HMSA's
Health Plan Hawaii Plus
Health Maintenance Organization (HMO)

Guide to Benefits
January 2011

HMSA
Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

Working for a Healthier Hawaii

Health Plan Hawaii™

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CHAPTER 1

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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, Care Connection programs 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 in *Chapter 1: Important Information* 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 information 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 skilled nursing 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 ***Personal Care Provider (PCP)*** means the provider you choose within your health center to act as your personal health care manager.

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 contact Customer Service at any of the locations listed below. More details about plan benefits will be provided free of charge.

- Honolulu, 818 Keeaumoku Street, 96814
  Telephone: 948-6372
- Hilo, Hawaii, 670 Ponahawai Street, Suite 121, 96720
  Telephone: 935-5441
- Kailua-Kona, Hawaii, 75-1029 Henry Street, Suite 301, 96740
  Telephone: 329-5291
- Lihue, Kauai, 4366 Kukui Grove Street, Suite 103, 96766
  Telephone: 245-3393
- Kahului, Maui, 33 Lono Avenue, Suite 350, 96732
  Telephone: 871-6295
- Molokai & Lanai:
  Telephone: (800) 639-4672
- Telephone Display Device (TDD): (808) 948-6222

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 in *Chapter 1: Important Information.*

Please note: For prescription 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, annual HealthPass visit, Online Care and mental health and substance abuse services. For more information 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 personal 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 personal 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 information (what are the office hours, what hospital can the Provider practice at, what is their experience with certain diseases).
- You may select any personal 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 in *Chapter 1: Important Information.*

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 personal care Provider is responsible for providing and arranging all your medical care. Having a continuous relationship with your personal care Provider allows you the best possible care. If you need to change your personal care Provider, please call your nearest Customer Service office listed in *Chapter 1: Important Information*, 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 personal 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, a skilled nursing 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 personal care Provider's agreement with HMSA ends, we will notify you of the need to select a new personal care Provider from your health center. If you do not make a selection, you will be assigned a new personal 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 non-participating or out-of-state physician or facility. This should happen only when a provider with the specialty designation and clinical expertise required to treat your condition is not available within the Health Plan Hawaii network or HMSA participating providers.

Your PCP must submit an administrative review request to HMSA prior to services being rendered by a non-participating or out-of-state physician or facility. If your PCP does not get an approval before you get 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, annual HealthPass visit, Online Care and mental health and substance abuse services. For more information 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 in *Chapter 1: Important Information*.

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. For more information, see the section *Miscellaneous Medical Treatments* in *Chapter 4: Description of Benefits.*

Care While You are Away from Home

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") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Hawaii, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside of Hawaii, you will obtain care 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"). In some instances, you may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

Emergency and Urgent Care

We cover only limited healthcare services received outside your plan service area. As used in this section, "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 when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or 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.

BlueCard® Participating Providers

Under the BlueCard® Program, when you obtain Care Outside of Hawaii within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain Care Outside of Hawaii, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the 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.*

Whenever you access covered healthcare services outside of Hawaii and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, 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, going forward, also take into account adjustments to correct for over – and underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price HMSA uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculations methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Nonparticipating Providers Outside Hawaii

When Care Outside of Hawaii is received from non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in the Guide to Benefits.

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for covered services as set forth in the Guide to Benefits.

Benefit payments for covered emergency services provided by non-participating providers are a "reasonable amount" as defined by federal law at 45CFR §147.138(b).

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 in *Chapter 1: Important Information.* 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 *Chapter 1: Important Information.* 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 telephone 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 receive benefits, the care you receive must be a covered treatment, service, or supply. See *Chapter 4: Description of Benefits* for a listing of covered treatment, services and supplies.

Does the Care Meet Payment Determination Criteria?

All covered services you receive 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 regarding 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 the least costly appropriate 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 receive the care.

Is the Care Consistent with HMSA's Medical Policies?

To be covered, the care you get must be consistent with 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 to get a copy of a policy related to your care, please call your nearest Customer Service office listed in *Chapter 1: Important Information.*

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, annual HealthPass visit, Online Care and mental health and substance abuse services. For more information 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 dollar amount, the duration, or the number of visits. For information 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 by us, 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 your nearest Customer Service office listed in *Chapter 1: Important Information.*

Did a Recognized Provider Order the Care?

All covered treatment, services, and supplies must be ordered by a recognized provider.

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. You will get this report in the mail. Make sure you are billed only for those services you received.

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 HMSA 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 is necessary 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

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Eligible Charge

Definition

For most medical services, except for emergency services provided by non-participating providers, 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 provided by 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 eligible charge for emergency services provided by non-participating providers is calculated in accord with federal law as described at 45 CFR § 147.138(b).

Please note: If you receive 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.
- 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.

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 amount 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 contract

When You Pay More

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

- Copayments for Online Care, Skilled Nursing Facility room and board, Blood and Blood Products, Inter-island Transportation, Medical Foods, Prescription Drugs and Supplies.
- 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 paid 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 information on HMSA's payment practices under the BlueCard Program, see in *Chapter 1: Important Information.*
- For *prescription 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 receive will not reduce the charges that your copayments are based on. We apply discounts and rebates to reduce prescription 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 dollar amount, duration, or number of visits. The maximum may apply per:

- *Service.* For example, Online Care is limited to no more than 15 minutes per session.
- *Calendar year.* For example, you are eligible to receive benefits for up to 60 skilled nursing facility days per benefit period.

Where to Look for Limitations

See *Chapter 4: Description of Benefits.*

Carryover of Benefits from Previous Coverage

Definition

If you were covered by HMSA under a different group coverage just prior to this coverage, any maximums you accrued under the previous coverage carry forward. These maximums will count against the same types of maximum amounts under this coverage. Any copayment amounts you paid toward meeting your copayment maximum will also carry over.

If you become a member under another HMSA coverage, then you will be subject to the carryover provisions of the new coverage, and not this coverage.

