- We cover Supportive Care referral visits during which a patient is advised of Supportive Care options, regardless of whether the referred member is later admitted to Supportive Care.
- Coverage is limited to 90 calendar days of services in a 12 month period that begins the first day Supportive Care services are provided.

Chemotherapy and Radiation Therapy

Chemotherapy – Infusion/Injections

Covered, including chemical agents to treat malignancy. Chemotherapy drugs must be FDA approved.

Please note: Coverage includes at least one antineoplastic (monoclonal antibodies) drug.

Please note: Benefits for high-dose chemotherapy, high-dose radiation therapy, or related services and supplies are covered when provided in conjunction with stem-cell transplants. See later in this chapter under *Stem-Cell Transplants (including Bone Marrow Transplants)* in the section *Organ and Tissue Transplants.*

Please note: For chemotherapy visits/administration to treat infections or malignancy coverage see *Physician Visits*.

Radiation Therapy

Covered.

Please note: Benefits for high-dose chemotherapy, high-dose radiation therapy, or related services and supplies are covered when provided in conjunction with stem-cell transplants. See later in this chapter under *Stem-Cell Transplants (including Bone Marrow Transplants)* in the section *Organ and Tissue Transplants.*

Miscellaneous Medical Treatments

Advance Care Planning

Covered.

Ambulance (air)

Covered, for intra-island or inter-island air ambulance services to the nearest, adequate hospital to treat your illness or injury.

We will cover your ambulance transportation if the following apply:
- Services to treat your illness or injury are not available in the hospital or nursing facility where you are an inpatient.
- Transportation starts where an injury or illness took place or first needed emergency care.
- Transportation ends at the nearest facility equipped to furnish emergency care.
- Transportation is for the purpose of emergency treatment.
- Transportation takes you to the nearest facility equipped to furnish emergency treatment.

Please note: Air ambulance is limited to transportation within the state of Hawaii except as described in the next section labeled *"Ambulance (air) – to the Continental United States"*.

Ambulance (air) – to the Continental United States

Covered in certain situations when treatment for critical care is not available in Hawaii and air ambulance transportation to the continental US with life supporting equipment and/or a medical support team is needed. Services are covered in accord with HMSA's medical policy on air ambulance services which can be found at www.hmsa.com.

Please note: Air ambulance services to the continental US must be precertified. See *Chapter 5: Precertification*.

Please note*:* Exclusions or limitations may apply. See *Chapter 6: Services Not Covered, Miscellaneous Exclusions*.

Ambulance (ground)

Covered, for ground ambulance services to the nearest, adequate hospital to treat your illness or injury.

We will cover your ambulance transportation if the following apply:
- Services to treat your illness or injury are not available in the hospital or nursing facility where you are an inpatient.
- Transportation starts where an injury or illness took place or first needed emergency care.
- Transportation ends at the nearest facility equipped to furnish emergency care.
- Transportation is for the purpose of emergency treatment.
- Transportation takes you to the nearest facility equipped to furnish emergency treatment.

Blood and Blood Products

Covered, for blood, blood products, blood bank services, and blood processing including collection, processing and storage of autologous blood for a scheduled surgery when prescribed by a provider whether or not the units are used.

You are not covered for any of the following:
- Blood bank processing for blood transfused as an outpatient.
- Storage of or lab fees for blood or blood products.
- Peripheral stem cell transplants except as described in this chapter under *Stem-Cell Transplants (including Bone Marrow Transplants).*

Breast Pump

Covered, for purchase of one device including attachments per pregnancy when purchased from a Health Plan Hawaii Network Provider or Participating Medical Pharmacy that provides medical equipment and supplies. You do not need a referral from your PCP.

Covered, for the rental of a hospital-grade breast pump in accord with HMSA's medical policy on breast pumps which can be found at www.hmsa.com.

Please note: Hospital-grade rentals must be precertified. See *Chapter 5: Precertification*.

Contraceptive IUD

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.

Contraceptive Implants

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.

Contraceptive Injectables

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.

Dialysis and Supplies

Covered.

Durable Medical Equipment and Supplies

Covered, but only when prescribed by your treating provider.

The equipment must meet all of the following criteria:
- FDA-approved for the purpose that it is being prescribed.
- Able to withstand repeated use.
- Primarily and customarily used to serve a medical purpose.
- Appropriate for use in the home. ***Home*** means the place where you live other than a hospital or skilled or intermediate nursing facility.
- Necessary and reasonable to treat an illness or injury, or to improve the functioning of a malformed body part. It should not be useful to a person in the absence of illness or injury.

Durable medical equipment (DME) can be rented or purchased; however, certain items are covered only as rentals.

Supplies and accessories necessary for the effective functioning of the equipment are covered subject to certain limitations and exclusions. Please call your nearest HMSA office listed on the back cover of this Guide for details.

Repair and replacement of durable medical equipment is covered subject to certain limitations and exclusions. Please call your nearest HMSA office listed on the back cover of this Guide for details.

Examples of durable medical equipment include:
- oxygen equipment,
- hospital beds,
- mobility assistive equipment (wheelchairs, walkers, power mobility devices), and
- insulin pumps.

Please note: Benefits for insulin pump tubing can be found in *Drugs and Supplies* section.

Please note: Certain durable medical equipment must have precertification. See *Chapter 5: Precertification*.

Gender Identity Services

Covered, in accord with HMSA's medical policy for "Gender Identity Services" which can be found at www.hmsa.com.

The services listed below are covered, but only when deemed medically necessary to treat gender dysphoria. Your copayment may vary depending on the type of service or supply you receive. Copayment amounts are listed in *Chapter 3: Summary of Benefits and Your Payment Obligations.* Benefit details about the service or supply you receive can be found in other sections of this chapter.
- Gender confirmation surgery
- Hospital room and board
- Hormone injection therapy
- Laboratory monitoring
- Other gender confirmation surgery related services and supplies which are medically necessary and not excluded. These include but are not limited to ***sexual identification counseling***, pre-surgery consultations and post-surgery follow-up visits
- Otherwise covered services deemed medically necessary to treat gender dysphoria

Please note: Certain services must be precertified. See *Chapter 5: Precertification*.

Please note*:* Exclusions or limitations may apply. See *Chapter 6: Services Not Covered, Miscellaneous Exclusions*.

Growth Hormone Therapy

Covered, but only if you meet HMSA's criteria and if growth hormone is for replacement therapy services to treat:

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

Please note: These services must have precertification. See *Chapter 5: Precertification.*

Implanted Internal Items/Implants - Outpatient

Covered, for outpatient implanted internal items. For a description of implanted internal items, see *Chapter 11: Glossary*.

Please note: Certain items must have precertification. See *Chapter 5: Precertification.*

Inhalation Therapy

Covered, for inpatient and outpatient inhalation therapy.

Injections – Other than Self-Administered

Covered, for outpatient services and supplies for the injection or intravenous administration of:

- medication,
- biological therapeutics and biopharmaceuticals, or
- nutrient solutions needed for primary diet.

Injectable drugs must be FDA approved.

If you have an HMSA drug plan with a similar benefit, there shall be no duplication or coordination of benefits between this plan and your HMSA drug plan.

Please note: Coverage includes at least one drug in each of the following drug categories and classes:

- Blood products/modifiers/volume expanders (coagulants)
- Immunological agents (immunizing agents, passive)

Please note**:** Certain services must have precertification. See *Chapter 5: Precertification.*

Injections – Self-Administered

Covered, Injectable drugs must be FDA approved.

If you have an HMSA drug plan with a similar benefit, there shall be no duplication or coordination of benefits between this plan and your HMSA drug plan.

Please note: Certain services must have precertification. See *Chapter 5: Precertification.*

Medical Foods

Covered, to treat inborn errors of metabolism in accord with Hawaii law and HMSA guidelines.

Medical Nutrition Therapy

Covered to treat medical conditions, such as chronic kidney disease, in accord with Hawaii law and HMSA's medical policy on "Medical Nutrition Therapy" which can be found at www.hmsa.com.

If you are diagnosed with an eating disorder by a qualified provider, medical nutrition therapy must be rendered by a recognized licensed dietitian.

Other counseling services identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations are described in other sections of this chapter. See *Routine and Preventive, Preventive Health Services*.

Please note: Certain services must have precertification. See *Chapter 5: Precertification.*

Orthodontic Services to Treat Orofacial Anomalies

Covered, to treat orofacial anomalies resulting from birth defects or birth defect syndromes, in accord with Hawaii law and HMSA's medical policy.

Benefit Limitation: Benefits are limited to a maximum of $6,900 per treatment phase.

Please note: Services must be precertified. See *Chapter 5: Precertification*.

Orthotics and External Prosthetics

Orthotics are covered, when prescribed by your treating provider to provide therapeutic support or restore function.

Supplies necessary for the effective functioning of an orthotic are covered subject to certain limitations and exclusions. Please call your nearest HMSA office listed on the back cover of this Guide for details.

Examples of orthotics include:
- braces,
- orthopedic footwear, and
- shoe inserts.

Foot orthotics are only covered for members with specific diabetic conditions as defined by Medicare guidelines; for partial foot amputations; if they are an integral part of a leg brace; or if they are being prescribed as part of post-surgical or post-traumatic casting care.

External prosthetics are covered when prescribed by your treating provider to replace absent or non-functioning parts of the human body with an artificial substitute.

Supplies necessary for the effective functioning of a prosthetic are covered subject to certain limitations and exclusions. Please call your nearest HMSA office listed on the back cover of this Guide for details.

Repair and replacements are covered subject to certain limitations and exclusions. Please call your nearest HMSA office listed on the back cover of this Guide for details.

Examples of prosthetics include artificial limbs and eyes, post-mastectomy or post-lumpectomy breast prostheses, external pacemakers and post-laryngectomy electronic speech aids.

Please note: Certain orthotics/external prosthetics require precertification. See *Chapter 5: Precertification.*

Outpatient IV Therapy

Covered, for services and supplies for outpatient injections or intravenous administration of medication, biological therapeutics, biopharmaceuticals, or intravenous nutrient solutions needed for primary diet. Drugs must be FDA approved.

***Please note*:** Certain services must have precertification. See *Chapter 5: Precertification.*

Routine Care Associated with Clinical Trials

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

***Please note*:** These services must have precertification. See *Chapter 5: Precertification*.

Vision and Hearing Appliances

Vision appliances, which include eyeglasses and contact lenses, are covered for certain medical conditions and are subject to special limits. Please call your nearest HMSA office listed on the back cover of this Guide for details.

***Please note*:** Exclusions or limits apply. See *Chapter 6: Services Not Covered* under *Dental, Drug, and Vision* and *Miscellaneous Exclusions.*

Hearing aids are limited to one hearing aid per ear every 60 months. Fitting, adjustment, and batteries are not covered.

Please note: Repairs or replacements are covered subject to certain limitations and exclusions. See *Chapter 6: Services Not Covered* under *Miscellaneous Exclusions*.

Please note: Repairs or replacements must be precertified. See *Chapter 5: Precertification*.

Behavioral Health – Mental Health and Substance Abuse

Covered, if:

- You are diagnosed with a condition found within the most current Diagnostic and Statistical Manual of the American Psychiatric Association.
- The services are from a licensed physician, psychiatrist, psychologist, clinical social worker, marriage and family therapist, licensed mental health counselor, or advanced practice registered nurse.

***Please note*:** The following do not in and of themselves constitute a mental health disorder:

- Epilepsy,
- neurocognitive disorders,
- intellectual disabilities, or
- other developmental disabilities and addiction to or abuse of intoxicating substances.

Benefits for inpatient hospital and facility services are subject to the limits described earlier in this chapter under *Hospital Room and Board*.

Please note: Precertification is required for the admission and continued treatment at all residential treatment facilities. In addition, partial hospitalization and intensive outpatient treatment at non-contracted and out-of-state facilities require precertification. See *Chapter 5: Precertification*.

Alcohol or Drug Dependence Treatment

You are not covered for detoxification services and educational programs to which drinking or drugged drivers are referred by the judicial system solely because you have been referred or services performed by mutual self-help groups.

Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us

Covered, but only for autism spectrum disorders, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, in accord with Hawaii law and HMSA's medical policy. Services must be provided in the state where you reside by a Behavior Analyst recognized by us.

Please note: Certain services must be precertified. See *Chapter 5: Precertification.*

Autism Spectrum Disorders – Diagnosis and Treatment

Covered, in accord with Hawaii law and HMSA's medical policies, for the following services:

- Behavioral health treatment. Benefits for Applied Behavior Analysis rendered by a Recognized Behavior Analyst as described more fully in the section labeled "*Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us*".
- Psychiatric care.
- Psychological care.
- Therapeutic care.
- Pharmacy care. Benefits for drugs to treat autism spectrum disorders are described later in this chapter under *Drugs and Supplies.*

You are not covered for care that is custodial in nature or provided by family or household members.

***Please note**:* Certain services must be precertified. See *Chapter 5: Precertification.*

How to Access Services

You may get mental health or substance abuse services from any provider who practices at your designated health center or any provider listed under the HMO Behavioral Health Network in the Health Plan Hawaii Directory of Health Centers and Providers. A referral from your PCP is not necessary. However, any services from a provider outside your health center or the HMO Behavioral Health Network require an administrative review request by your PCP as described in *Chapter 1: Important Information*. Copies of the Health Plan Hawaii Directory of Health Centers and Providers are available by contacting Customer Service. Our phone numbers are listed on the back cover of this Guide.

Organ and Tissue Transplants

Covered, but only as described in this section and subject to all other conditions and provisions of your Agreement including that the transplant meets payment determination criteria. For a definition of payment determination criteria, see *Chapter 1: Important Information* under *Questions We Ask When You Receive Care.* Expenses related to one transplant evaluation and wait list fees at one transplant facility per approved transplant request are covered.

Also, all transplants (with the exception of corneal and kidney transplant surgeries) must:

- Receive our approval. Without approval for the specified transplants, benefits are not available. Your PCP will get approval for you.
- Be from a facility that:
  - Accepts you as a transplant candidate, and
  - Is located in the State of Hawaii and has a contract with us to perform the transplant, or
  - Is an approved Blue Distinction Center for Transplants. You may call HMSA for a current list of providers

Benefits are not available for:

- Artificial (mechanical) organs, except for artificial hearts when used as a bridge to a permanent heart transplant.
- Non-human organs.
- Organ or tissue transplants not listed in this section.
- Your transportation for organ or tissue transplant services.
- Transportation of organs or tissues.
- Organ or tissue transplants received out of the country.

Corneal Transplant Surgery

Covered, but only if you meet HMSA's criteria. Coverage for related services are described in other sections of this Guide.

Heart and Lung Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification.*

Heart Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification*.

Kidney Transplant Surgery

Covered, but only if you meet HMSA's criteria. Coverage for related services are described in other sections of this Guide.

Liver Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification*.

Lung Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification.*

Pancreas Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification.*

Simultaneous Kidney/Pancreas Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification*.

Small Bowel and Multivisceral Transplants

Covered, for small bowel (small intestine) and the small bowel with liver or small bowel with multiple organs such as the liver, stomach and pancreas, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification*.

Stem-Cell Transplants (including Bone Marrow Transplants)

Allogeneic stem-cell transplants, reduced intensity conditioning for allogeneic stem-cell transplants and autologous stem-cell transplants are available only for treatment prescribed in accord with HMSA's medical policies and with our approval. See *Chapter 5: Precertification.*

Transplant Evaluation

Covered, if we approve, for:
- heart,
- heart-lung,
- liver,
- lung,
- pancreas,
- simultaneous kidney/pancreas,
- small bowel and multivisceral, or
- stem-cell transplants.