Chapter 3: Summary of Benefits and Your Payment Obligations

CHAPTER 3

This Chapter Covers

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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.***
- Tells you if a covered service or supply is subject to limits or Precertification.
- Gives you the page number where you can find more information 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 information 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, annual HealthPass visit, Online Care and mental health and substance abuse services. For more information 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.

☎ = A telephone next to a service or supply means that our approval is required. *Be sure and review Chapter 5: Precertification.*

Chapter 3: Summary of Benefits and Your Payment Obligations

☎ = approval required	more info. on page:	Your Copayment Amount Is:
Routine and Preventive		
Gynecological Exam	24	None
Disease Management and Preventive Services Programs	24	None
HealthPass Visit	24	None
Immunizations	25	None
Unexpected Mass Immunizations	25	50% of eligible charge
Mammography (screening)	25	None
Physical Examinations (routine annual checkup)	25	None
Screening Services	25	None
Vision Exam	26	$15
Well-Child Care (through age twenty-one)	26	None
Online Care		
Online Care	26	$10 for up to 10 minutes $5 for an additional 5 minute extension
Physician Visits		
Away from Home Care	26	$15 for out of network urgent care in Hawaii $15 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 page 6 for more information
Home	26	$15
Inpatient Hospital	26	None
Office	26	$15
Outpatient Hospital	26	$15
Skilled Nursing Facility	26	None
Surgical Center	26	$15

☎ = approval required	more info. on page:	Your Copayment Amount Is:
Test, Laboratory and X-Rays		
Allergy Testing	27	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Diagnostic Tests	27	10% of eligible charge (office visit) 10% of eligible charge (hospital outpatient) None (hospital inpatient)
Evaluation for the Use of Hearing Aids	27	$15 (office visit)
☎ Genetic Testing	27	10% of eligible charge (office visit) 10% of eligible charge (hospital outpatient) None (hospital inpatient)
Laboratory and Pathology	27	10% of eligible charge (office visit) 10% of eligible charge (hospital outpatient) None (hospital inpatient)
☎ X-ray and Other Radiology	27	10% of eligible charge (office visit) 10% of eligible charge (hospital outpatient) None (hospital inpatient)
Surgery		
Anesthesia	27	$15 (outpatient professional charges) None (inpatient professional charges)
Assistant Surgeon Services	27	$15 (outpatient professional charges) None (inpatient professional charges)
Oral Surgery	27	$15 (outpatient professional charges) None (inpatient professional charges)
☎ Surgical Procedures	28	None (outpatient surgical center) $15 (outpatient professional charges) None (hospital operating room) None (inpatient professional charges)

Chapter 3: Summary of Benefits and Your Payment Obligations

☎ = approval required	more info. on page:	Your Copayment Amount Is:
Maternity		
Artificial Insemination	28	$15
☎ In Vitro Fertilization	28	20% of eligible charge
Pregnancy Termination	29	$15 (outpatient) None (inpatient)
Routine Pre/Post Natal Care and Delivery	29	None
Hospital and Facility Services		
Ancillary Services	29	None
Hospital Room and Board	29	$75 per day (You may owe amounts in addition to your copayment. Please see page 29 for more information.)
Outpatient Facility	30	None
Skilled Nursing Facility	30	None
Private Duty Nursing	30	50% of eligible charge
Emergency Services		
Emergency Room Facility Services	30	$75
Emergency Room Physician Visits	30	None
All Other Services and Supplies	Varies	See copayment amounts listed in this chart for the services or supplies
Air Ambulance	31	20% of eligible charge
Ground Ambulance	31	20% of eligible charge
Rehabilitation Therapy Services		
Physical and Occupational Therapy	32	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Speech Therapy Services	32	$15 (outpatient) None (inpatient)
Home Health Care and Hospice		
Home Health Care	33	None
Hospice Services	33	None

☎ = approval required	more info. on page:	Your Copayment Amount Is:
Miscellaneous Medical Treatments		
Blood and Blood Products	34	None
Chemotherapy – Infusion/Injections and Radiation Therapy	34	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Contraceptive Implants	34	50% of eligible charge
Contraceptive Injectables	34	50% of eligible charge
Contraceptive IUD	34	50% of eligible charge
Dialysis and Supplies	34	10% of eligible charge (hospital outpatient) None (hospital inpatient)
☎ Growth Hormone Therapy	34	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
☎ Home IV Therapy	35	None
Inhalation Therapy	35	$15(office visit) $15 (hospital outpatient) None (hospital inpatient)
Injections	35	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Inter-island Transportation	35	None
Medical Equipment, Appliances, and Supplies – External Items	35	50% of eligible charge (You may owe amounts in addition to your copayment. Please see page 35 for more information.)
Medical Equipment, Appliances, and Supplies – Implanted Internal Items	35	None (You may owe amounts in addition to your copayment. Please see page 35 for more information.)
Medical Foods	36	20% of eligible charge

☎ = approval required	more info. on page:	Your Copayment Amount Is:
Behavioral Health - Mental Health and Substance Abuse		
☎ Hospital/Facility Charges	36	None (hospital outpatient) $75 per day (hospital inpatient) (You may owe amounts in addition to your copayment. Please see page 29 for more information.)
Physician Visits	36	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Psychological Testing	36	None (office visit) None (hospital outpatient) None (hospital inpatient)
Transplants		
☎ Organ and Tissue Transplants	37	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Organ Donations	38	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)

Prescription Drugs and Supplies

Copayments for ***Prescription Drugs and Supplies*** are listed below. This plan covers prescription 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 information.