See *Chapter 5: Precertification*. ***Transplant Evaluation*** means those procedures, including:
- lab and diagnostic tests,
- consultations, and
- psychological evaluations, that a facility uses in evaluating a potential transplant candidate.

This coverage is limited to one evaluation per transplant request and must be rendered either at a facility that is located in the State of Hawaii and has a contract with us to perform the transplant or is an approved Blue Distinction Center for Transplants. For details about donor screening benefits, see in this chapter under *Organ Donor Services*.

Organ Donations

Organ Donor Services

Covered, when you are the recipient of the organ. No benefits are available under this coverage if you are donating an organ to someone else.

Please note: This coverage is secondary and the living donor's coverage is primary when:
- You are the recipient of an organ from a living donor; and
- The donor's health coverage provides benefits for organs donated by a living donor.

Benefits for the screening of donors are limited to expenses of the actual donor. No benefits are available for screening expenses of candidates who do not become the actual donor.

Case Management Services

Case Management Services

Covered, for a chronic condition, a serious illness or complex health care needs which may include the following:
- Assessment of individual/family needs related to the understanding of health status and physician treatment plans, self-care and compliance capability and continuum of care.
- Education of individual/family on disease, treatment compliance and self-care techniques.
- Help with organization of care, including arranging for needed services and supplies.
- Assistance in arranging for a Primary Care Provider to deliver and coordinate the care and/or consultation with physician specialists; and
- Referrals to community resources.

Your benefit will vary depending on the type of Case Management Service you receive. For instance, if you receive a physician visit pertaining to Case Management Services, the physician visit benefit will apply. See copayment amounts for the service you receive through case management services in *Chapter 3: Summary of Benefits and Your Payment Obligations*.

Drugs and Supplies

Covered, but only drugs to treat autism spectrum disorders, oral chemotherapy drugs, contraceptives, diabetic drugs, supplies and insulin, and U.S. Preventive Services Task Force Recommended Drugs. Coverage will be provided only when the drugs and supplies are:

- Approved by the FDA, under federal control,
- Prescribed by a licensed Provider,
- Dispensed by a licensed pharmacy or Provider, and
- You do not have an HMSA drug plan or your HMSA drug plan does not cover the drug or supply covered in this section.

Please note: The list of U.S. Preventive Services Task Force (USPSTF) recommended drugs may change. Examples of drugs recommended include, but are not limited to, aspirin and folic acid. If you need more information about the USPSTF recommended drugs, including a current list of recommendations, please visit our website at www.hmsa.com or call us at one of the phone numbers listed on the back of this Guide.

***Please note*:** Some drugs and supplies must have precertification. See *Chapter 5: Precertification*.

Benefits for drugs and supplies vary depending on whether the drug is a generic drug, a Preferred Formulary drug, or Non-Preferred Formulary drug.

Benefit Limitations

Contraceptive benefits are limited to one contraceptive method per period of effectiveness.

Over-the-counter contraceptives are covered when you receive a written prescription for the contraceptive.

Diabetic supplies are limited to coverage for:

- Syringes.
- Needles.
- Lancets.
- Lancet devices.
- Test strips.
- Acetone test tablets.
- Insulin pump tubing.
- Calibration solutions.

Copayment amounts for covered drugs or supplies are for a maximum 30-day supply or fraction thereof. A 30-day supply means a supply that will last you for a period consisting of 30 consecutive days. For example, if the prescribed drug must be taken by you only on the last five days of a one-month period, a 30-day supply would be the amount of the drug that you must take during those five days.

If you get more than a 30-day supply under one prescription:

- you must pay an additional copayment for each 30-day supply or fraction thereof, and
- The pharmacy will fill the prescription in the quantity specified by your Provider up to a 12-month supply for contraceptives. For all other drugs or supplies the maximum benefit payment is limited to two more 30-day supplies or fractions thereof.

Definitions

Biological products

- Biological products, or biologics, are medical products. Many products are made from a variety of natural sources –(i.e., human, animal, or microorganism). It may be produced by biotechnology methods and other cutting-edge technologies. Like drugs, some biologics are intended to treat diseases and medical conditions. Other products are used to prevent or diagnose diseases. Examples may include:
  - Vaccines.
  - Blood and blood products for transfusion and /or manufacturing into other products.
  - Allergenic extracts that are used for both diagnosis and treatment, i.e., allergy shots.
  - Human cells and tissues used for transplantation (e.g., tendons, ligaments and bones).
  - Gene therapies.
  - Cellular therapies.

– Tests to screen potential blood donors for infectious agents such as HIV.

• ***Reference product*** refers to the original FDA-approved biologic product that a biosimilar is based.

• ***Biosimilar product*** – A biological product that is FDA-approved based on a showing that it is highly similar to an already FDA-approved reference product. It has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Only minor differences in clinically inactive components are allowable in biosimilar products.

• ***Interchangeable biologic product*** – An FDA-approved biologic product that meets the additional standards for interchangeability to an FDA-approved reference product included in:

– The Hawaii list of equivalent generic drugs and biological products.
– The Orange Book.
– The Purple Book.
– Other published findings and approvals of the United States Food and Drug Administration.

In accordance with any applicable state and federal regulations and laws, an interchangeable biological product may be substituted for the reference product by a pharmacist without the intervention of the healthcare provider who prescribed the reference product.

Brand name drug is a drug that is marketed under its distinctive trade name. A brand name drug is or at one time was protected by patent laws or deemed to be biosimilar by the U.S. Food and Drug Administration. A brand name drug is a recognized trade name prescription drug product, usually either the innovator product for new drugs still under patent protection or a more expensive product marketed under a brand name for multi-source drugs and noted as such in the national pharmacy database used by HMSA.

Generic drug is a drug, supply, or insulin that is prescribed or dispensed under its commonly used generic name rather than a brand name. Generic drugs are not protected by patent and are identified by HMSA as “generic”. A generic drug shall meet any of the following:

• It is identical or therapeutically equivalent to its brand counterpart in dosage form, safety, strength, route of administration and intended use.
• It is a non-innovator product approved by the FDA under an Abbreviated New Drug Application (an application to market a duplicate drug that has been approved by the FDA under a full New Drug Application).
• It is defined as a generic by Medi-Span or an equivalent nationally recognized source.
• It is not protected by patents(s), exclusivity, or cross-licensure.
• Generic drugs include all single-source and multi-source generic drugs as set forth by a nationally recognized source selected and disclosed by HMSA.
• Unless explicitly defined or designated by HMSA, once a drug has been deemed a generic drug it must be considered a generic drug for purposes of benefit administration.

Non-Preferred Formulary drug, supply, and insulin is a brand name drug, supply, or insulin that is not identified as preferred on the HMSA Select Prescription Drug Formulary.

Oral chemotherapy drug is an FDA-approved oral cancer treatment that may be delivered to the patient for self-administration under the direction or supervision of a Provider outside of a hospital, medical office, or other clinical setting.

Over-the-counter drugs are drugs that may be purchased without a prescription.

Preferred Formulary drug, supply and insulin is a brand name drug, supply or insulin identified as preferred on the HMSA Select Prescription Drug Formulary.

Prescription drug is a medication required by Federal law to be dispensed only with a prescription from a licensed provider. Medications that are available as both a Prescription Drug and a nonprescription drug are not covered as a Prescription drug under this plan.

Drug Benefit Management

We have arranged with Participating Providers to assist in managing the usage of certain drugs, including drugs listed in the HMSA Select Prescription Drug Formulary.

- We have identified certain kinds of drugs listed in the HMSA Select Prescription Drug Formulary that require preauthorization of HMSA. The criteria for preauthorization are that:
  - the drug is being used as part of a treatment plan,
  - there are no equally effective drug substitutes, and
  - the drug meets Payment Determination and other criteria established by us.

A list of these drugs in the HMSA Select Prescription Drug Formulary has been distributed to all Participating Providers.

- Participating providers may prescribe up to a 30-day supply for first time prescriptions of maintenance drugs and contraceptives. For subsequent refills, the participating provider may prescribe up to a 12-month supply for contraceptives, and a maximum 90-day supply for all other drugs after confirming that:
  - You have tolerated the drug without adverse side effects that could cause the drug to be discontinued, and
  - Your Provider has determined that the drug is effective.

Mail Order Providers

Benefits for mail order drugs, supplies, and insulin are only available through contracted providers. Call your nearest HMSA office listed on the back cover of this Guide for a list of contracted providers. If you receive mail order drugs and supplies from a provider that does not contract with HMSA, no benefits will be paid.

The contracted provider will fill the prescription in the quantity specified by the Provider up to a 12-month supply for contraceptives. For all other drugs or supplies, copayment amounts are for a maximum 90-day supply or fraction thereof. A 90-day supply means a supply that will last you 90 consecutive days or a fraction thereof. You must pay a 90-day copayment even if the prescription is written for less than a 90-day supply or the pharmacy dispenses less than 90 doses or less than a 90-day supply. Situations in which this would occur include, but are not limited to:

- You are prescribed a drug in pill form that must be taken only on the last five days of each month. A 90-day supply would be fifteen pills, the number of pills you must take during a three-month period.
- You are prescribed a 30-day supply with two refills. The mail order pharmacy will fill the prescription in the quantity specified by the Provider, in this case 30 days, and will not send you a 90-day supply. You owe the 90-day copayment even though a 30-day supply has been dispensed.
- You are prescribed a 30-day supply of a drug that is packaged in less than 30-day quantity, for example, a 28-day supply. The pharmacy will fill the prescription by providing you a 28-day supply. You owe the 90-day copayment. If you are prescribed a 90-day supply, the pharmacy would fill the prescription by giving you three packages each containing a 28-day supply of the drug. Again, you would owe a 90-day copayment for the 84-day supply.

Unless your Provider directs the use of a brand name drug by clearly indicating it on the prescription, your prescription will be filled with the generic equivalent when available and permissible by law.

Refills are available if indicated on your original prescription and only after two-thirds of your prescription has already been used.

Refills

Except for certain drugs managed under Drug Benefit Management, refills will be paid if indicated on your original prescription and only after two-thirds of your prescription has already been used. At the discretion of your pharmacist, you may refill your prescriptions for maintenance drugs earlier if you need to synchronize such prescriptions to pick them up at the same time. Your copayment for each prescription may be adjusted accordingly.

Please note: Certain limitations or restrictions apply. Please see our Medication Synchronization policy at www.hmsa.com.

You May Owe Additional Amounts When There is a Generic Equivalent

This plan requires the substitution of Generic Drugs listed on the FDA Approved Drug Products with Therapeutic Equivalence Evaluations for a brand name drug. Exceptions will be made when a Provider directs that substitution is not permissible. If you choose not to use the generic equivalent, we will pay only the amount that would have been paid for the generic equivalent. This provision will apply even if the generic equivalent is out-of-stock or is not available at the pharmacy.

In the event a generic equivalent is out-of-stock or not available, you may wish to purchase the generic equivalent from another pharmacy.

CHAPTER 5

This Chapter Covers

Definition

Precertification is a special approval process to make sure that certain medical treatments, procedures, or devices meet payment determination criteria before the service is rendered. HMSA requires pre-certification of various services before the services are given. Your physician is aware of the guidelines to follow and will submit the information and papers that are needed for consideration. When pre-certification is authorized, you should receive services at your selected health center unless the services are referred.

Services and Supplies Which Require Precertification

A few common examples of things you must obtain precertification for:

- **Lab, X-ray and Other Diagnostic Tests** such as:
  - genetic testing,
  - polysomnography and sleep studies,
  - computed tomography (CT), and
  - functional MRI.
- **Surgeries** such as:
  - organ and tissue transplants and
  - varicose veins treatment.
- **Treatment Therapies** such as:
  - applied behavior analysis,
  - physical, occupational and speech therapies,
  - chiropractic services,
  - in vitro fertilization,
  - growth hormone therapy,
  - home IV therapy,
  - drugs such as:
    - oral chemotherapy agents,
    - infusibles and injectables,
    - new drug to market (specialty medical drugs), and
    - off-label drug use.
- **Durable Medical Equipment and Orthotics and Prosthetic Devices** such as:
  - wheelchairs and
  - positive airway pressure and oral devices to treat obstructive sleep apnea.

The list of services that need prior approval may change periodically. To ensure your treatment or procedure is covered, call us at (808) 948-6464 for Oahu and (800) 344-6122 for Neighbor islands or visit our website at www.hmsa.com/precert.

Our Response to Your Non-Urgent Precertification Request

If your request for precertification is not urgent, HMSA will respond to your request within a reasonable time that is appropriate to the medical circumstances of your case. We will respond within 15 days after we get your request. We may extend the time once for 15 days if we cannot respond to your request within the first 15 days and if it is due to circumstances beyond our control. If this happens, we will let you know before the end of the first 15 days. We will tell you why we are extending the time and the date we expect to have our decision. If we need more details from you or your provider, we will let you or your provider know and give you at least 45 days to provide it.

Our Response to Your Urgent Precertification Request

Your precertification request is urgent if the time periods that apply to a non-urgent request:

- Could seriously risk your life or health or your ability to regain maximum function, or
- In the opinion of your treating physician, would subject you to severe pain that cannot be adequately managed without the care that is the subject of the request for precertification.

HMSA will respond to your urgent precertification request as soon as possible given the medical circumstances of your case. It will be no later than 72 hours after all information sufficient to make a determination is provided to us.

If you do not provide enough details for us to determine if or to what extent the care you request is covered, we will notify you within 24 hours after we get your request. We will let you know what details we need to respond to your request and give you a reasonable time to respond. You will have at least 48 hours to provide it.

Appeal of Our Precertification Decision

If you do not agree with our precertification decision, you may appeal it. See *Chapter 8: Dispute Resolution.*

CHAPTER 6

This Chapter Covers

About this Chapter

Your health care coverage does not provide benefits for certain procedures, services or supplies that are listed in this chapter or limited by this chapter or Chapter 4. We divided this chapter with category headings. These category headings will help you find what you are looking for. Actual exclusions are listed across from category headings.

Please note: Even if a service or supply is not specifically listed as an exclusion in this chapter, there are more exclusions as described by the limitations in Chapter 4. If that service or supply is not specifically listed as an exclusion in this chapter or as a limitation exclusion in Chapter 4, it will not be covered unless:

- it is described in *Chapter 4: Description of Benefits*, and meets all of the criteria, circumstances or conditions described, and
- it meets all of the criteria described in *Chapter 1: Important Information* under *Questions We Ask When You Receive Care*.

If a service or supply does not meet the criteria described in Chapter 4, then it should be considered an exclusion or service that is not covered. This chapter should be read in conjunction with Chapter 4 in order to identify all items that are excluded from coverage.

If you are unsure if a specific procedure, service or supply is covered or not covered, please call Customer Service, and we will help you. We list our phone numbers on the back cover of this Guide.

Counseling Services

Bereavement Counseling

You are not covered for bereavement counseling or services of volunteers or clergy.

Genetic Counseling

You are not covered for genetic counseling, except as described in *Chapter 4: Description of Benefits* under *Testing, Laboratory, and Radiology* and *Routine and Preventive* or as identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations. If you need more details about USPSTF recommended counseling, including a current list of recommendations, please visit our website at www.hmsa.com or call us at one of the phone numbers listed on the back cover of this Guide.

Marriage or Family Counseling

You are not covered for marriage and family counseling or other training services, except as described in *Chapter 4: Description of Benefits*. See *Behavioral Health – Mental Health and Substance Abuse*.