☎ = approval required	more info. on page:	Your Copayment Amount Is:
Chemotherapy – Oral Drugs		***If you have an HMSA drug plan with benefits for oral chemotherapy drugs, the HMSA drug plan benefits will apply.***
Chemotherapy – Oral	39	**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.***
Contraceptive Diaphragms/Cervical Caps	39	**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
Contraceptives Oral	39	**If you have an HMSA drug plan with benefits for oral contraceptives, the HMSA drug plan benefits will apply.** **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
Contraceptives - Other Methods	39	**If you have an HMSA drug plan with benefit for other contraceptive methods, the HMSA drug plan benefits will apply.** **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

☎ = approval required	more info. on page:	Your Copayment Amount Is:
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.***
Diabetic Drugs	39	**Network Pharmacy** 20% of eligible charge (Generic) 20% of eligible charge (Preferred Brand Name) 30% of eligible charge (Other Brand Name) **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 100% of the remaining eligible charge after deducting: 20% of eligible charge (Generic) 20% of eligible charge (Preferred Brand Name) 30% of eligible charge (Other Brand Name) **Contracted Mail Order Pharmacy** 20% of eligible charge (Generic) 20% of eligible charge (Preferred Brand Name) 30% of eligible charge (Other Brand Name)
Diabetic Supplies	39	**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	39	**Network Pharmacy** 20% of eligible charge (Preferred Brand Name) 30% of eligible charge (Other Brand Name) **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 100% of the remaining eligible charge after deducting: 20% of eligible charge (Preferred Brand Name) 30% of eligible charge (Other Brand Name) **Contracted Mail Order Pharmacy** 20% of eligible charge (Preferred Brand Name) 30% of eligible charge (Other Brand Name)
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.***
USPSTF Recommended Drugs	39	**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, annual HealthPass visit, Online Care and mental health and substance abuse services. 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. For more information 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:

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- Physician Visits 26
- Testing, Laboratory, and Radiology 27
- Surgery 27
- Maternity 28
- Hospital and Facility Services 29
- Emergency Services 30
- Rehabilitation Therapy Services 32
- Home Health Care and Hospice Services 33
- Miscellaneous Medical Treatments 34
- Behavioral Health - Mental Health and Substance Abuse 36
- Organ and Tissue Transplants 37
- Organ Donations 38
- Integrated Case Management 39
- Prescription Drugs and Supplies 39

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 additional 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 in conjunction with *Chapter 6: Services Not Covered*, in order to identify all items excluded from coverage.

Routine and Preventive

Gynecological Exam

Covered, for an annual gynecological exam. You may receive an annual gynecological exam from a participating Health Plan Hawaii gynecologist or nurse midwife without a referral. Any services from a provider outside the Health Plan Hawaii network require an administrative review request by your PCP as described in *Chapter 1: Important Information.*

Disease Management Programs

Covered, for HMSA's Care Connection disease management programs for members with asthma, diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and behavioral health conditions (mental health and substance abuse). The programs offer services to help you manage your care and make informed health choices. Services may vary from program to program but include member and physician education.

You may be automatically enrolled in some of these programs and may choose not to participate by calling us. HMSA reserves the right to, at any time, add other programs or end programs. Check with Customer Service for more information. Our phone numbers are listed in *Chapter 1: Important Information.*

Preventive Services Programs

Covered, for HMSA programs such as the RSVP (*Reminder for Screening and Vaccination*) program where you will receive reminders for scheduling preventive screenings and shots. *The Good Pregnancy-He Hapai Pono* helps expectant couples through normal and at-risk pregnancies with information and support services. The *Ready, Set, Quit!* program offers support to help you stop smoking.

You may automatically be enrolled in some of these programs and may choose not to participate by calling us. HMSA reserves the right to, at any time, add other programs or end programs. Check with Customer Service for more information. Our phone numbers are listed in *Chapter 1: Important Information.*

HealthPass

Covered, if you are 14 years of age or older when provided by HealthPass. HealthPass is a screening program that provides you with information about how to build a healthier life by looking at your current lifestyle, health habits, and health history.

You are eligible to receive a health risk assessment questionnaire through www.hmsa.com or you can call HealthPass for a paper questionnaire. To schedule your screening appointment, call HealthPass

HealthPass will:

- Evaluate your lifestyle, health habits and health risks.
- Measure your blood pressure, cholesterol, glucose and body composition.
- Provide consultation on your screening results.
- Offer health coaching services to support you in achieving your health and wellness goals.
- Refer you to healthy lifestyle programs, interventions and health education classes (Nutrition, Exercise, Weight Management, Stress Management and Smoking Cessation).

If you have certain risk factors that become apparent during your screening, HealthPass will refer you to your PCP for follow-up care.

Please note: Benefits for additional screenings are described in other sections of this chapter under *Routine and Preventive* and *Testing, Laboratory, and Radiology.*

HealthPass operates under the oversight of a program director and a physician who serves as the program's medical director. HealthPass health consultants are trained in health promotion and prevention.

Immunizations

Covered, for standard immunizations and immunizations for high risk conditions such as Hepatitis B and other vaccines in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP).

If you would like information about high risk criteria, call our Customer Service number. Our phone number is listed in *Chapter 1: Important Information.*

Mammography (Screening)

Covered.

Please note: Benefits for diagnostic mammography is described in other sections of this chapter under *X-rays and Other Radiology.*

Physical Examination

Covered.

Physical examinations 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. Physical examinations that are needed by a third party and are coincidentally performed as part of a routine annual physical examination are covered.

Screening Services

Covered for the following screenings:

- anemia and lead screening for children
- colorectal cancer screening
- chlamydia detection
- fecal occult blood test
- lipid evaluation
- newborn metabolic screening
- cervical cancer screening
- osteoporosis screening
- diabetes screening

Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following:

- Preventive Counseling Services
- Screening Laboratory Services:
  - Screening for Asymptomatic Bacteriuria in Adults
  - Screening for Gonorrhea
  - Screening for Hepatitis B Virus Infection
  - Screening for HIV
  - Screening for Syphilis Infection
  - Screening for Iron Deficiency Anemia
  - Screening for Rh (D) Incompatibility
  - Screening for Congenital Hypothyroidism
  - Screening for Phenylketonuria (PKU)
  - Screening for Sickle Cell Disease in Newborns
- Screening Radiology Services:
  - Screening for Abdominal Aortic Aneurysm

Please note: Benefits for other U.S. Preventive Services Task Force (USPSTF) Grade A and B recommended screenings may be found in other sections of 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 in *Chapter 1: Important Information.*
Well-Child Care	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. Care is available for 10 minute sessions which may be extended up to 5 additional minutes. Each session is limited to a total of 15 minutes. ***Please note:*** Copayment for Online Care do not apply toward meeting the Annual Copayment Maximum. Sessions and eligibility are subject to the Online Care Consumer User Agreement.