Sexual Orientation Counseling

You are not covered for ***sexual orientation counseling***.

Coverage Under Other Programs or Laws

Military

You are not covered for treatment of an illness or injury related to military service when you get care in a hospital operated by an agency of the U.S. government. You are not covered for services or supplies that are needed to treat an illness or injury received while you are on active status in the military service.

Payment Responsibility

You are not covered when someone else has the legal obligation to pay for your care, and when, in the absence of this coverage, you would not be charged.

Third Party Reimbursement

You are not covered for services or supplies for an injury or illness caused or alleged to be caused by a third party and/or you have or may have a right to get payment or recover damages in connection with the illness or injury. You are not covered for services or supplies for an illness or injury for which you may recover damages or get payment without regard to fault. For more details about third party reimbursement, see *Chapter 9: Coordination of Benefits and Third Party Liability.*

Dental, Drug, and Vision

Dental Care

You are not covered for dental care under this health coverage except those oral surgery services performed for medical conditions listed in *Chapter 4: Description of Benefits* under *Surgery, Oral Surgery*. The following exclusions apply regardless of the symptoms or illnesses being treated:

- Orthodontics except as described in *Chapter 4: Description of Benefits* under *Orthodontic Services to Treat Orofacial Anomalies*.
- Dental splints and other dental appliances.
- Dental prostheses.
- Maxillary and mandibular implants (osseointegration) and all related services.
- Removal of impacted teeth.
- Any other dental procedures involving the teeth, gums and structures supporting the teeth.
- Any services in connection with the treatment of TMJ (temporomandibular joint) problems or malocclusion of the teeth or jaws, except for limited medical services related to the initial diagnosis of TMJ or malocclusion.

Drugs

You are not covered for:

- Drugs and supplies except as stated in *Chapter 4: Description of Benefits* under *Drugs and Supplies* and as identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations.
- Drugs from foreign countries.
- Replacement for lost, stolen, damaged, or destroyed drugs and supplies.

Eyeglasses and Contacts

Except as described in *Chapter 4: Description of Benefits under Miscellaneous Medical Treatments, Vision and Hearing Appliances*, you are not covered for:

- Exams for a fitting or prescription (including vision exercises).
- Frames including repair and replacement of frame parts and accessories.
- Lenses including:
  - Nonstandard items for lenses including tinting and blending.
  - Oversized lenses, and invisible bifocals or trifocals.
  - Telescopic lenses.
  - Low vision lenses.
  - Corrective low vision lenses.
- Nonprescription industrial safety goggles.
- Prescription inserts for diving masks or other protective eyewear.
- Sunglasses.

Vision Services

You are not covered for:

- Refractive eye surgery to correct visual acuity problems.

- Replacement of lost, stolen or broken lenses, contact lenses or frames.
- Vision training.
- Aniseikonic studies and prescriptions.
- Reading problem studies or other procedures determined to be special or unusual.

Fertility and Infertility

Contraceptives

You are not covered for contraceptives except as described in *Chapter 3: Summary of Benefits and Your Payment Obligations and Chapter 4: Description of Benefits* under *Miscellaneous Medical Treatments* and *Drugs and Supplies*.

Infertility Treatment

Except as described in *Chapter 4: Description of Benefits* under *Maternity*, you are not covered for services or supplies related to the treatment of infertility, including but not limited to:

- Collection, storage and processing of sperm.
- Cryopreservation of oocytes, sperm and embryos.
- In vitro fertilization benefits when services of a surrogate are used.
- Cost of donor oocytes and donor sperm.
- Any donor-related services, including but not limited to collection, storage and processing of donor oocytes and donor sperm.
- Ovum transplants.
- Gamete intrafallopian transfer (GIFT).
- Zygote intrafallopian transfer (ZIFT).
- Services related to conception by artificial means, including drugs and supplies related to such services except as described in *Chapter 4: Description of Benefits* under *Maternity.*
- In vitro fertilization services that are inconsistent with the benefit maximums described in *Chapter 4: Description of Benefits* under *Maternity, In Vitro Fertilization.*

Sterilization Reversal

You are not covered for the reversal of a vasectomy or tubal ligation.

Provider Type

Complementary and Alternative Medicine Provider

You are not covered for complementary and alternative medicine services or supplies including but not limited to:

- botanical medicine,
- aromatherapy,
- herbal/nutritional supplements,
- medication techniques,
- relaxation techniques,
- movement therapies,
- energy therapies, and
- massage therapy when not part of rehabilitative therapy.

Dietitian

You are not covered for nutritional counseling services except as described in *Chapter 4: Description of Benefits.* See *Routine and Preventive, Preventive Health Services* and *Miscellaneous Medical Treatments, Medical Nutrition Therapy*.

Provider is an Immediate Family Member

You are not covered for professional services or supplies when furnished to you by a provider who is within your immediate family. ***Immediate Family*** is a parent, child, spouse, or yourself.

Provider Nondiscrimination

To the extent an item or service is a Covered Service under this Plan and consistent with reasonable medical management techniques specified under this Plan with respect to the frequency, method, treatment or setting for an item or service, HMSA shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under Hawaii law. HMSA is not required to accept all types of providers into its network. And HMSA has discretion governing provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

Social Worker

You are not covered for services and supplies from a social worker. This exclusion does not apply to covered mental health or substance abuse services or Covered Services within the scope of the social worker's professional license issued in Hawaii.

Please note: Social workers are not Network Providers under this plan except as noted above. Services received from these providers will be subject to HMSA's Referral Process, see *Chapter 1: Important Information*, *Referrals*.

Transplants

Living Donor Transport

You are not covered for expenses of transporting a living donor.

Living Organ Donor Services

You are not covered for organ donor services if you are the organ donor.

Mechanical or Non-Human Organs

You are not covered for mechanical or non-human organs, except for artificial hearts when used as a bridge to a permanent heart transplant.

Organ Purchase

You are not covered for the purchase of any organ.

Transplant Services or Supplies

You are not covered for transplant services or supplies or related services or supplies other than those described in *Chapter 4: Description of Benefits* under *Organ and Tissue Transplants.* ***Related Transplant Supplies*** are those that would not meet payment determination criteria but for your receipt of the transplant, including, and without limit, all forms of stem-cell or peripheral stem-cell transplants.

Transportation Related to Organ and Tissue Transplants

You are not covered for transportation for organ or tissue transplant services or transportation of organs or tissues.

Miscellaneous Exclusions

Act of War

To the extent allowed by law, you are not covered for services needed to treat an injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists.

Acupuncture

You are not covered for services or supplies related to acupuncture.

Airline Oxygen

You are not covered for airline oxygen.

Ambulance (air)

You are not covered for air ambulance services except as described in *Chapter 4: Description of Benefits.* The following air ambulance services are not covered:

- Transportation from the continental US to Hawaii.
- Transportation within the continental US.
- Transportation for patients whose condition allows for transportation via commercial airline.
- Transportation on a commercial airline.

Biofeedback

You are not covered for biofeedback and any related diagnostic tests.

Blood

You are not covered for blood except as described in *Chapter 4: Description of Benefits.*

Carcinoembryonic Antigen (CEA)

You are not covered for carcinoembryonic antigen when used as a screening test.

Cardiac Rehabilitation

You are not covered for cardiac rehabilitation services except as described in *Chapter 4: Description of Benefits* under *Dr. Ornish's Program for Reversing Heart Disease™.*

Chemotherapy (High-Dose)

You are not covered for high-dose chemotherapy except when provided in conjunction with stem-cell transplants described in *Chapter 4: Description of Benefits* under *Stem-Cell Transplants (including Bone Marrow Transplants).*

Complementary and Alternative Medicine Services

You are not covered for complementary and alternative medicine services or supplies including, but not limited to:
- botanical medicine,
- aromatherapy,
- herbal/nutritional supplements,
- medication techniques,
- relaxation techniques,
- movement therapies,
- energy therapies, and
- massage therapy when not part of rehabilitative therapy.

Complications of a Non-Covered Procedure

You are not covered for complications of a non-covered procedure, including complications of recent or past cosmetic surgeries, services or supplies, except treatment rendered by a Health Plan Hawaii Network physician for complications resulting from non-covered cosmetic services performed by a Health Plan Hawaii Network physician while you were enrolled in a Health Plan Hawaii group plan.

Convenience Treatments, Services or Supplies

You are not covered for treatments, services or supplies that are prescribed, ordered or recommended primarily for your comfort or convenience, or the comfort or convenience of your provider or caregiver. Such items may include:
- ramps,
- home remodeling,
- hot tubs,
- swimming pools,
- deluxe/upgraded items, or
- personal supplies such as surgical stockings.

Cosmetic Services, Surgery or Supplies

You are not covered for cosmetic services or supplies that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function. You are also not covered for complications of recent or past cosmetic surgeries, services or supplies, except treatment rendered by a Health Plan Hawaii Network physician for complications resulting from non-covered cosmetic services performed by a Health Plan Hawaii Network physician while you were enrolled in a Health Plan Hawaii group plan.

Custodial Care

You are not covered for custodial care, sanatorium care, or rest cures. ***Custodial Care*** consists of training in personal hygiene, routine nursing services, and other forms of personal care, such as:
- help in walking,
- getting in and out of bed,
- bathing,
- dressing,
- eating, and
- taking medicine.

Also excluded are supervising services by a physician or nurse for a person who is not under specific medical, surgical, or psychiatric care to improve that person's condition and to enable that person to live outside a facility providing this care.

Developmental Delay

You are not covered for treatment of developmental delay or services related to developmental delay that are available through government programs or agencies.

Ductal Lavage

You are not covered for ductal lavage.

Duplicate Item

You are not covered for duplicate items that are intended to be used as a back-up device, for multiple residences, or for traveling, including:
- durable medical equipment and supplies,
- orthotics and external prosthetics, and
- vision and hearing appliances

Some examples of duplicate items are a second wheeled mobility device specifically for work or school use or a back-up manual wheelchair when a power wheelchair is the primary means of mobility.

Effective Date

You are not covered for services or supplies that you get before the effective date of this coverage.

Electron Beam Computed Tomography (EBCT or Ultrafast CT)

You are not covered for electron beam computed tomography for coronary artery calcifications.

Enzyme-potentiated Desensitization

You are not covered for enzyme-potentiated desensitization for asthma.

Erectile Dysfunction

Refer to Sexual Dysfunction.

Extracorporeal Shock Wave Therapy

You are not covered for extracorporeal shock wave therapy except to treat kidney stones.

False Statements

You are not covered for services and supplies if you are eligible for care only by reason of a fraudulent statement or other intentional misrepresentation that you or your employer made on an enrollment form for membership or in any claims for benefits. If we pay benefits to you or your provider before learning of any false statement, you or your employer are responsible for reimbursing us.

Foot Orthotics

You are not covered for foot orthotics except, under the following conditions:

- Foot orthotics for persons with specific diabetic conditions per Medicare guidelines;
- Foot orthotics for persons with partial foot amputations;
- Foot orthotics that are an integral part of a leg brace and are necessary for the proper functioning of the brace, and;
- Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.

Genetic Testing

You are not covered for genetic tests except as stated in *Chapter 4: Description of Benefits* under *Testing, Laboratory, and Radiology* and *Routine and Preventive.*

Growth Hormone Therapy

You are not covered for growth hormone therapy except as stated in *Chapter 4: Description of Benefits.*

Hair Loss

You are not covered for services or supplies related to the prevention and/or treatment of baldness or hair loss regardless of condition. This includes hair transplants and topical medications.

Hypnotherapy

You are not covered for hypnotherapy.

Incontinence Supplies

You are not covered for incontinence supplies including but not limited to pads, diapers, protective underwear, underpads, gloves and wipes.

Intradiscal Electro Thermal Therapy (IDET)

You are not covered for intradiscal electro thermal therapy.

Massage Therapy

Massage therapy is not covered unless rendered as part of an approved rehabilitative therapy treatment plan.

Microprocessor (Upper/Lower Prostheses and Orthoses)

You are not covered for microprocessor or computer controlled, or myoelectric parts of upper and lower limb prosthetic and orthotic devices.

Motor Vehicles

This plan does not cover the cost to buy or rent motor vehicles such as cars and vans. You are also not covered for equipment and costs related to converting a motor vehicle to accommodate a disability.

Non-Medical Items

You are not covered for durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances, and devices that are not primarily medical in nature. Some examples of non-medical items that are not primarily medical in nature are:

- environmental control equipment or supplies (such as air conditioners, humidifiers, dehumidifiers, air purifiers or sterilizers, water purifiers, vacuum cleaners, or supplies such as filters, vacuum cleaner bags and dust mite covers);
- hygienic equipment;
- exercise equipment;
- items primarily for participation in sports or leisure activities, and
- educational equipment.

Non-Related Items Exclusion

You are not covered for any service, procedure, or supply that is directly or indirectly related to a non-covered service, procedure, or supply.

Physical Exams (routine annual check-up)

Physical exams and any associated screening procedures in connection with third party requests or requirements, such as those for:

- employment,
- participation in employee programs,
- sports,
- camp,
- insurance,
- disability licensing, or
- on court order or for parole or probation are not covered.

This limitation is not intended to affect coverage of physical exams or associated screening procedures that would otherwise have been covered, and that have separately and incidentally been requested or required by a third party.

Private Duty Nursing

You are not covered for outpatient private duty nursing services.

Prohibited by Law

You are not covered for services or supplies we are prohibited from covering under the law.

Radiation (High-dose)

You are not covered for high-dose radiotherapy except when provided in conjunction with stem-cell transplants described in *Chapter 4: Description of Benefits* under *Stem-Cell Transplants (including Bone Marrow Transplants)*.

Radiation (Nonionizing)

You are not covered for treatment with nonionizing radiation.

Recreational Therapy

You are not covered for recreational therapy and/or programs such as:

- wilderness therapy,
- health resorts,
- horseback riding,
- swimming with dolphins,
- outdoor skills programs,
- relaxation or lifestyle programs, and
- any other services provided in conjunction or related to (or as part of) those programs.

Repair/Replacement

You are not covered for the repair or replacement of any item covered under the manufacturer or supplier warranty, including:

- durable medical equipment and supplies,
- orthotics and external prosthetics, and
- vision and hearing appliances

Replacement items that meet the same medical need as the current item but in a more efficient manner or is more convenient, when there is no change in your medical condition are also not covered.

Reversal of Gender Confirmation Surgery

You are not covered for reversal of gender confirmation surgery, except in the case of a serious medical barrier to completing gender confirmation or the development of a serious medical condition requiring a reversal.

Self-Help or Self-Cure

You are not covered for self-help and self-cure programs or equipment.

Services Related to Employment

You are not covered for services related to getting or maintaining employment.

Sexual Dysfunction

You are not covered for services or supplies related to sexual dysfunction, except for erectile dysfunction as stated below.