Physician Visits

Away From Home Visits	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.*
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.
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
Skilled Nursing Facility Physician Visits	Covered, when you are in a skilled nursing facility center, 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)

Evaluation for the Use of Hearing Aids

Covered.

Genetic Testing and Screening

Covered, if you meet HMSA criteria. Call Customer Service for more information. Our phone number is listed in *Chapter 1: Important Information.*

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

Laboratory Tests

Covered. Some examples of lab tests include:

- Urinalysis
- Blood tests
- Throat cultures

X-rays and Other Radiology

Covered. Some examples of other radiology include:

- Computerized tomography scan (CT Scan)
- Nuclear medicine
- Ultrasound
- Diagnostic mammography

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 physician and when appropriate for your condition. Services include:

- General Anesthesia.
- Regional Anesthesia.
- Monitored anesthesia when you meet HMSA's high-risk 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.

Oral Surgery

Covered. You have benefits for services of a dentist if you require oral surgery and the surgery (or emergency procedure) could be performed by either a physician or a dentist.

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.

Surgical Procedures

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

Maternity

Artificial Insemination

Covered.

In Vitro Fertilization

Covered, when provided or arranged by your PCP. But coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are an HPH or HMSA member. If you receive benefits for in vitro fertilization services under an HPH or HMSA plan, you will not be eligible for in vitro fertilization benefits under any other HPH or HMSA plan. Also, coverage is limited to members who meet the following criteria:

- The in vitro fertilization is for you or your spouse. In vitro fertilization services are not covered when a surrogate is used.
- Either of the following two statements is true:
  - You and your spouse have a history of infertility for at least five years; or
  - The infertility is related to one or more of these medical conditions: endometriosis; exposure in utero to diethylstilbestrol (DES); blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or abnormal male factors contributing to the infertility.
- You have been unable to attain a successful pregnancy through other covered infertility treatment.
- The in vitro procedures are 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 minimal standards for programs of in vitro fertilization.

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 may relate to this benefit are described in *Chapter 6: Services Not Covered* in the section labeled *Fertility and Infertility.*

Pregnancy Termination

Covered.

Please note: Coverage is limited to 2 elective pregnancy terminations per lifetime.

Maternity 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.

Newborn Care

Covered for the baby's:

- Routine non-surgical physician care (see *Chapter 3: Summary of Benefits and Your Payment Obligations*, Physician Visits - Inpatient Hospital) and
- Routine newborn nursery care (see *Chapter 3: Summary of Benefits and Your Payment Obligations*, *Hospital and Facility Services* - Hospital Room and Board) after birth.

If the newborn requires additional care other than routine —for example, the newborn is treated for jaundice— benefits for the newborn are available when you add the child to your coverage within 31 days of birth. See *Chapter 10: General Provisions* under *Eligibility for Coverage.*

Maternity Care

You have benefits for physician services, including prenatal, false labor, delivery, and postnatal services. HMSA pays physicians a global fee related to a bundle of maternity care. If benefit payments are made separately before delivery, payments will be considered an advance and we will deduct the amount from the global benefit payment for maternity care.

Other maternity related services such as nursery care, labor room, hospital room and board, and diagnostic tests, labs and radiology are covered in other sections of this guide.

Hospital and Facility Services

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.

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.

Outpatient Facility

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

Skilled Nursing Facility

Covered, for skilled nursing facility room and board charges based on the minimum semi-private room rate.

To be eligible for benefits, these statements must be true:

- You are admitted by your PCP.
- Care is ordered and certified by your PCP.
- Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care.
- If days exceed 30, the attending physician must submit a report showing the need for more days at the end of each 30-day period.
- The confinement is not longer than 60 days per ***benefit period***.
  A benefit period begins on the first day you are admitted to an inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you have not been inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital or SNF after one benefit period has ended, a new benefit period begins.
- The confinement is not for custodial care.

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

Please note: Copayments for Skilled Nursing Facility room and board do not apply toward meeting the Annual Copayment Maximum.

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

Emergency Services

Covered, but only to stabilize a medical condition which 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. Examples also include 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, ear aches, 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 necessary.

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.

Air Ambulance

Covered, when all of these statements are true:

- Your condition requires emergency care.
- The air ambulance transportation is for inter-island transportation within the state of Hawaii.

Ground Ambulance

Covered, as follows:

- For ground ambulance transportation required due to a sudden illness or injury that requires emergency care, the transportation must start where the injury or illness took place or first needed emergency care; and
- The ground transportation must end at the nearest facility equipped to furnish emergency services.
- For ground ambulance transportation required to transport you to another facility, the reason for your transportation must be because care for your illness or injury is not available in the hospital or nursing facility where you are currently an inpatient.

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.

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 information 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.*

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.

Rehabilitation Therapy Services

Physical and Occupational Therapy

Covered, but only when all of these are true:

- The diagnosis is established by a Provider and the medical records document the need for skilled physical and/or occupational therapy.
- The therapy is ordered by a Provider under an individual treatment plan.
- The therapy is provided by 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 provided by 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: Precertification is required after the first visit.

Group exercise programs are not covered.

Physical therapy evaluations are not covered when provided by an occupational therapist.

Speech Therapy Services

Covered, for the treatment of communication impairments and swallowing disorders but only when all of the following statements are true:

- The diagnosis is established by a Provider and the medical records document the need for skilled speech therapy services.
- The therapy is ordered by a Provider.

- 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 provided by 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 skilled nursing facility care.
- 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 provided by 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.