	You are not covered for services and supplies (including prosthetic devices) related to erectile dysfunction except if due to an organic cause or to treat gender dysphoria as described in *Chapter 4: Description of Benefits* under *Miscellaneous Medical Treatments*, *Gender Identity Services*. This includes, but is not limited to, penile implants. You are not covered for drug therapies related to erectile dysfunction except certain injectables approved by us to treat erectile dysfunction due to an organic cause or to treat gender dysphoria as described in *Chapter 4: Description of Benefits* under *Miscellaneous Medical Treatments*, *Gender Identity Services*.
Supplies	You are not covered for take home supplies or supplies billed separately by your provider when the supplies are integral to services performed by your provider.
Thoracic Electric Bioimpedance (Outpatient/Office)	You are not covered for outpatient thoracic electric bioimpedance in an outpatient setting which includes a physician's office.
Topical Hyperbaric Oxygen Therapy	You are not covered for topical hyperbaric oxygen therapy.
Travel or Lodging Cost	You are not covered for the cost of travel or lodging.
Vertebral Axial Decompression (VAX-D)	You are not covered for vertebral axial decompression.
Vitamins, Minerals, Medical Foods, and Food Supplements	You are not covered for: • vitamins, • minerals, • medical foods or • food supplements except as described in *Chapter 4: Description of Benefit* under *Miscellaneous Medical Treatments* and *Drugs and Supplies*.
Weight Reduction Programs	You are not covered for weight reduction programs and supplies, whether or not weight reduction is medically appropriate. This includes: • dietary supplements, • food, • equipment, • lab tests, • exams, and • drugs and supplies.
Wigs	You are not covered for wigs and artificial hairpieces.

CHAPTER 7

This Chapter Covers

When to File Claims

When to File

Most providers in Hawaii file claims for you. If your provider does not file for you, please submit an itemized bill or receipt which lists the services you received. No payment will be made on any claim or itemized bill or receipt received by us more than one year after the last day on which you received services. If you have any questions after reading this section, please contact us. Our phone numbers appear on the back cover of this Guide.

How to File Claims

One Claim Per Person and Per Provider

File a separate claim for each covered family member and each provider.

You should follow the same procedure for filing a claim for services received in- or out-of-state or out-of-country.

What Information You Must File

Subscriber Number

The subscriber number that appears on your member card.

Provider Statement

The provider statement must be from your provider. All services must be itemized. (Statements you prepare, cash register receipts, receipt of payment notices or balance due notices cannot be accepted.) Without the provider statement, claims are not eligible for benefits. It is helpful to us if the provider statement is in English on the stationery of the provider who performed the service. An accompanying English translation is acceptable.

The provider statement must include:

- Provider's full name and address.
- Patient's name.
- Date(s) you received service(s).
- Date of the injury or start of illness.
- The charge for each service in U.S. currency.
- Description of each service.
- Diagnosis or type of illness or injury.
- Where you received the service (office, outpatient, hospital, etc.).
- If applicable, information about other health coverage you may have.

Phone Number

Please include a phone number where you can be reached during the day.

Signature

Make sure you sign the claim.

Proof of Payment

Make sure you enclose proof of payment.

Other Claim Filing Information

Where to Send Claim

For Professional claims, send to:
HMSA – CMS 1500 Claims
P.O. Box 44500
Honolulu, Hawaii 96804-4500

For Facility claims, send to:
HMSA – UB-04 Claims
P.O. Box 32700
Honolulu, Hawaii 96803-2700

Keep a Copy

You should keep a copy of the information for your records.

Information given to us will not be returned to you.

Report to Member

Once we get and process your claim, a report explaining your benefits will be provided. You may get copies of your report online through My Account on hmsa.com or by mail upon request. The ***Report To Member*** tells you how we processed the claim. It includes services performed, the actual charge, any adjustments to the actual charge, our eligible charge, the amount we paid, and the amount you owe.

If we need more details to make a decision about your claim, need more time to review your claim due to circumstances beyond our control or deny your claim, this report will let you know within 15 days of receipt of written claims or 7 days of receipt of claims filed electronically. If we need more details, you will have at least 45 days to provide it. Otherwise, we will reimburse you within 30 days of receipt of written claims and 15 days from receipt of claims filed electronically.

If, for any reason, you believe we wrongly denied a claim or coverage request, please call us for help. Our phone numbers appear on the back cover of this Guide. If you are not satisfied with the information you get, and you wish to pursue a claim for coverage, you may request an appeal. See *Chapter 8: Dispute Resolution.*

Cash or Deposit any Benefit Payment in a Timely Manner

If a check is enclosed with your Report To Member, you must cash or deposit the check before the check's expiration date. If you ask us to reissue the expired check, there will be a service charge.

CHAPTER 8

This Chapter Covers

Your Request for an Appeal

Writing Us to Request an Appeal

If you wish to dispute a decision made by HMSA related to coverage, reimbursement, this Agreement, or any other decision or action by HMSA you must ask for an appeal. Your request must be in writing unless you are asking for an expedited appeal. We must get it within one year from the date of the action or decision you are contesting. In the case of coverage or reimbursement disputes, this is one year from the date we first informed you of the denial or limitation of your claim, or of the denial of coverage for any requested service or supply.

Send written requests to:

HMSA Member Advocacy and Appeals
P.O. Box 1958
Honolulu, HI 96805-1958

Or, send us a fax at (808) 952-7546 or (808) 948-8206

And, provide the information described in the section below labeled “What Your Request Must Include”. Requests that do not comply with the requirements of this chapter will not be recognized or treated as an appeal by us.

If you have any questions about appeals, you can call us at (808) 948-5090, or toll free at 1-800-462-2085.

Appeal of Our Precertification Decision

We will respond to your appeal as soon as possible given the medical circumstances of your case. It will be within 30 days after we get your appeal.

Appeal of Any Other Decision or Action

We will respond to your appeal within 60 calendar days after we get your appeal.

Expedited Appeal

You may ask for an expedited appeal if the time periods for appeals above may:

- Seriously risk your life or health,
- Seriously risk your ability to gain maximum functioning, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

You may request expedited external review of our initial decision if you have requested an expedited internal appeal and the adverse benefit determination involves a medical condition for which the completion of an expedited internal appeal would meet the requirements above. The process for requesting an expedited external review is discussed below.

You may ask for an expedited appeal by calling us at (808) 948-5090, or toll free at 1-800-462-2085.

We will respond to your request for expedited appeal as soon as possible taking into account your medical condition. It will be no later than 72 hours after all information sufficient to make a determination is provided to us.

Who Can Request an Appeal

Either you or your authorized representative may ask for an appeal. Authorized representatives include:

- Any person you authorize to act on your behalf as long as you follow our procedures. This includes filing a form with us. To get a form to authorize a person to act on your behalf, call us at (808) 948-5090, or toll free at 1-800-462-2085. (Requests for appeal from an authorized representative who is a physician or practitioner must be in writing unless you are asking for an expedited appeal.)
- A court appointed guardian or an agent under a health care proxy.
- A person authorized by law to provide substituted consent for you or to make health care decisions on your behalf.
- A family member or your treating health care professional if you are unable to provide consent.

What Your Request Must Include

To be recognized as an appeal, your request must include all of this information:

- The date of your request.
- Your name and phone number (so we may contact you).
- The date of the service we denied or date of the contested action or decision. For precertification for a service or supply, it is the date of our denial of coverage for the service or supply.
- The subscriber number from your member card.
- The provider name.
- A description of facts related to your request and why you believe our action or decision was in error.
- Any other details about your appeal. This may include written comments, documents, and records you would like us to review.

You should keep a copy of the request for your records. It will not be returned to you.

Information Available From Us

If your appeal relates to a claim for benefits or request for precertification, we will provide upon your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim as defined by the Employee Retirement Income Security Act.

If our appeal decision denies your request or any part of it, we will provide an explanation, including the specific reason for denial, reference to the health plan terms on which our decision is based, a statement of your external review rights, and other information on our denial.

If You Disagree with Our Appeal Decision and You are Enrolled in a Group Plan that is not Self Funded

If you are enrolled in a group plan that is not self funded and you would like to appeal HMSA's decision, you must do one of the following:

- If you are appealing an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness; or a determination by HMSA that the service or treatment is experimental or investigational, you must request review by an Independent Review Organization (IRO) selected by the Insurance Commissioner.
- For all other issues, you must:
  - Request arbitration before a mutually selected arbitrator; or
  - File a lawsuit against HMSA under 29 USC 1132(a) unless your plan is one of the two bulleted types below in which case you must select arbitration:
    - A church plan as defined in 29 USC 2002(33) and no selection has been made in accord with 26 USC 410(d), or
    - A government plan as defined in 29 USC 1002(32).

Request Review by Independent Review Organization (IRO) Selected by the Insurance Commissioner

If you choose review by an IRO, you must submit your request to the Insurance Commissioner within 130 days of HMSA's decision on appeal to deny or limit the service or supply.

Unless you qualify for expedited external review of our appeal decision, before requesting review, you must have exhausted HMSA's internal appeals process or show that HMSA violated federal rules related to claims and appeals unless the violation was 1) de minimis; 2) non-prejudicial; 3) attributable to good cause or matters beyond HMSA's control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of non-compliance.

Your request must be in writing and include:

- A copy of HMSA's final internal appeal decision.
- A completed and signed authorization form releasing your medical records relevant to the subject of the IRO review. Copies of the authorization form are available from HMSA by calling (808) 948-5090, or toll free at 1-800-462-2085 or on HMSA.com.
- A complete and signed conflict of interest form. Copies of the conflict of interest form are available from HMSA by calling (808) 948-5090, or toll free at 1-800-462-2085 or on HMSA.com.
- A check for $15.00 made out to the Insurance Commissioner. It will be refunded to you if the IRO overturns HMSA's decision. You are not required to pay more than $60.00 in any calendar year.

You must send the request to the Insurance Commissioner at:

Hawaii Insurance Division
ATTN: Health Insurance Branch – External Appeals
335 Merchant Street, Room 213
Honolulu, HI 96813
Phone: (808) 586-2804

You will be informed by the Insurance Commissioner within 14 business days if your request is eligible for external review by an IRO.

You may submit more information to the IRO. It must be received by the IRO within 5 business days of your receipt of notice that your request is eligible. Information received after that date will be considered at the discretion of the IRO.

The IRO will issue a decision within 45 calendar days of the IRO's receipt of your request for review.

The IRO decision is final and binding except to the extent HMSA or you have other remedies available under applicable federal or state law.

Expedited IRO Review

You may request expedited IRO review if:

- You have requested an expedited internal appeal at the same time and the timeframe for completion of an expedited internal appeal would seriously jeopardize your life, health, or ability to gain maximum functioning or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse determination;
- The timeframe for completion of a standard external review would seriously jeopardize your life, health, or ability to gain maximum functioning, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse determination; or
- If the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which you received emergency services; provided you have not been discharged from a facility for health care services related to the emergency services.

Expedited IRO review is not available if the treatment or supply has been provided.

The IRO will issue a decision as expeditiously as your condition requires but in no event more than 72 hours after the IRO's receipt of your request for review.

External Review of Decisions Regarding Experimental or Investigational Services

You may request IRO review of an HMSA determination that the supply or service is experimental or investigational.

Your request may be oral if your treating physician certifies, in writing, that the treatment or supply would be significantly less effective if not promptly started.

Written requests for review must include, and oral requests must be promptly followed up with, the same documents described above for standard IRO review plus a certification from your physician that:

- Standard health care services or treatments have not been effective in improving your condition;
- Standard health care services or treatments are not medically appropriate for you; or
- There is no available standard health care service or treatment covered by your plan that is more beneficial than the health care service or treatment that is the subject of the adverse action.

Your treating physician must certify in writing that the service recommended is likely to be more beneficial to you, in the physician's opinion, than any available standard health care service or treatment, or your licensed, board certified or board eligible physician must certify in writing that scientifically valid studies using accepted protocols demonstrate the service that is the subject of the external review is likely to be more beneficial to you than any available standard health care services or treatment.

The IRO will issue a decision as expeditiously as your condition requires but in no event more than 7 calendar days of the IRO's receipt of your request for review.

Request Arbitration

If you choose arbitration, you must submit a written request for arbitration to HMSA, Legal Services, P.O. Box 860, Honolulu, Hawaii 96808-0860. Your request for arbitration will not affect your rights to any other benefits under this plan. You must have fully complied with HMSA's appeals procedures described above and we must get your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the issue. No other parties may be joined in the arbitration. The arbitration is binding and the parties waive their right to a court trial and jury.

Before arbitration starts, both parties (you and we) must agree on the person to be the arbitrator. If we both cannot agree within 30 days of your request for arbitration, either party may ask the First Circuit Court of the State of Hawaii to appoint an arbitrator.

The arbitration hearing shall be in Hawaii. The rules of the arbitration shall be those of the Dispute Prevention and Resolution, Inc. to the extent not inconsistent with this *Chapter 8: Dispute Resolution.* The arbitration shall be conducted in accord with the Federal Arbitration Act, 9 U.S.C. §1 et seq., and such other arbitration rules as both parties agree upon.

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

HMSA will pay the arbitrator's fee. You must pay your attorney's or witness's fees, if you have any, and we must pay ours. The arbitrator will decide who will pay all other costs of the arbitration.

HMSA waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.

If You Disagree with Our Appeal Decision and You are Enrolled in a Self Funded Group Plan

If you are enrolled in a self funded group plan and you would like review of HMSA's appeal decision, you must do one of the following:

- If you are appealing an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness; or a determination by HMSA that the service or treatment is experimental or investigational, you must request review by an Independent Review Organization (IRO) selected by HMSA at random from a panel of three IROs.
- For all other issues, you must:
  - Request arbitration with your employer or group sponsor before a mutually selected arbitrator; or
  - File a lawsuit against your employer or group sponsor under 29 USC 1132(a) unless your plan is one of the two bulleted types below in which case you must select review by an IRO or arbitration:
    - A church plan as defined in 29 USC 2002(33) and no selection has been made in accord with 26 USC 410(d), or
    - A government plan as defined in 29 USC 1002(32).

Request Review by Independent Review Organization (IRO) Selected by HMSA

If you choose review by an IRO you must submit your request in writing within 130 days of HMSA's appeal decision to deny or limit the service or supply. Send written requests to:

HMSA Member Advocacy and Appeals
P.O. Box 1958
Honolulu, HI 96805-1958

Or, send us a fax at (808) 952-7546 or (808) 948-8206

Within 6 business days following the date of receipt of your request, we will notify you in writing whether your appeal is eligible for external review.

We will assign an IRO to review your appeal. The IRO will inform you of its decision within 45 days after the IRO received the assignment from us.

The IRO decision is final and binding except to the extent HMSA or you have other remedies available under applicable federal or state law.

Expedited Review by an IRO Selected by HMSA

You may request expedited external review if:

- The timeframe for completion of an expedited internal appeal would seriously jeopardize your life, health, or your ability to regain maximum functioning and you have filed an expedited internal appeal.
- The timeframe for completion of standard external review would seriously jeopardize your life, health, or your ability to regain maximum functioning.
- HMSA's internal appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services and you have not been discharged from a facility.

Upon our determination that you meet the above criteria we will assign an IRO to review your appeal. The IRO will inform you of its decision as expeditiously as your condition or circumstances require but in no event more than 72 hours after it receives the assignment from us.

Request Arbitration

If you choose arbitration, with your employer or group sponsor, you must submit a written request for arbitration to HMSA, Legal Services, P.O. Box 860, Honolulu, Hawaii 96808-0860. Your request for arbitration will not affect your rights to any other benefits under this plan. You must have fully complied with HMSA's appeals procedures described above and we must receive your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the issue. No other parties may be joined in the arbitration. The arbitration is binding and the parties waive their right to a court trial and jury.

Before arbitration starts, both parties (you and your employer or group sponsor) must agree on the person to be the arbitrator. If you and your employer or group sponsor cannot agree within 30 days of your request for arbitration, either party may ask the First Circuit Court of the State of Hawaii to appoint an arbitrator.