Hospice services must be received from a hospice that is currently under contract with us to provide hospice benefits. You are not covered for hospice services provided by a hospice not under contract with us.

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

Miscellaneous Medical Treatments

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).*

Please note: Copayments for Blood and Blood Products do not apply toward meeting the Annual Copayment Maximum.

Chemotherapy – Infusion/Injectables and Radiation Therapy (for malignancy)

Covered, subject to these limitation:
- The chemotherapy or radiation therapy is not for high-dose radiation therapy, or related services and supplies except 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*.

Contraceptive Implants

Covered.

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

Copayments for Contraceptives do not apply toward meeting the Annual Copayment Maximum.

Contraceptive Injectables

Covered.

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

Copayments for Contraceptives do not apply toward meeting the Annual Copayment Maximum.

Contraceptive IUD

Covered.

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

Copayments for Contraceptives do not apply toward meeting the Annual Copayment Maximum.

Dialysis and Supplies

Covered.

Growth Hormone Therapy

Covered, 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.*

Home IV Therapy

Covered, for outpatient services and supplies for the injection or intravenous administration of either medication, biological therapeutics, biopharmaceuticals, or nutrient solutions needed for primary diet, including home infusion services and self administered injectable medication from a contracted provider.

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

Inhalation Therapy

Covered, for inpatient and outpatient inhalation therapy.

Injections

Covered, for injections received as an inpatient or outpatient, including allergy injections and biological therapeutics and biopharmaceuticals. However, you are not covered for injections you administer to yourself except as authorized.

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.*

Inter-island Transportation

Covered, as follows:

- The transportation is for the covered person who requires treatment; and
- The transportation is necessary because treatment is not available at your health center but is available on another island in the state of Hawaii.

Benefit Limitation: Benefits for inter-island transportation is limited to one round-trip inter-island transportation required for one complete episode of treatment. You are not covered for fees charged by the airlines for cancellation or changes to your reservations. Please call customer service for more information. Our phone numbers are listed in *Chapter 1: Important Information.*

Please note: Copayments for Inter-island Transportation do not apply toward meeting the Annual Copayment Maximum.

Medical Equipment, Appliances, and Supplies

Covered, but only when prescribed by your provider.

Examples of medical appliances include hearing aids; cardiac pacemakers; artificial limbs, eyes, hips, and similar appliances approved by HMSA and prescribed by your provider.

Foot orthotics are covered only for specific diabetic conditions as defined by Medicare guidelines.

Vision appliances, that include eyeglasses and contact lenses, for certain medical conditions are subject to special limitations. Please call the number listed in *Chapter 1: Important Information* for details.

Examples of medical equipment include crutches; oxygen and rental equipment for its administration; rental of wheelchair and hospital-type bed; charges for the use of an iron lung; artificial kidney machine; and pulmonary resuscitator.

Appliance and medical equipment must meet all of the following criteria:

- The item is:
  - Durable enough to withstand repeated use.
  - Primarily and customarily used to serve a medical purpose.
  - Not useful to a person in the absence of illness or injury.
  - Appropriate for use in the home.
- The item is necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member.
- The item is used in your home. ***Home*** means the place where you live other than a hospital or skilled or intermediate nursing facility.

Please note: Certain appliance and equipment must have precertification. See *Chapter 5: Precertification.*

Benefits for the rental or purchase of medical equipment is determined based on the following criteria:

- Items intended for short-term use are only eligible for benefits when the item is rented.
- Items intended for long-term use are eligible for benefits when the item is purchased, but only if the cost of renting will exceed the cost of purchasing the equipment.

Please note: Benefit payment for the rental of appliances and medical equipment is limited to no more than the purchase price.

Benefit Limitation: Benefits for the medical appliance hearing aids are limited to one hearing aid per ear every 60 months. Benefit payments for hearing aids are limited to no more than the eligible charge. You are responsible for the copayment plus the difference between the eligible charge and the cost of the hearing aid of your choice.

Medical Foods

Covered, but only to treat an inborn error of metabolism in accord with Hawaii law and HMSA guidelines.

Please note: Copayments for Medical Foods do not apply toward meeting the Annual Copayment Maximum.

Routine Care Associated With Clinical Trials

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

Please note: These services require precertification. 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 provided by a licensed physician, psychiatrist, psychologist, clinical social worker, marriage and family therapist, licensed mental health counselor, or advanced practice registered nurse.

Please note: Epilepsy, senility, mental retardation, or other developmental disabilities and addiction to or abuse of intoxicating substances, do not in and of themselves constitute a mental disorder.

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

Residential care facility services outside the state of Hawaii require precertification. See *Chapter 5: Precertification.*

Alcohol an 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.

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 in *Chapter 1: Important Information.*

Organ and Tissue Transplants

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 transplants) must:

- Receive our approval. Without approval for the specified transplants, benefits are not available. Your PCP will get approval for you.
- Be received 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.

Transplant Evaluations	Covered, if we approve, for stem-cell, heart, heart-lung, liver, lung, pancreas, simultaneous kidney/pancreas, or small bowel and multivisceral 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 information about donor screening benefits, see the section *Organ Donations* later in this chapter.
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.*
Corneal Transplants	Covered, but only if you meet HMSA's criteria.
Heart Transplants	Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification.*
Heart and Lung Transplants	Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification.*
Kidney Transplants	Covered, but only if you meet HMSA's criteria.
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.*

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.

Integrated Case Management

Integrated Case Management

Covered, when approved by us. ***Integrated Case Management*** is a special program to help members with certain medical conditions that need costly, long-term care and when a hospital may not be the most appropriate setting for your care. If you meet HMSA's criteria, your coverage provides you with alternate benefits to help meet health care needs that result from extreme illness or injury (providing costs do not exceed inpatient facility costs). You, your physician, and the hospital can work with our case managers to identify and arrange alternate treatment plans to meet your special needs and to assist in preserving your health care benefits.