The arbitration hearing shall be in Hawaii. The arbitration shall be conducted in accord with the Hawaii Uniform Arbitration Act, HRS Chapter 658A, and the rules of Dispute Prevention and Resolution, Inc., to the extent not inconsistent with this *Chapter 8: Dispute Resolution*, and such other arbitration rules as both parties agree upon. The arbitrator may hear and determine motions for summary disposition pursuant to HRS §658A-15(b). The arbitrator shall also hear and determine any challenges to the arbitration agreement and any disputes regarding whether a controversy is subject to an agreement to arbitrate. In order to make the arbitration hearing fair, expeditious and cost-effective, discovery by both parties shall be limited to requests for production of documents material to the claims or defenses in the arbitration. Limited depositions for use as evidence at the arbitration hearing may occur as authorized by HRS §658A-17(b).

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

Your employer or group sponsor will pay the arbitrator's fee. You must pay your attorney's or witness's fees, if you have any, and your employer or group sponsor must pay theirs. The arbitrator will decide who will pay all other costs of the arbitration.

Your employer or group sponsor waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.

CHAPTER 9

This Chapter Covers

What Coordination of Benefits Means

Coverage that Provides Same or Similar Coverage

You may have other benefit coverage that provides benefits that are the same or similar to this plan.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced when the combination of the primary plan's payment and this plan's payment exceed the Eligible Charge. As the secondary plan, this plan's payment will not exceed the amount this plan would have paid if it had been your only coverage. Also, when this plan is secondary, benefits will be paid only for those services or supplies covered under this plan.

If there is a benefit maximum under this plan, the service or supply for which payment is made by either the primary or the secondary plan shall count toward that benefit maximum. For example, this plan covers one well woman exam per calendar year, if this plan is secondary and your primary plan covers one well woman exam per calendar year, the exam covered under the primary plan will count toward the yearly benefit maximum and this plan will not provide benefits for a second exam within the calendar year. However, the first twenty days of confinement to an extended care facility that are paid in full by Medicare shall not count toward the benefit maximum.

What You Should Do

When you get services, you need to let us know if you have other coverage. Other coverage includes:

- Group insurance.
- Other group benefit plans.
- Nongroup insurance.
- Medicare or other governmental benefits.
- The medical benefits coverage in your automobile insurance (whether issued on a fault or no fault basis).

You should also let us know if your other coverage ends or changes.

If we need more details regarding your other coverage, we will contact you in writing. Your benefit payment may be delayed or denied if you do not provide the information we need to coordinate your benefits.

To help us coordinate your benefits, you should:

- Inform your provider by giving him or her information about the other coverage at the time services are rendered, and
- Indicate that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form.

Chapter 9: Coordination of Benefits and Third Party Liability

What We Will Do

Once we have the details about your other coverage, we will coordinate benefits for you. There are certain rules we follow to help us determine which plan pays first when there is other insurance or coverage that provides the same or similar benefits as this plan.

General Coordination Rules

This section lists four common coordination rules. The complete text of our coordination of benefits rules is available on request.

No Coordination Rules

The coverage without coordination of benefits rules pays first.

Member Coverage

The coverage you have as an employee pays before the coverage you have as a spouse or dependent child.

Active Employee Coverage

The coverage you have as the result of your active employment pays before coverage you hold as a retiree or under which you are not actively employed.

Earliest Effective Date

When none of the general coordination rules apply (including those not described above), the coverage with the earliest continuous effective date pays first.

Dependent Children Coordination Rules

Birthday Rule

For a child who is covered by both parents who are not separated or divorced and have joint custody, the coverage of the parent whose birthday occurs first in a calendar year pays first.

Court Decree Stipulates

For a child who is covered by separated or divorced parents and a court decree says which parent has health insurance responsibility, that parent's coverage pays first.

Court Decree Does Not Stipulate

For a child who is covered by separated or divorced parents and a court decree does not stipulate which parent has health insurance responsibility, then the coverage of the parent with custody pays first. The payment order for this dependent child is as follows:

- Custodial parent.
- Spouse of custodial parent.
- Non-custodial parent.
- Spouse of non-custodial parent.

Earliest Effective Date

If none of these rules apply, the parent’s coverage with the earliest continuous effective date pays first.

If You Are Hospitalized When Coverage Begins

If You are Hospitalized on the Effective Date of Coverage

If you are an inpatient on the effective date of this coverage and you had other insurance or coverage that was not with us immediately prior to the effective date, we will work with your prior insurer or coverage to decide if our coverage will supplement the prior insurance or coverage. Please call us if this applies to you so that we can coordinate with your prior insurer or coverage. If you had coverage with us immediately prior to the effective date of this coverage, or if you had no other insurance or coverage immediately prior to the effective date, then our coverage terms for services related to the hospitalization will apply.

Motor Vehicle Insurance Rules

Automobile Coverage

If your injuries or illness are due to a motor vehicle accident or other event for which we believe motor vehicle insurance coverage reasonably appears available under Hawaii Revised Statutes Chapter 431, Article 10C, then that motor vehicle coverage will pay before this coverage. You are responsible for any cost sharing payments required under such motor vehicle insurance coverage. We do not cover such cost sharing payments. Before we pay benefits under this coverage for an injury covered by motor vehicle insurance, you must give us a list of medical expenses paid by the motor vehicle insurance. The list must show the

date expenses were incurred, the provider of service, and the amount paid by the motor vehicle insurance. We will review the list of expenses to verify that the motor vehicle insurance coverage available under Hawaii Revised Statutes Chapter 431, Article 10C is exhausted. After it is verified, you are eligible for covered services in accord with this Guide to Benefits.

Please note that you are also subject to the Third Party Liability Rules at the end of this chapter if:

- your injury or illness is caused or alleged to have been caused by someone else and you have or may have a right to recover damages or receive payment in connection with the illness or injury, or
- you have or may have a right to recover damages or receive payment without regard to fault (other than personal injury protection coverage available under Hawaii Revised Statutes Chapter 431, Article 10C-103.5).

Any benefits paid by us in accord with this section or the *Third Party Liability Rules*, are subject to the provisions described later in this chapter under *Third Party Liability Rules*.

Medicare Coordination Rules

Medicare as Secondary Payer

Since 1980, Congress has passed legislation making Medicare the secondary payer and group health plans the primary payer in a variety of situations. These laws apply only if you have both Medicare and employer group health coverage, and your employer has the minimum required number of employees as described in the following paragraphs. For more information, contact your employer or the Centers for Medicare & Medicaid Services.

If You are Age 65 or Older

If your group employs 20 or more employees and if you are age 65 or older and eligible for Medicare only because of your age, the coverage described in this plan will be provided before Medicare benefits as long as your employer or group health plan coverage is based on your status as a current active employee or the status of your spouse as a current active employee.

If You are Under Age 65 with Disability

If your employer or group employs 100 or more employees and if you are under age 65 and eligible for Medicare only because of a disability (and not ESRD), coverage under this plan will be provided before Medicare benefits as long as your group health plan coverage is based on your status as a current active employee or the status of your spouse as a current active employee or on the current active employment status of an individual for whom you are a dependent.

If You are Under Age 65 with End-Stage Renal Disease (ESRD)

If you are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), coverage under this plan will be provided before Medicare benefits, but only during the first 30 months of your ESRD coverage. Then, the coverage described in this plan will be reduced by the amount that Medicare pays for the same covered services.

Dual Medicare Eligibility

If you are eligible for Medicare because of ESRD and a disability, or because of ESRD and you are age 65 or older, the coverage under this plan will be provided before Medicare benefits during the first 30 months of your ESRD Medicare coverage if this plan was primary to Medicare when you became eligible for ESRD benefits.

This Plan Secondary Payer to Medicare

If you receive services covered under both Medicare and this plan, and Medicare is allowed by law to be the primary payer, this plan will cover over and above what Medicare pays up to the Medicare approved charge not to exceed the amount this plan would have paid if it had been your only coverage. If you are entitled to Medicare benefits, we will begin paying benefits after all Medicare benefits (including lifetime reserve days) are exhausted.

If you get inpatient services and have coverage under Medicare Part B only or have exhausted your Medicare Part A benefits, we will pay inpatient benefits based on our eligible charge less any payments made by Medicare for Part B benefits (i.e., for inpatient lab, diagnostic and x-ray services).

Benefits will be paid after we apply any deductible you may have under this plan.

Facilities or Providers Not Eligible or Entitled to Medicare Payment

When you get services at a facility or by a provider that is not eligible or entitled to reimbursement from Medicare, and Medicare is allowed by law to be the primary payer, we will limit payment to an amount that supplements the benefits that would have been payable by Medicare had the facility or provider been eligible or entitled to such payments, regardless of whether or not Medicare benefits are paid.

Third Party Liability Rules

If You have Coverage Under Worker's Compensation or Motor Vehicle Insurance

If you have or may have coverage under worker's compensation or motor vehicle insurance for the illness or injury, please note:

- **Worker's Compensation Insurance.** If you have or may have coverage under worker's compensation insurance, such coverage will apply instead of the coverage under this Guide to Benefits. Medical expenses from injuries or illness covered under worker's compensation insurance are excluded from coverage under this Guide to Benefits.
- **Motor Vehicle Insurance.** If you are or may be entitled to medical benefits from your automobile coverage, you must exhaust those benefits first, before receiving benefits from us. Please refer to the section in this Chapter entitled "Motor Vehicle Insurance Rules" for a detailed explanation of the rules that apply to your automobile coverage.

What Third Party Liability Means

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

- The illness or injury is caused or alleged to have been caused by someone else and you have or may have a right to recover damages or get payment in connection with the illness or injury; or
- You have or may have a right to recover damages or get payment without regard to fault.

In such cases, any payment made by us on your behalf in connection with such injury or illness will only be in accord with the following rules.

What You Need to Do

Your cooperation is required for us to determine our liability for coverage and to protect our rights to recover our payments. We will provide benefits in connection with the injury or illness in accord with the terms of this Guide to Benefits only if you cooperate with us by doing the following:

- **Give Us Timely Notice.** You must give us timely notice in writing of each of the following:
  - your knowledge of any potential claim against any third party or other source of recovery in connection with the injury or illness;
  - any written claim or demand (including legal proceeding) against any third party or against other source of recovery in connection with the injury or illness; and
  - any recovery of damages (including any settlement, judgment, award, insurance proceeds, or other payment) against any third party or other source of recovery in connection with the injury or illness.
  - To give timely notice, your notice must be no later than 30 calendar days after the occurrence of each of the events stated above.
- **Sign Requested Documents.** You must promptly sign and deliver to us all liens, assignments, and other documents we deem necessary to secure our rights to recover payments. You hereby authorize and direct any person or entity making or receiving any payment on account of such injury or illness to pay to us so much of such payment as needed to discharge your reimbursement obligations described above;
- **Provide Us Information.** You must promptly provide us any and all information reasonably related to our investigation of our liability for coverage and our determination of our rights to recover payments. We may ask you to complete an Injury/Illness report form, and provide us medical records and other relevant information;
- **Do Not Release Claims Without Our Consent.** You must not release, extinguish, or otherwise impair our rights to recover our payments, without our express written consent; and
- **Cooperate With Us**. You must cooperate to help protect our rights under these rules. This includes giving notice of our lien as part of any written claim or demand made against any third party or other source of recovery in connection with the illness or injury.

Any written notice required by these Rules must be sent to:

HMSA
Attn: 8 CA/Other Party Liability
P.O. Box 860
Honolulu, Hawaii 96808-0860

If you do not cooperate with us as described above, your claims may be delayed or denied. We shall be entitled to reimbursement of payments made on your behalf to the extent that your failure to cooperate has resulted in erroneous payments of benefits or has prejudiced our rights to recover payments.

Payment of Benefits Subject to Our Right to Recover Our Payments

If you have complied with the rules above, we will pay benefits in connection with the injury or illness to the extent that the medical treatment would otherwise be a covered benefit payable under this Guide to Benefits. However, we shall have a first-priority right to subrogation and reimbursement for any benefits we provide, from any recovery received from or on behalf of any third party or other source of recovery in connection with the injury or illness, including, but not limited to, proceeds from any:

- Settlement, judgment, or award;
- Motor vehicle insurance (other than personal injury protection benefits) including liability insurance or your underinsured or uninsured motorist coverage;
- Workplace liability insurance;
- Property and casualty insurance;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowner's insurance coverage;
- Medical malpractice coverage; or
- Any other payments from a source intended to compensate you for injuries resulting from an accident or alleged negligence.

As used herein, the term "Third Party," means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as "Third Party Injuries". "Third Party" includes any party responsible for payment of expenses associated with the care of treatment of Third Party Injuries.

If this plan pays benefits under this Guide to Benefits to you for expenses incurred due to Third Party Injuries, then the Plan retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the Third Party Injuries.

By accepting benefits under this plan, you specifically acknowledge the Plan's right of subrogation. In the event you suffer injuries for which a Third Party is responsible (such as someone injuring you in an accident), and the Plan pays benefits as a result of those injuries, the Plan will be subrogated and succeed to the right of recovery against such Third Party to the extent of the benefits the Plan has paid. This means that the Plan has the right, independently of you, to proceed against the Third Party responsible for your injuries to recover the benefits the Plan has paid. In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

By accepting benefits under this plan, you also specifically acknowledge the Plan's right of reimbursement. This right of reimbursement attaches when this plan has paid health care benefits for expenses incurred due to Third Party Injuries and you or your representative has recovered any amounts from a Third Party. By providing any benefit under this Guide to Benefits, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

We shall have a first lien on such recovery proceeds, up to the amount of total benefits we pay or have paid related to the injury or illness. You must reimburse us for any benefits paid, even if the recovery proceeds obtained (by settlement, judgment, award, insurance proceeds, or other payment):

- Do not specifically include medical expenses;
- Are stated to be for general damages only;
- Are for less than the actual loss or alleged loss suffered by you due to the injury or illness;
- Are obtained on your behalf by any person or entity, including your estate, legal representative, parent, or attorney;
- Are without any admission of liability, fault, or causation by the third party or payor.

No court costs or attorney fees may be deducted from our lien.

Our lien will attach to and follow such recovery proceeds even if you distribute or allow the proceeds to be distributed to another person or entity. Our lien may be filed with the court, any third party or other source of recovery money, or any entity or person receiving payment regarding the illness or injury.

If we are entitled to reimbursement of payments made on your behalf under these rules, and we do not promptly receive full reimbursement pursuant to our request, we shall have a right to set-off from any future payments payable on your behalf under this Guide to Benefits.

Our rights of reimbursement, lien, and subrogation described above, are in addition to all other rights of equitable subrogation, constructive trust, equitable lien and/or statutory lien we may have for reimbursement of these payments. All of these rights are preserved and may be pursued at our option against you or any other appropriate person or entity.

For any payment made by us under these rules, you are still responsible for your copayments, deductibles, timeliness in submission of claims, and other obligations under this Guide to Benefits.

Nothing in these Third Party Liability Rules shall limit our ability to coordinate benefits as described in this Chapter.

CHAPTER 10

This Chapter Covers

Eligibility for Coverage

When You are Eligible for Coverage

You may enroll in this coverage when you are first eligible according to your employer's rules for eligibility. If you do not enroll in this coverage when you first become eligible or by the first day of the month immediately following the first four consecutive weeks of employment, you will not be eligible to enroll until the next open enrollment period. ***Open Enrollment*** happens once a year. However, if we agree that there was unusual and justifiable cause for submitting your enrollment form late, you may enroll sooner.

Please note: To be eligible, you must also live in the service area of the health center specified on your enrollment form.