Conditions and treatments for which benefits management might be appropriate are: AIDS, coma, traumatic brain injury, respirator dependency, spinal cord injury, and long-term intravenous therapy.

Before benefits are available for alternate treatment plans, approval must be received. Without approval, no benefits for alternate treatment plans are available. Your physician will contact us on your behalf to identify and arrange alternate treatment plans.

Prescription Drugs and Supplies

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

- Approved by the FDA, under federal control,
- Prescribed by your 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: Some prescription drugs and supplies must have precertification. See *Chapter 5: Precertification.*

Please note: Copayments for Prescription Drugs and Supplies do not apply toward meeting the Annual Copayment Maximum.

Benefits for prescription drugs and supplies vary depending on whether the drug is a generic drug, a Preferred drug, or Other brand name drug.

Definitions

Brand name drug is one which is marketed under its distinctive trade name and which is or was at one time protected by patent laws.

Generic drugs are drugs prescribed or dispensed under their commonly used generic name rather than a brand name and which are not protected by patent, or drugs identified by HMSA as "generic".

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.

Other brand name drugs, supplies, and insulin are brand name drugs, supplies, or insulin which are not identified as preferred on the HMSA Select Prescription Drug Formulary.

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

Preferred drugs, supplies and insulin are brand name drugs, supplies or insulin identified as preferred on the HMSA Select Prescription Drug Formulary.

Prescription drug is a medication that is under Federal control. By Federal law, prescription drugs can only be dispensed with a prescription. Medications that are available as both a Prescription Drug and a nonprescription drug are not covered as a Prescription Drug under this plan.

Benefit Limitations

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

Diabetic supplies are limited to coverage for syringes, needles, lancets, lancet devices, test strips, acetone test tablets, insulin tubing, and calibration solutions.

Copayment amounts for all 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 obtain more than a 30-day supply under one prescription:

- you must pay an additional copayment for each 30-day supply or fraction thereof, and
- our maximum benefit payment will be limited to benefits for two additional 30-day supplies or fractions thereof.

Drugs Dispensed in Manufacturer's Original Unbreakable Package: Except for insulin, copayments for prescription drugs and supplies that are dispensed in a manufacturer's original unbreakable package are determined by the number of calendar days that are covered by the prescription. Copayments for insulin are based on the lesser of the calendar days supply and the "discard after" date on the medication. You owe one copayment for each prescription for up to 59 days, two copayments for 60-89 days, and three copayments for 90-119 days. An example of drugs that come in unbreakable packages is oral contraceptives.

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 the "payment determination" criteria and other criteria as 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 dispense up to a 30-day supply for first time prescriptions of maintenance drugs. For subsequent refills, the participating provider may dispense up to a 90-day supply 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.

Additional Amounts You May Owe 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.

You will be required to pay the entire cost of the brand name drug when you choose to obtain a brand name drug instead of the generic equivalent or the particular generic equivalent was out-of-stock or not available at the pharmacy. In this situation, you will be responsible for submitting a claim to us. In the event a generic equivalent is out-of-stock or not available, you may wish to purchase the generic equivalent from another pharmacy.

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.

Mail Order Providers

Benefits for mail order prescription 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 prescription drugs and supplies from a provider that does not contract with HMSA, no benefits will be paid.

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.

Drugs Dispensed in Manufacturer's Original Unbreakable Package: Except for insulin, copayments for prescription drugs and supplies that are dispensed in a manufacturer's original unbreakable package are determined by the number of calendar days that are covered by the prescription. Copayments for insulin are based on the lesser of the calendar days supply and the "discard after" date on the medication. You owe one copayment for each prescription for up to 119 days. An example of drugs that come in unbreakable packages is oral contraceptives.

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.

CHAPTER 5

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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.

A table with a list of the treatments, procedures and devices that need precertification appears later in this chapter.

Changes to this Guide's List of Services and Supplies Which Require Precertification

From time to time, we need to update the list of services and supplies that require precertification. Changes are needed so that your plan benefits remain current with the way therapies are delivered. Changes may occur at any time during your plan year. If you would like to know if a treatment, procedure or device has been added or deleted from the list in this Guide, call your nearest Customer Service office listed in *Chapter 1: Important Information.*

If you would like to check on the status of the precertification, call your nearest Customer Service office listed in *Chapter 1: Important Information.*

Our Response to Your Request for Precertification of Non-Urgent Care

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 receive 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 added details from you, we will let you know and give you at least 45 days to provide the information.

Our Response to Your Request for Precertification of Urgent Care

Your care is urgent if the time periods that apply to non-urgent care:

- 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 request for precertification of urgent care as soon as possible given the medical circumstances of your case. It will be no later than 24 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 receive your request. We will let you know what information we need to respond to your request and give you a reasonable time to respond. You will have at least 48 hours to provide the information.

Appeal of Our Precertification Decision

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

Specific Types of Care

Precertification is required for the following services and devices. Call HMSA at:

- **Oahu – (808) 948-6464**
- **Neighbor islands – 1 (800) 344-6122**

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.

A through D

- Artificial Disc Replacement - Cervical
- Autologous Chondrocyte Implantation (ACI)
- Bexxar
- Bi-PAP and Oral Appliances for the Treatment of Obstructive Sleep Apnea
- Blepharoplasty and Repair of Blepharoptosis
- Bone Mineral Density Studies (for members under 18 and for members determined to be at high risk for osteoporosis requiring studies more frequently than once every two years)
- Chemotherapy – Oral
  - Afinitor
  - Gleevac
  - Nexavar
  - Revlimid
  - Sprycel
  - Sutent
  - Tarceva
  - Tasigna
  - Tykerb
  - Zolinza
- Cinryze
- Computed Tomography (CT) - Outpatient (not required for emergency room)
- Continuous Glucose Monitoring of Interstitial Fluid (Real time)
- Coronary CT Angiography
- CT Colonography (virtual colonoscopy)

E through H

- Functional MRI
- Genetic Risk Assessment – for symptomatic and asymptomatic individuals with:
  - Family history of breast cancer
  - Family history of ovarian cancer

Precertification is required for the following services and devices. Call HMSA at:

- **Oahu – (808) 948-6464**
- **Neighbor islands – 1 (800) 344-6122**

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.