Categories of Coverage

There are different categories of coverage you may hold.

- With single coverage, you the member, are the only one covered.
- With family coverage, you the member, and your spouse, and each of your eligible, dependent children have coverage. Each covered family member must be listed on the member's enrollment form or added later as a new dependent.

Enrollment Process

You must enroll your spouse or child(ren) by naming him or her on the enrollment form or other form and submitting it within 31 days of the date the spouse or child becomes eligible. If you do not enroll within this time frame, you may enroll at the next open enrollment period. Open enrollment takes place once a year.

If you decline enrollment in this plan for yourself or your dependents (including your spouse) because of other health plan coverage, you may be able to enroll yourself or your dependents in this plan at a later date if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must enroll by complying with our usual enrollment process within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

What You Should Know about Enrolling Your Child(ren)

In general, you may enroll a child if the child meets all of these requirements:

- The child is your son, daughter, stepson or stepdaughter, your legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian, or your eligible foster child (defined as an individual who is placed with you by an authorized placement agency or by judgment, decree, or other court order).
- The child is under 26 years of age.

Also, you may enroll children who meet all of the criteria in one of these categories:

- Children with Special Needs

• Children Who Are Newborns or Adopted.

Children with Special Needs

You may enroll your child if he or she is disabled by providing us with written documentation acceptable to us demonstrating that:

• Your child is incapable of self-sustaining support because of a physical or mental disability.
• Your child's disability existed before the child turned 26 years of age.
• Your child relies primarily on you for support and maintenance as a result of his or her disability.

You must provide this documentation to us within 31 days of the child's 26th birthday, or anticipated enrollment with HMSA, and subsequently at our request but not more frequently than annually.

Children Who are Newborns or Adopted

You may enroll a newborn or adopted child, effective as of the date listed below, if you comply with the requirements described below and enroll the child in accord with our usual enrollment process:

• The birth date of a newborn, providing you comply with our usual enrollment process within 31 days of the child's birth.
• The date of adoption, providing you comply with our usual enrollment process within 31 days of the date of adoption.
• The birth date of a newborn adopted child, providing we get notice of your intent to adopt the newborn within 31 days of the child's birth.
• The date the child is placed with you for adoption, providing we get notice of the placement within 31 days of the placement. Placement occurs when you assume a legal obligation for total or partial support of the child in anticipation of adoption.

Qualified Medical Child Support Order (QMCSO)

Qualified Medical Child Support Orders or QMCSOs are court orders that meet certain federal guidelines and require a person to provide health benefits coverage for a child. Claims for benefits for a child covered by a Qualified Medical Child Support Order may be made by any of the following:

• The child.
• The child's custodial parent.
• The child's court-appointed guardian.
• Any benefits otherwise payable to the member with respect to any such claim shall be payable to the child's custodial parent or court-appointed guardian.

If you would like more information about how HMSA handles QMCSOs, you may call us at one of the phone numbers listed on the back cover of this Guide.

When Coverage Begins

When You are Eligible to Receive Benefits

This coverage takes effect and you are eligible for benefits on your effective date, as long as:

• Your initial dues were paid; and
• We accepted your enrollment form and gave you written notice of your effective date.

When Coverage Ends

Reasons for Coverage Termination

Unless prohibited by state or federal law, your coverage will end at the end of the month in which any of these take place:

• You choose to end this coverage. In this case, you must provide written notice of your intent to terminate 30 days before the termination date.
• You or your employer or group sponsor fails to make payments to us when due, or your employer or group sponsor decides to discontinue this coverage, and we have given 10-days advance written notice to your employer and the Director of the Hawaii Department of Labor and Industrial Relations.
• Your employer or group sponsor decides to replace this coverage with another coverage and there is no lapse in coverage.
• We end our agreement with your employer or group sponsor, and we have given 10-days advance written notice to your employer and the Director of the Hawaii Department of Labor and Industrial Relations.
• For the member, upon your retirement, termination of employment, severance from the group, or termination of this Agreement.

- For the member's spouse, upon your termination of coverage or upon the dissolution of the marriage.
- For the member's *children*, when any of the following occurs:
  - The member's coverage ends; or
  - The child fails to meet the criteria outlined earlier in this chapter under What *You Should Know about Enrolling Your Child(ren)*

Also, Health Plan Hawaii may terminate a member's or dependent's Health Center enrollment under this plan if any of the following occur:

- You use a member card other than the one under which you are enrolled or permit a person not enrolled under your member card to use it.

Notifying Us When Your Child's Eligibility Ends

You must inform us, in writing, if a child no longer meets the eligibility requirements. You must notify us on or before the first day of the month following the month the child no longer meets the requirements. For example, let's say that your child turns 26 on June 1. You would need to notify us by July 1.

If you fail to inform us that your child is no longer eligible, and we make payments for services on his or her behalf, you must reimburse us for the amount we paid.

Termination for Fraud

Your eligibility for coverage will end if you or your employer use this coverage fraudulently or intentionally misrepresent or conceal material facts on your enrollment form or in any claim for benefits.

If we determine that you or your employer has committed fraud or made an intentional misrepresentation or concealment of material facts, we will provide you written notice 30 days prior to termination of your coverage. During that time, you have a right to appeal our determination of fraud or intentional misrepresentation. For more details on your appeal rights, see *Chapter 8: Dispute Resolution.*

If your coverage is terminated for fraud, intentional misrepresentation, or the concealment of material facts:

- We will not pay for any services or supplies provided after the date the coverage is terminated.
- You agree to reimburse us for any payments we made under this coverage.
- We will retain our full legal rights. This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation.

Continuity of Care

Continuing Care Patient

You may be eligible for continuity of care if you are a continuing care patient receiving a course of treatment from a Health Plan Hawaii Network provider and one of the following occurs:

- the contractual relationship between the Health Plan Hawaii Network provider and HMSA is terminated;
- benefits provided under your plan with respect to the Health Plan Hawaii Network provider are terminated because of a change in the terms of the participation of such Health Plan Hawaii Network provider in such plan; or
- you are under a group health plan and the contract between such group health plan and HMSA is terminated.

With respect to the above occurrences, the term "terminated" does not include a termination of a contract for failure to meet applicable quality standards or for fraud.

A "Continuing Care Patient" is defined as an individual who, with respect to a provider:

- is undergoing a course of treatment for a serious and complex condition from the provider,
- is undergoing a course of institutional or inpatient care from the provider,
- is scheduled for non-elective surgery from the provider, including receipt of post-operative care from such provider with respect to such a surgery,
- is pregnant and undergoing a course of treatment for the pregnancy from the provider, or

• is or was determined to be terminally ill and is receiving treatment for such illness from such provider.

For purposes of the ”Continuing Care Patient” definition, a serious and complex condition means either:

• in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
• in the case of a chronic illness or condition, a condition that is (i) life-threatening, degenerative, potentially disabling, or congenital and (ii) requires specialized medical care over a prolonged period of time.

If we determine you are eligible for continuity of care, we will inform you of the options under transitional care. If you qualify for transitional care, you may elect to continue your current benefits and copayments under this Plan with respect to the course of treatment furnished by such provider relating to your status as a continuing care patient. Plan benefits will apply, beginning on the date HMSA’s notice of termination is provided and ending 90 days later or when you are no longer eligible as a continuing care patient, whichever is sooner.

No Surprises Act Emergency Services and Surprise Bills

Under the No Surprises Act (“NSA”), a provider or emergency facility may not bill or hold you liable for a payment amount that exceeds the copayment requirement had such service or item been received from a Health Plan Hawaii Network provider unless you signed a valid consent allowed by law.

If coverage is approved and applies, benefits for services rendered subject to the NSA will be paid directly to the non-network provider. Services or items subject to the NSA are:

• Emergency Services rendered by a non-network provider;
• Non-emergency items and services furnished or rendered by a non-network provider at certain participating health care facilities, provided the beneficiary has not validly waived the applicability of the NSA; and
• Air ambulance services covered by the Plan and provided by non-network air ambulance providers.

Please note: Copayment amounts will apply toward meeting the annual deductibles and annual copayment maximums.

Continued Coverage

Continued Coverage Under Federal Law - COBRA Rights

When your coverage ends under this Agreement you may have the opportunity to continue your group coverage for a limited time under the Consolidated Omnibus Budget Reconciliation Act (COBRA). The act applies to employers with 20 or more employees.

Qualifying Events

COBRA entitles you and your eligible dependents, if already covered, to continue this coverage if coverage is lost due to any of the following qualifying events:

• Employer or group sponsor from whom you retired files bankruptcy under federal law.
• Death of the employee covered under this coverage.
• Divorce or legal separation.
• Child no longer meets our eligibility rules.
• Enrollment in Medicare.
• Termination of employment for reasons other than gross misconduct, or if your work hours are reduced to the point that you are no longer eligible for coverage.

Please note that dependents covered as domestic partners are not eligible for COBRA coverage.

If you lose your coverage, contact your employer or group sponsor immediately. You are entitled to receive a COBRA election form within 44 days if the qualifying event is a termination of employment or reduction in hours. If the qualifying event is divorce, legal separation, or a child ceasing to be a dependent child, the form and notice must be provided to you within 14 days after you notify your employer of the event.

Please note: You or your spouse is responsible for notifying your employer or group sponsor of your divorce or legal separation, or if a child loses eligibility status under our rules for coverage.

If you or your spouse believes you have had a qualifying event and you have not received your COBRA election form on a timely basis, please contact your employer.

Payment of COBRA Premiums

If you or your dependents are entitled to and elect COBRA continuation coverage, you must pay your employer the premiums for the continuing coverage that may be up to 102% of the full cost of the coverage. In the case of a disabled individual whose coverage is being continued for 29 months, you or your dependents may be required to pay up to 150% of the full cost of the coverage for any month after the 18th month.

Within 45 days of the date you elect COBRA coverage you must pay an initial COBRA premium to cover from the date of your qualifying event to the date of your election. You will be notified of the amount of the premiums you must pay thereafter. If you fail to make the initial payment or any subsequent payment in a timely fashion (a 30 days grace period applies to late subsequent payments), your COBRA coverage will terminate.

What You Must Do

If you wish to continue your coverage, you must complete an election form and submit it to your employer within 60 days of the later of the date:

- You are no longer covered; or
- You are notified of the right to elect COBRA continuation coverage.

You or your dependents must notify your employer in the following circumstances:

- If coverage for you or your dependents is being continued for 18 months under COBRA and it is determined under Title XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event which would have caused coverage to terminate, then you or your dependent must notify your employer of such determination . Notice must be provided within 60 days of the determination of disability. Notice must also be given within 30 days of any notice that you or your dependent is no longer disabled.
- If coverage for a dependent would terminate due to your divorce, a legal separation, or the dependent's ceasing to be a dependent under this plan, then you or your dependent must provide notice to your employer of the event. This notice must be given within 60 days after the later of the occurrence of the event or the date coverage would terminate due to the occurrence of the event.

If notice is not provided on time, COBRA coverage will not be available to you or your dependents.

Adding Your Child

If during the period of COBRA coverage, a child is born to you or placed with you for adoption and you are on COBRA because you terminated employment or had a reduction in hours, the child can be covered under COBRA and can have election rights of his or her own. Please be aware that dependent children of domestic partners are not eligible for COBRA continuation coverage.

Length of Coverage Under COBRA

Continuation coverage ends at the earliest of one of these events:

- The last day of the 18-, 29-, or 36-month maximum coverage period, whichever is applicable. If you or any of your dependents who has elected COBRA coverage is determined to be disabled under the Social Security Act during the first 60 days of continuation coverage, your COBRA coverage may continue for up to 29 months. The 29-month period will apply to you and your eligible dependents who elected COBRA coverage. You must provide notice of the disability determination to your employer within 60 days after the determination.
- The first day (including grace periods, if applicable) on which timely payment is not made by you.
- The date on which the employer ceases to maintain any group health plan (including successor plans).
- The date the qualified beneficiary enrolls in Medicare benefits. ***Qualified Beneficiary*** means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan:

– as the spouse of the covered employee; or
– as the dependent child of the covered employee.

• The first day on which a beneficiary is actually covered by any other group health plan. However, if the new group health plan contains an exclusion or limitation relating to any preexisting condition of the beneficiary, then coverage will end on the earlier of the satisfaction of the waiting period for preexisting conditions contained in the new group health plan, or the occurrence of any one of the other events stated in this chapter.

If the new group health plan contains a preexisting condition exclusion, the preexisting condition exclusion period will be reduced by the qualified beneficiary's preceding aggregate periods of creditable coverage (if any). The creditable coverage is applicable to the qualified beneficiary as of the enrollment date in the new group health plan as long as there has been no interruption of coverage longer than 63 days. Creditable Coverage means any of the following:

• A group health plan.
• Health insurance coverage.
• Part A or B of Medicare.
• Medicaid.
• Chapter 55 of Title 10, United States Code.
• A medical care program of the Indian Health Service or of a tribal organization.
• A state health benefits risk pool.
• A health plan offered under Chapter 89 of Title 5, United States Code.
• A public health plan as defined in government regulations.
• A health benefit plan under section 5(e) of the Peace Corps Act.

You may request a certificate of creditable coverage by calling HMSA Customer Service. Our phone number is listed on the back cover of this Guide.

Other Continuation Coverage

If you are not eligible for COBRA coverage, you may be eligible for one of HMSA's individual payment plans. Please call us for more information.

Continued Coverage if Member Dies

Upon the death of a member, his or her spouse, if not eligible for group coverage, may become a member under an individual payment plan. In this case, all dependent children of such deceased member may continue to be enrolled as though they were dependents of such new member.

Continued Coverage if You have Medicare

When you are no longer eligible for this coverage and are enrolled in Medicare Parts A and B, you may be eligible to enroll in another HMSA plan. If you would like more information, call us at the number listed on the back cover of this Guide.

Confidential Information

Your medical records and information about your care are confidential. HMSA does not use or disclose your medical information except as allowed or required by law. You may need to provide information to us about your medical treatment or condition. In accordance with law, we may use or disclose your medical information (including providing this information to third parties) for the purpose of payment activities and health care operations such as:

• quality assurance;
• disease management;
• provider credentialing;
• administering the plan;
• complying with government requirements; and
• research or education.

Dues and Terms of Coverage

Dues

You or your employer or group sponsor must pay us on or before the first day of the month in which benefits are to be provided. We have the right to change the monthly dues after 30 days written notice to your employer or group sponsor. HMSA will accept dues payments directly from:

• you,
• your employer or group sponsor,
• your family,

- government programs,
- Ryan White HIV/AIDS programs,
- Native American tribal organizations and/or governments, and religious institutions and other not-for-profit organizations where the following criteria is met:
  - The assistance is provided on the basis of the insured's financial need;
  - The organization is not a healthcare provider; and
  - The organization is financially disinterested (i.e., the organization does not receive funding from an entity that has a pecuniary interest in the payment of health insurance claims and/or benefits).

In accordance with applicable law and regulatory guidance, HMSA declines dues payments from third-parties not included above. Notwithstanding the above, HMSA will not decline dues payments from third-parties for payments of dues for COBRA group health plan continuation coverage. Upon termination of a member's COBRA continuation coverage, and subsequent re-enrollment in other (non-COBRA) HMSA coverage, the general prohibition on third-party payments described above will apply.

Timely Payment

If you or your employer or group sponsor fail to pay monthly dues on or before the due date, we may end coverage, unless all dues are brought current within 10 days of our written notice of default to your employer or group sponsor and the state of Hawaii Department of Labor and Industrial Relations. We are not liable for benefits for services received after the termination date. This includes benefits for services you receive if you are enrolled in this coverage under the provisions of the:

- Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Terms of Coverage

By submitting the enrollment form, you also accept and agree to the provisions of our constitution and bylaws now in force and as amended in the future. You also appoint your employer or group as your administrator for dues payment and for sending and receiving all notices to and from HMSA concerning the plan.

Authority to Terminate, Amend, or Modify Coverage

Your employer or group sponsor has the authority to modify, amend, or end this coverage at any time. If your employer or group sponsor ends this coverage, you are not eligible to receive benefits under this coverage after the termination date. Any amendment or modification proposed by your employer or group sponsor must be in writing and accepted by us in writing.

We have the authority to modify the Agreement as long as we give 30 days prior written notice to your employer or group sponsor regarding the modification.

Governing Law

To the extent not superseded by the laws of the U.S., this coverage will be construed in accord with and governed by the laws of the state of Hawaii. Any action brought because of a claim against this coverage will be litigated, arbitrated, or otherwise resolved in the state of Hawaii and in no other.

Payment in Error

If for any reason we make payment under this coverage in error, we may recover the amount we paid.

Notice Address

You may send any notice required by this chapter to:

HPH
P.O. Box 860
Honolulu, Hawaii 96808-0860

Any notice from us will be acceptable when addressed to you at your address as it appears in our records.

ERISA Information

The Employee Retirement Income Security Act of 1974 (ERISA) provides that you will be entitled to:

- Examine all plan documents and copies of documents (such as annual reports) filed by the plan with the United States Department of Labor. You may examine these documents without charge at the plan administrator's office or at specified locations.

- Get copies of plan documents from the plan administrator upon written request. The plan administrator may request a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report if your employer or group sponsor has 100 or more participants in your plan. The plan administrator is required by law to furnish you with a copy of this summary annual report.

In addition to creating rights for you and other participants, ERISA imposes duties upon the people responsible for the operation of your employee benefit plan. The people responsible are called fiduciaries of the plan. Fiduciaries have a duty to operate your employee benefit plan prudently and in the interest of you and your family members. HMSA and the plan administrator (your employer or group sponsor), are fiduciaries under this Agreement; however, HMSA's duties are limited to those described in this Agreement, and the plan administrator is responsible for all other duties under ERISA. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from getting a covered benefit or exercising your rights under ERISA. In general, federal law prohibits health plans 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. Plans may require authorization for lengths of stay in excess of these time parameters. If your claim for a covered benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to request an appeal and reconsideration of your claim. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request plan documents from the plan administrator and do not receive it within 30 days, a federal court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the document, unless the document was not sent because of matters reasonably beyond the control of the plan administrator.

If you have a claim for benefits that 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 or entity 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, i.e., your employer or group sponsor. If you have questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your phone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20010.

CHAPTER 11

Actual Charge
The amount a provider bills for a covered service or supply.

Acute Care
Inpatient 24-hour hospital care that needs physician and nursing care on a minute-to-minute, hour-to-hour basis.

Administrative Review
Administrative review is an approval process that is required for services to be rendered by a provider who is located out of state or who does not participate with HMSA.

Admission
The formal acceptance of a patient into a facility for medical, surgical, or obstetric care.

Advance Care Planning
Advance care planning (ACP) prepares members in the event they become very sick. Members discuss with their doctor what matters most to them and document the desired care. ACP becomes important when a member cannot communicate decisions.

Agreement
The document made up of:
- This Guide to Benefits;
- Any riders or amendments;
- The enrollment form submitted to us; and
- The Agreement between us and your employer or group sponsor.

Alcohol Dependence
Any use of alcohol that produces a pattern of pathological use that causes impairment in social or occupational functions or produces physiological dependence evidenced by physical tolerance or withdrawal.

Allogeneic Transplant
Transplant in which the tissue or organ for a transplant is obtained from someone other than the person receiving the transplant.

Ambulance Service
Air or ground emergency transport to a hospital.

Ambulatory Surgical Center
A facility that provides surgical services on an outpatient basis for patients who do not need an inpatient, acute care hospital bed.

Ancillary Services
Facility charges other than room or board. For example, charges for inpatient drugs and biologicals, dressings, or medical supplies.

Anesthesia
The use of anesthetics to produce loss of feeling or consciousness, usually with medical treatment such as surgery.

Annual Copayment Maximum
The maximum copayment amounts you pay in a calendar year. Once you meet the copayment maximum you are no longer responsible for copayment amounts unless otherwise noted.

Applied Behavior Analysis
The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of:
- direct observation,
- measurement, and

• functional analysis of the relations between environment and behavior.

Arbitration

When one person (an arbitrator) reviews the positions of two parties who have a dispute and makes a decision to end the dispute.

Assisting Surgeon

A physician who actively assists the physician in charge during a surgical procedure.

Autologous Transplant

Transplant in which the tissue or organ for a transplant is obtained from the person receiving the transplant.

Away from Home Care

A program sponsored by the Blue Cross and Blue Shield Association. The program offers medical benefits when you need medical care while you are away from your service area (but within the U.S.).

Benefit Maximum

A limit that applies to a specified covered service or supply. A service or supply may be limited by duration or the number of visits. The maximum may apply per service or calendar year.

Benefits

Services and supplies that are medically necessary and qualify for payment under this coverage.

Bereavement Services

Services that focus on healing from emotional loss.

Biofeedback

A technique in which a person uses information about a normally unconscious bodily function, such as blood pressure, to gain conscious control over that function. The condition to be treated must be a normally unconscious physiological function. A device or feedback monitoring equipment (i.e., external feedback loop) must be used to treat the condition. The purpose of treatment is to exert control over that physiological function.

Biological Products

Biological products, or biologics, are medical products. Many products are made from a variety of natural sources (i.e., human, animal, or microorganism). It may be produced by biotechnology methods and other cutting-edge technologies. Like drugs, some biologics are intended to treat diseases and medical conditions. Other products are used to prevent or diagnose diseases. Examples may include:

- Vaccines.
- Blood and blood products for transfusion and /or manufacturing into other products.
- Allergenic extracts that are used for both diagnosis and treatment, i.e., allergy shots.
- Human cells and tissues used for transplantation (e.g., tendons, ligaments and bones).
- Gene therapies.
- Cellular therapies.
- Tests to screen potential blood donors for infectious agents such as HIV.

Biological Therapeutics and Biopharmaceuticals

Any biology-based therapeutics that structurally mimic compounds found in the body. This includes:

- recombinant proteins,
- monoclonal and polyclonal antibodies,
- peptides,
- antisense oligonucleotides,
- therapeutic genes, and
- certain therapeutic vaccines.

Biosimilar Product

A biological product that is FDA-approved based on a showing that it is highly similar to an already FDA-approved reference product. It has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Only minor differences in clinically inactive components are allowable in biosimilar products.

Birthing Center

A facility that provides services for normal childbirth. This facility may be in a hospital or it may be a separate, independent facility.

Blood Transfusion

Transferring blood products such as blood, blood plasma, and saline solutions into a blood vessel, usually a vein.

BlueCard Provider

A provider that participates with the Blue Cross and Blue Shield Association. BlueCard participating providers file claims for you and accept the eligible charge as payment in full.

Breast Prostheses (External)

Artificial breast forms intended to simulate breasts for women who have uneven- or unequal-sized breasts who decide not to, or are waiting to, undergo surgical breast reconstruction after a covered mastectomy or lumpectomy. They include:

- mastectomy bras (surgical bras),
- forms,
- garments and
- sleeves.

Calendar Year

The period starting January 1 and ending December 31 of any year. The first calendar year for anyone covered by this plan begins on that person's effective date and ends on December 31 of that same year.

Chemotherapy

Treatment of infections or malignant diseases by drugs that act selectively on the cause of the disorder, but which may have substantial effects on normal tissue. Chemotherapy drugs must be FDA approved.

Chemotherapy - Oral

An FDA-approved oral cancer treatment that may be delivered for self-administration under the direction or supervision of a physician outside of a hospital, medical office, or other clinical setting.

Child

Means any of the following: your son, daughter, stepson or stepdaughter, your legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian, or your eligible foster child (defined as an individual who is placed with you by an authorized placement agency or by judgment, decree or other court order).

Chiropractor

A health care professional who practices the system of healing through spinal manipulation and specific adjustment of body structures.

Claim

A written request for payment of benefits for services covered by this coverage.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 that offers you and your eligible dependents continuation of this coverage if you lose coverage due to a qualifying event.

Consultation Services

A formal discussion between physicians on a case or its treatment.

Contact Lenses

Ophthalmic corrective lenses ground as prescribed by a physician or optometrist who fit the lenses directly to your eyes.

Contraceptive Services

Services that facilitate the use of contraceptives to prevent pregnancy.

Contraceptives

Any prescription contraceptive supplies or devices, including:

- oral medicine,
- implants,
- injectables,
- IUDs or
- other appropriate methods intended to prevent pregnancy.

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Coordination of Benefits (COB)

Applies when you are covered by more than one insurance policy providing benefits for like services.

Copayment

A copayment applies to most covered services. It is either a fixed percentage of the eligible charge or a fixed dollar amount. Exception: For services provided at a participating facility, your copayment is based on the lower of the facility's actual charge or the maximum allowable fee. You owe a copayment even if the facility's actual charge is less than the maximum allowable fee.

Cosmetic Services

Services that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function, or are prescribed for psychological or psychiatric reasons.

Covered Services

Services or supplies that meet payment determination criteria and are:
- Listed in this Guide in *Chapter 4: Description of Benefits,* and
- Not listed in this Guide in *Chapter 6: Services Not Covered*.

Creditable Coverage

Any of the following: a group health plan; health insurance coverage; Part A or B of Medicare; Medicaid; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5, United States Code; or a public health plan as defined in government regulations health benefit plan under section 5(e) of the Peace Corps Act.

Custodial Care

Care that helps you meet your daily living activities. This type of care does not need the ongoing attention and help from licensed medical or trained paramedical personnel.

Custom-Fabricated

Items that are individually made for a specific patient (no other patient would be able to use it) starting with basic materials including, but not limited to:
- plastic,
- metal,
- leather, or
- cloth in the form of sheets, bars, etc.

It involves substantial work such as:
- vacuum forming,
- cutting,
- bending,
- molding,
- sewing, etc.

It may involve the incorporation of some prefabricated components but it involves more than:
- trimming,
- bending, or
- making other modifications to a substantially prefabricated item.

Deluxe/Upgraded Items

Items that have certain convenience or luxury features that enhance standard or basic equipment. Standard equipment is equipment that meets the medical needs of a patient to perform activities of daily living primarily in the home and is not designed or customized for a specific individual's use.

Dependent

The member's spouse and/or eligible child(ren).

Detoxification Services

A process of detoxifying a person who is dependent on alcohol and/or drugs. The process involves helping a person through the period of time needed to get rid of, by metabolic or other means, the intoxicating alcohol or drug dependency factors.

Diagnosis

The medical description of the disease or condition.

Diagnostic Testing

A measure used to help identify the disease process and signs and symptoms.

Directory of Health Centers and Providers

A complete listing of HPH health centers and network providers.

Dr. Ornish's Program for Reversing Heart Disease™

A comprehensive approach to cardiovascular disease management and overall well-being improvement that addresses modifiable risk factors under the supervision of a multidisciplinary team.

Drug

Any chemical compound that may be used on or given to help diagnose, treat or prevent disease or other abnormal condition, to relieve pain or suffering, or to control or improve any physiologic or pathogenic condition.

Drug Dependence

Any pattern of pathological use of drugs that cause impairment in social or occupational function and produces psychological or physiological dependence or both, as evidenced by physical tolerance or withdrawal.

Dues

The monthly premium amount for HPH membership.

Durable Medical Equipment

An item that meets these criteria:

- FDA-approved for the purpose that it is being prescribed.
- Able to withstand repeated use.
- Primarily and customarily used to serve a medical purpose.
- Appropriate for use in the home. ***Home*** means the place where you live other than a hospital or skilled or intermediate nursing facility.
- Necessary and reasonable to treat an illness or injury, or to improve the functioning of a malformed body part. It should not be useful to a person in the absence of illness or injury

Examples of durable medical equipment include oxygen equipment, hospital beds, mobility assistive equipment (wheelchairs, walkers, power mobility devices), and insulin pumps.

Effective Date

The date on which you are first eligible for benefits under this coverage.

Eligible Charge

The ***Eligible Charge*** is the lower of either the provider's actual charge or the amount we establish as the maximum allowable fee. HMSA's payment, and your copayment, are based on the eligible charge. Exception: For services from participating facilities, HMSA's payment is based on the maximum allowable fee and your copayment is based on the lower of the actual charge or the maximum allowable fee.

Emergency

A medical condition accompanied by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

- serious risk to the health of the person (or, with respect to a pregnant woman, the health of the woman and her unborn child);
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ part.

ERISA

The Employee Retirement Income Security Act of 1974, a federal law that protects your rights under this coverage.

Extended Care Facility

A facility that provides ongoing skilled nursing care, sub-acute care, or long-term acute care as ordered and certified by your attending Provider.

Facility

Examples include hospitals, extended care facilities, birthing centers, and ambulatory surgical facilities

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False Statement Any fraudulent or intentional misrepresentation you or your employer made on your membership enrollment form or in any claims for benefits.

Family Coverage Means coverage for the member, his or her spouse, and each of his or her eligible children.

Family Member The member's spouse and/or children who are eligible and enrolled for this coverage.

Foot Orthotics Devices that are placed into shoes to assist in restoring or maintaining normal alignment of the foot, relieve stress from strained or injured soft tissues, bony prominences, deformed bones and joints and inflamed or chronic bursae.

Frame An eyeglass frame or similar frame into which two lenses are fitted.

Gender Dysphoria The distress experienced when a person’s gender assigned at birth does not match their gender identity.

Gender Identity A person's internal sense of being male, female, a gender different from the gender assigned at birth, a transgender person, or neither male nor female.

Gender Transition The process of a person changing the person's outward appearance, including sex characteristics, to accord with the person's gender identity.

Generic Drug A drug, supply, or insulin that is prescribed or dispensed under its commonly used generic name rather than a brand name. A generic drug is not protected by patent, or is identified by HMSA as “generic”.

Group Those members who share a common relationship such as employment or membership. The group has executed the group plan agreement with us and by getting health coverage through the group, you designate the group as your administrator.

Guest Membership Prearranged membership from an HMO Host Plan offered by the Blue Cross and/or Blue Shield plan in the service area where you require services.

Guide to Benefits This document, along with any riders or amendments that provide a written description of your health care coverage.

HMSA Hawai‘i Medical Service Association, an independent licensee of the Blue Cross and Blue Shield Association.

HMSA Select Prescription Drug Formulary A list of drugs by therapeutic category published by HMSA.

High-Dose Chemotherapy A form of chemotherapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a stem-cell transplant is needed.

High-Dose Radiotherapy A form of radiation therapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a stem-cell transplant is needed.

Home Health Agency (HHA) An approved agency that provides skilled nursing care in your home.

Home Infusion Therapy Treatment in the home that involves giving nutrients, antibiotics and other drugs and fluids intravenously or through a feeding tube. Drugs must be FDA approved.

Homebound

Due to an illness or injury, you are unable to leave home, or leaving your home requires a large and taxing effort.

Hospice Program

A program that provides care in a comfortable setting for patients who are terminally ill and have a life expectancy of six months or less. Care is normally provided in the patient's home.