- Genetic Risk Assessment – for asymptomatic individuals with:
  - Familial adenomatous polyposis
  - Hereditary nonpolyposis colorectal cancer
- Genetic Testing for:
  - BRCA1 and BRCA2 Mutations
  - Carrier Status for Spinal Muscular Dystrophy
  - Carrier Status for Tay-Sachs, Canavan Disease, Familial Dysautomia, and Gaucher's Disease
  - Cystic Fibrosis
  - Developmental Delay/ Mental Retardation/ Autism Spectrum Disorder
  - Factor V Leiden, Prothrombin G20210A Mutation and Reductase Gene Mutation
  - Fragile X Syndrome
  - Hereditary Hemochromatosis Mutations
  - Long QT Syndrome
  - Thiopurine Methyltransferase Gene
- Growth Hormone Therapy
- Home IV Therapy:
  - Albumin Therapy
  - Immune Globulin Therapy
  - Inotropic Infusion Therapy
  - Intravenous Anti-Infective Therapy (beyond standard duration of treatment)
  - Intravenous Hydration for Hyperemesis Gravidarum (after the first 14 days)
  - Intravenous Hydration Therapy for Adults (after the first seven days)
  - Pain Management Infusion Therapy
  - Total Parenteral Nutrition Therapy for Adults
- Home Pulse Oximeters (for children)
- Hyperbaric Oxygen Therapy (for diabetic wounds, osteoradionecrosis and soft tissue radiation necrosis)

Precertification is required for the following services and devices. Call HMSA at:

- **Oahu – (808) 948-6464**
- **Neighbor islands – 1 (800) 344-6122**

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.

I through K

- In Vitro Fertilization
- Injectable Drugs:
  - Alimta
  - Avastin
  - Enbrel (for treatment of plaque psoriasis)
  - Erbitux
  - Erythropoiesis Stimulating Agents (for Myelodysplastic Syndrome and Anemia of Chronic Disease)
  - Flolan
  - Forteo
  - Humira (for treatment of plaque psoriasis)
  - Ilaris
  - Immune Globulin (for Chronic Inflammatory Demyelinating Polyneuropathy, Guillain-Barre Syndrome, Multifocal Motor Neuropathy, and Relapsing-Remitting Multiple Sclerosis)
  - Low Molecular Weight Heparin (if used beyond the FDA indicated duration, beyond six months in patients with cancer, and perioperative bridge therapy)
  - Lupron (for treatment exceeding 3 months for anemia caused by fibroids or 6 months for management of endometriosis, for therapy beyond 11 years for girls and 12 years for boys for central precocious puberty, for off-label use in the palliative treatment of advanced breast cancer)
  - Nplate
  - Remodulin
  - Rituxin (for non-rheumatoid arthritis, non-cancer indications)
  - Stelara
  - Synagis
  - Vectibix
  - Velcade
  - Xolair
  - Zevalin
- Insulin Pumps
- Intensity Modulated Radiation Therapy (IMRT)

Precertification is required for the following services and devices. Call HMSA at:

- **Oahu – (808) 948-6464**
- **Neighbor islands – 1 (800) 344-6122**

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.

	▪ Intrastromal Corneal Ring Segments for Keratoconus (INTACS) ▪ Knee Braces, Custom-fabricated ▪ Kyphoplasty and Vertebroplasty
L through O	▪ Lung Volume Reduction Surgery ▪ Magnetic Resonance Angiography (MRA) and Magnetic Resonance Venography (MRV) - Outpatient (not required for emergency room) ▪ Magnetic Resonance Imaging (MRI) - Outpatient (not required for emergency room) ▪ Mental Health or Substance Abuse Residential Care Facility Services Outside the State of Hawaii ▪ Negative Pressure Wound Therapy ▪ Non-Coronary Brachytherapy ▪ Nuclear Cardiology – Outpatient (not required for emergency room) ▪ Occupational Therapy Services ▪ Off Label Drug Use (for drugs requiring precertification) ▪ Oncotype DX ▪ Oscillatory Device for Bronchial Drainage (The Vest)
P through R	▪ Panniculectomy/Abdominoplasty ▪ Photochemotherapy (for Pityriasis Rosea, Lichen Planus, and Other Atopic Dermatitis and Related Conditions) ▪ Photodynamic Therapy (for superficial basal cell skin cancer and Bowen's disease) ▪ Physical Therapy Services ▪ Positron Emission Tomography (PET) ▪ Power Mobility Devices ▪ Prophylactic Mastectomy ▪ Proton Beam Therapy ▪ Prosthetics and Orthotics over $10,000 ▪ Pulmonary Vein Ablation for Atrial Fibrillation ▪ Reduction Mammaplasty ▪ Routine Care Associated With Clinical Trials
S through T	▪ Soliris ▪ Speech Therapy Services – for members up to age 21; after 12 visits for members 21 years and older ▪ Spinal Cord Stimulators for Pain Management

Precertification is required for the following services and devices. Call HMSA at: • **Oahu – (808) 948-6464** • **Neighbor islands – 1 (800) 344-6122** **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.**	
	▪ Stereotactic Radiosurgery and Fractionated Stereotactic Radiotherapy Beams (Gamma-knife and X-knife Surgery) ▪ Surgery for Hyperhidrosis ▪ Surgery to Correct Morbid Obesity (bariatric surgery) ▪ Surgeries, therapies or procedures employing new technology or representing a new application of existing technology ▪ Torisel ▪ Transcutaneous Electrical Nerve Stimulation (TENS) Unit ▪ Transplants. See below under *Organ and Tissue Transplants* ▪ Transplants Evaluations ▪ Treatment of Hepatitis C with Interferons and Ribavirin ▪ Treatment of Varicose Veins
U through Z	▪ Uterine Artery Embolization to Treat Fibroids ▪ Wheelchairs (Pediatric Tilt-in-Space, Adult High Strength Lightweight and Ultra Lightweight, and Custom Wheelchairs)