Hospital

An institution that provides diagnostic and therapeutic services for surgical and medical diagnosis, treatment and care of injured or sick persons.

Illness or Injury

Any bodily disorder, injury, disease or condition, including pregnancy and its complications.

Immediate Family Member

Your child, spouse, parent, or yourself.

Immunization

An injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

Implanted Internal Items/Implants (Surgical/Orthopedic)

Internal prosthetic devices used during surgery that are necessary for anatomical repair or reconstructive purposes. These devices remain in the body and replace a missing biological structure or support or enhance a damaged biological structure.

Examples include, but are not limited to:

- cardiac pacemakers,
- defibrillators,
- heart valves and stents,
- breast implants for post-mastectomy reconstruction,
- hip and knee replacements,
- hardware necessary to anchor fractured bones,
- implanted cataract lenses,
- cochlear implants,
- adjustable gastric bands for bariatric surgery, and
- human tissue.

The device must be FDA-approved for the purpose it is being used.

In Vitro Fertilization

A method used to treat infertility in women.

Incidental Procedure

A procedure that is an integral part of another procedure. Such procedures are not reimbursed separately.

Inhalation Therapy

Therapy to treat conditions of the cardiopulmonary system.

Injection

The introduction of a drug, biological therapeutic, biopharmaceutical, or vaccine into the body by using a syringe and needle. Injectable drugs must be FDA approved.

Inpatient Admission

A stay in an inpatient facility, usually involving overnight care.

Interchangeable Biologic Product

An FDA-approved biologic product that meets the additional standards for interchangeability to an FDA-approved reference product included in:

- The Hawaii list of equivalent generic drugs and biological products.
- The Orange Book.
- The Purple Book.
- Other published findings and approvals of the United States Food and Drug Administration.

In accordance with any applicable state and federal regulations and laws, an interchangeable biological product may be substituted for the reference product by a pharmacist without the intervention of the healthcare provider who prescribed the reference product.

Intravenous Injection — An injection made into the vein.

Laboratory Services — Services used to help diagnose, prevent, or treat disease.

Lenses — Ophthalmic corrective lenses ground as prescribed by a physician or optometrist for fitting into a frame.

Limited Services — Those covered services that are limited per service, per episode, per calendar year or per lifetime.

Long-Term Acute Care — A level of care for patients who:
- no longer require care in an acute hospital,
- are chronically and severely ill,
- are felt to have the potential for improvement, and
- require an intensity and specialization of care that is beyond that provided in any other level of post-acute care.

Examples include:
- skilled nursing facility,
- home healthcare,
- inpatient rehabilitation facility, and
- for a limited period until the condition is stabilized or a predetermined treatment course is completed.

Mammogram — An x-ray exam of the breast using equipment dedicated specifically for mammography.

Mammography (screening) — An x-ray film that screens for breast abnormalities.

Maternity Care — Routine prenatal visits, delivery, and one postpartum visit.

Maximum Allowable Fee — The maximum dollar amount HMSA will pay for a covered service, supply, or treatment.

Medicaid — A form of public assistance sponsored jointly by the federal and state governments providing medical assistance for eligible persons whose income falls below a certain level. The Hawaii Department of Human Services pursuant to Title XIX of the federal Social Security Act administers this program.

Medication — The treatment of disease without surgery.

Medicine — To diagnose and treat disease and to maintain health.

Member — The person who meets eligibility requirements and who executes the enrollment form that is accepted in writing by us.

Member Card — Your member card issued to you by us. You must present this card to your provider at the time you get services.

Mental Health Outpatient Facility — A mental health clinic, institution, center, or community mental health center that provides for the diagnosis, treatment, care or rehabilitation of people who are mentally ill.

Mental Health Illness/Disorder — A syndrome of clinically significant psychological, biological, or behavioral abnormalities that result in personal distress or suffering, impairment of capacity to function, or both. Mental health illness and disorder are used interchangeably in this Guide and as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or in the International Classification of Disease.

Microprocessor-Controlled Prosthetic Device	Prosthetic devices that use feedback from sensors to adjust joint movement on a real-time as-needed basis.
Myoelectric Prosthetic Device	Prosthetic devices powered by electric motors with an external power source. For example, the movement of an upper limb prosthesis (e.g., hand, wrist, and/or elbow) is driven by micro-chip-processed electrical activity in the muscles of the remaining limb stump.
Network Provider	All providers represented in all health centers that have contracted with Health Plan Hawaii to care for its members.
Newborn	A recently born infant.
Newborn Care	All routine non-surgical physician services and nursery care provided to a newborn during the mother's initial hospital stay.
Non-Assignment	When benefits for covered services and supplies cannot be transferred or assigned to anyone for use.
Non-Network Provider	A provider that is not under contract with HMSA to treat Health Plan Hawaii members.
Non-Preferred Formulary Drug, Supply, or Insulin	A brand name drug, supply, or insulin that is not listed as preferred on the HMSA Select Prescription Drug Formulary.
Nurse Midwife	A health care professional who provides services such as pre and post natal care, normal delivery services, routine gynecological services, and any other services within the scope of his or her certification.
Occupational Therapy	A form of therapy involving the treatment of neurological and musculoskeletal dysfunction through the use of specific tasks or goal-directed activities designed to improve the functional performance of an individual.
Online Care	Care provided by video conferencing, phone or web if obtained from HMSA Online.
Ophthalmologist	A physician specializing in the diagnosis and treatment of diseases and defects of the eye.
Optometrist	One who specializes in the examination, diagnosis, treatment and management of diseases and disorders of the visual system, the eye and related structures.
Oral Surgeon	A dentist licensed as a doctor of dentistry (D.M.D.) or dental surgery (D.D.S.) to diagnose and treat oral conditions that need surgery.
Organ Donor Services	Services related to the donation of an organ.
Orofacial Anomalies	Cleft lip or cleft palate and other birth defects of the mouth and face affecting functions such as eating, chewing, speech, and respiration.
Orthodontic Services to Treat Orofacial Anomalies	Direct or consultative services from a licensed dentist with a certification in orthodontics by the American Board of Orthodontics.
Orthotics/Orthotic Devices/Orthoses	Rigid or semi-rigid devices that are used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a diseased or injured part of the body. They must provide support and counterforce (i.e., a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support)

	on the limb or body part that it is being used to brace. An orthotic can be either prefabricated or custom-fabricated.
Osteopathy	Medicine that specializes in diseases of the bone.
Other Providers	Health care providers other than facilities and practitioners. Examples include hospice agencies, ambulance services, retail pharmacies, home medical equipment suppliers, and independent labs.
Our	Reference to HMSA (Hawai‘i Medical Service Association).
Outpatient	Care received in a practitioner's office, the home, an ambulatory infusion suite, the outpatient department of a hospital or ambulatory surgery center.
Participating Medical Pharmacy	A participating retail pharmacy that also contracts with us to provide items that are covered under this plan such as medical equipment and supplies.
Physical Therapy	A form of therapy involving treatment of disease, injury, congenital anomaly or prior therapeutic intervention through the use of therapeutic modalities and other interventions that focus on a person’s ability to go through the functional activities of daily living and on alleviating pain.
Physician	A medical doctor (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.).
Physician Assistant	A practitioner who provides care under the supervision of a physician.
Physician Services	Professional services necessarily and directly performed by a doctor to treat an injury or illness.
Plan	This hospital and health benefits program offered to you as an eligible employee for purposes of ERISA.
Plan Administrator	Your employer or group sponsor for the purposes of ERISA.
Podiatrist	A health care professional who specializes in conditions of the feet.
Podiatry	Care and study of the foot.
Post-Acute Care	Comprehensive inpatient care (medical or behavioral health) designed for an individual who has an acute illness, injury or exacerbation of a disease process. It is goal-oriented treatment rendered immediately after acute inpatient hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments. Post-acute care requires the coordinated services of an interdisciplinary team and is given as part of a specifically designed treatment plan.
Postoperative Care	Care given after a surgical operation.
Postpartum	The period of time after childbirth.
Precertification	The process of getting prior approval for specified services and devices. Failure to get our approval will result in a denial of benefits if the services or devices do not meet HMSA’s payment determination criteria.
Preferred Formulary Drug, Supply, or Insulin	A brand name drug, supply, or insulin identified as preferred on the HMSA Select Prescription Drug Formulary.

Preoperative Care — Care that occurs, is performed, or is administered before, and usually close to, a surgical operation.

Prescription — The instructions written by a provider with statutory authority to prescribe directing a pharmacist to dispense a particular drug in a specific dose.

Primary Care Provider (PCP) — The provider you choose within your health center to act as your personal health care manager, and who renders general medical care focusing on preventive care and treatment of routine injuries and illnesses.

Private Duty Nursing — 24-hour nursing services by an approved nurse who is dedicated to one patient.

Prosthetic Appliances — Devices used as artificial substitutes to replace a missing natural part of the body and other devices to improve, aid, or increase the performance of a natural function.

Provider — A physician or other practitioner, facility, or other health care provider, such as an agency or program, recognized by us.

Psychological Testing — A standard task used to assess some aspect of a person's cognitive, emotional, or adaptive function.

Psychologist — An approved provider who specializes in the treatment of mental health conditions.

Qualified Beneficiary — Qualified Beneficiary means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan:
- as the spouse of the covered employee; or
- as the dependent child of the covered employee.

Qualified Medical Child Support Order (QMCSO) — A Medical Child Support Order that creates or recognizes in the person specified in the order the existence of the right to enroll in the health benefit plan for which the plan member or his/her dependents are eligible. To be a Qualified Medical Child Support Order, the order cannot require a health benefit plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act with respect to a group plan.

Radiology — The use of radiant energy to diagnose and treat disease.

Reference Product — Refers to the original FDA-approved biologic product that a biosimilar is based.

Referral — When your PCP determines that your condition requires the services of a specialist, he or she will arrange for you to get treatment from the appropriate provider.

Registered Bed Patient — A person who is registered by a hospital or extended care facility as an inpatient for an illness or injury covered by this Guide.

Report to Member — The report you get from us that notes how we applied benefits to a claim. You may get copies of your report online through My Account on hmsa.com or by mail upon request.

Service Area — The island or islands of Hawaii where the health center operates its facilities (excluding Hana, Maui) and where you reside.

Sexual Identification Counseling — Psychotherapy for a person with gender dysphoria.

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Sexual Orientation Counseling — Treatment of an enduring pattern of emotional, romantic and/or sexual attractions to men, women or both sexes. Sexual orientation also refers to a person's sense of identity based on those attractions, related behaviors and membership in a community of others who share those attractions.

Single Coverage — Coverage for the member only.

Skilled Nursing Care — A level of care for patients who require skilled nursing and/or rehabilitation care, i.e., services that must be performed by or under the supervision of professional or technical personnel, on a daily basis.

Skilled Nursing Facility — A facility that provides ongoing skilled nursing services as ordered and certified by your attending Provider.

Specialist — A provider who is specifically trained in a certain branch of medicine related to a service or procedure, body area or function, or disease.

Speech Therapy Services — Services for the diagnosis, assessment and treatment of communication impairments and swallowing disorders.

Spouse — Your husband or wife as the result of a marriage who is legally recognized in the state of Hawaii.

Sub-Acute Care — A level of care for patients who no longer require care in an acute hospital and require more intensive skilled care that is beyond that traditionally provided in a skilled nursing facility, e.g., require frequent and recurrent patient assessment and review of clinical course and treatment plan.

Subscriber Number — The number that appears on your HPH member card.

Substance Abuse Services — Providing medical, psychological, nursing, counseling, or therapeutic services as treatment for alcohol or drug dependence or both. Services may include aftercare and individual, group and family counseling services.

Supportive Care — A comprehensive approach to care for members with a serious or advanced illness including Stage 3 or 4 cancer, advanced Congestive Heart Failure (CHF), advanced Chronic Obstructive Pulmonary Disease (COPD), or any advanced illness that meets the requirements of the Supportive Care policy. Members get comfort-directed care, along with curative treatment from an interdisciplinary team of practitioners.

Surgical Services — Cutting, suturing, diagnostic, and therapeutic endoscopic procedures; debridement of wounds, including burns; surgical management or reduction of fractures and dislocations; orthopedic casting manipulation of joints under general anesthesia or destruction of localized surface lesions by chemotherapy cryotherapy, or electrosurgery.

Third Party Liability — Our rights to reimbursement when you or your family members get benefits under this coverage for an illness or injury and you have a lawful claim against another party or parties for compensation, damages, or other payment.

Transgender Person — A person who has gender identity disorder or gender dysphoria, received health care services related to gender transition, adopts the appearance or behavior of the opposite sex, or otherwise identifies as a gender different from the gender assigned to that person at birth.

Transplant — The transfer of an organ or tissue for grafting into another area of the same body or into another person.

Treatment	Management and care of the patient to combat a disease or disorder.
Tubal Ligation	A sterilization procedure for women.
Urgent Care	When you require medical care for an unexpected illness or injury that is not life threatening but cannot be reasonably postponed until your return to your service area.
Us	HMSA (Hawai‘i Medical Service Association).
Vasectomy	A sterilization procedure for men.
Vision Services	Services that test eyes for visual acuity and identify and correct visual acuity problems with lenses and other equipment.
We	HMSA (Hawai‘i Medical Service Association).
Well-Being Services	A variety of well-being tools, programs and services to take care of you and your family. Visit hmsa.com/wellbeing to find the latest benefits available to our members.
You and Your Family	You and your family members eligible for coverage under this Guide.

Serving you

Meet with knowledgeable, experienced health plan advisers. We'll answer questions about your health plan, give you general health and well-being information, and more. Hours of operation may change. Please go to **hmsa.com/contact** before your visit.

HMSA Center in Honolulu

818 Keeaumoku St.
Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center in Pearl City

Pearl City Gateway | 1132 Kuala St., Suite 400
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center in Hilo

Waiakea Center | 303A E. Makaala St.
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center in Kahului

Puunene Shopping Center | 70 Hookele St.
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Office - Lihue, Kauai

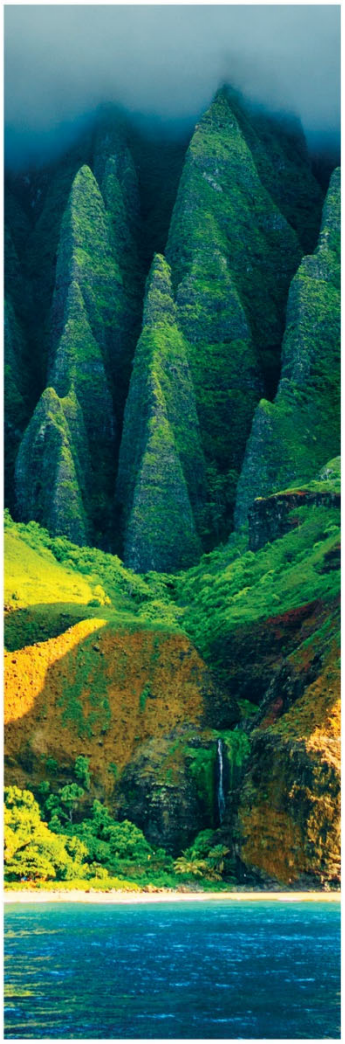
4366 Kukui Grove St., Suite 103
Monday–Friday, 8 a.m.–4 p.m

Contact HMSA. We're here with you.

Call (808) 948-6372 or 1 (800) 776-4672.

hmsa.com

@hmsahawaii



Together, we improve the lives of our members and the health of Hawaii.
Caring for our families, friends, and neighbors is our privilege.

hmsa