Organ and Tissue Transplants

Precertification is required for the following transplant services. Your provider must contact HMSA for approval. **Failure to get our approval will result in a denial of benefits if the service does not meet HMSA's payment determination criteria. Transplant evaluations require precertification.**	
A through H	▪ Allogeneic Stem-Cell Transplant, Autologous Stem-Cell Transplant, and Reduced Conditioning for Allogeneic Stem-Cell Transplant ▪ Heart Transplant ▪ Heart/Lung Transplant
I through R	▪ Liver Transplant ▪ Lung and Lobar Lung Transplant ▪ Pancreas Transplants
S through Z	▪ Simultaneous Kidney/Pancreas Transplant ▪ Small Bowel Transplant ▪ Small Bowel/Liver and Multivisceral Transplant

CHAPTER 6

This Chapter Covers

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- Counseling Services 51
- Coverage Under Other Programs or Laws 52
- Dental, Drug, and Vision 52
- Fertility and Infertility 53
- Provider Type 53
- Transplants 54
- Miscellaneous Exclusions 54

About this Chapter

Your health care coverage does not provide benefits for 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 additional exclusion 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. For your convenience, our phone numbers are listed in *Chapter 1: Important Information.*

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 identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations.

Marriage or Family Counseling

You are not covered for marriage and family counseling or other similar services.

Nutritional Counseling

You are not covered for nutritional counseling, except as identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations.

Sexual Identification Counseling

You are not covered for sexual identification counseling.

Coverage Under Other Programs or Laws

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.

Military

You are not covered for treatment of an illness or injury related to military service when you receive 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.

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 information 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 services listed in *Chapter 4: Description of Benefits.* Included in this exclusion are dental services that are generally provided only by dentists and not by physicians. The following exclusions apply regardless of the symptoms or illnesses being treated:

- Orthodontics.
- Dental splints and other dental appliances.
- Dental prostheses.
- Maxillary and mandibular implants (osseointegration) and all related services.
- Removal of impacted teeth.
- Any other dental procedures involving the teeth, gums and structures supporting the teeth.
- Any services in connection with the treatment of TMJ (temporomandibular joint) problems or malocclusion of the teeth or jaws, except for services in connection with the initial visit for diagnosis.

Drugs

You are not covered for prescription drugs and supplies except as stated in *Chapter 4: Description of Benefits under Prescription Drugs and Supplies* and as identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations.

Eyeglasses and Contacts

You are not covered for:

- Sunglasses.
- Prescription inserts for diving masks or other protective eyewear.
- Nonprescription industrial safety goggles.
- Nonstandard items for lenses including tinting and blending.
- Oversized lenses, and invisible bifocals or trifocals.

- Repair and replacement of frame parts and accessories.
- Eyeglasses and contact lenses, except as described in *Chapter 4: Description of Benefits* under *Miscellaneous Medical Treatments, Medical Equipment, Appliances, and Supplies*.
- Exams for a fitting or prescription (including vision exercises).
- Frames.

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 contraceptive foams, creams, condoms, or other non-prescription substances or supplies used individually or in conjunction with any other prescribed drug or device.

Infertility Treatment

You are not covered for services or supplies for any of the following:

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

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 services or supplies provided by complementary and alternative medicine providers, including but not limited to naturopathic and homeopathic care providers, acupuncturists, and massage therapists.

Chiropractor

You are not covered for services or supplies provided by a chiropractor.

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.

Physician Assistant

You are not covered for services and supplies received from a physician assistant unless he or she is employed by a medical group, M.D. or D.O.

Private Duty Nursing	You are not covered for outpatient private duty nursing services.
Social Worker	You are not covered for services and supplies received from a social worker. This exclusion does not apply to covered mental health or substance abuse services.

Transplants

Living Organ Donor Services	You are not covered for organ donor services if you are the organ donor.
Living Donor Transport	You are not covered for expenses of transporting a living 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.
Biofeedback	You are not covered for biofeedback and any related diagnostic tests.
Bionic Devices	You are not covered for bionic services or devices.
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.
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.
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).*
Complications of a Non-Covered Procedure	You are not covered for complications of a non-covered procedure.

Convenience Treatments, Services or Supplies

You are not covered for treatments, services or supplies that are prescribed, ordered or recommended primarily for your convenience or the convenience of your provider.

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.

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.

Environmental Control Equipment and Supplies

You are not covered for environmental control equipment 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.

Enzyme-potentiated Desensitization

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

Erectile Dysfunction

You are not covered for services and supplies (including prosthetic devices) related to erectile dysfunction except if due to an organic cause. 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.

Extracorporeal Shock Wave Therapy

You are not covered for extracorporeal shock wave therapy except for the treatment of 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 for specific diabetic conditions as defined by Medicare guidelines.

Genetic Testing and Screening

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

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 treatment of baldness or hair loss regardless of condition. This includes hair transplants and topical medications.

Hypnotherapy

You are not covered for hypnotherapy.

Intradiscal Electro Thermal Therapy (IDET)

You are not covered for intradiscal electro thermal therapy.

Chapter 6: Services Not Covered

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.
Personal Convenience Items and Supplies	You are not covered for personal convenience items such as ramps, home remodeling, hot tubs, swimming pools or personal convenience supplies such as surgical stockings and disposable underpads.
Physical Examinations	You are not covered for physical or health exams and any associated screening procedures except as described in *Chapter 4: Description of Benefits* under the *Routine and Preventive* sections.
Radiation (Nonionizing)	You are not covered for treatment with nonionizing radiation.
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).*
Self-Help or Self-Cure	You are not covered for self-help and self-cure programs or equipment.
Sexual Transformation	You are not covered for services and supplies related to sexual transformation regardless of cause. This includes, but is not limited to, sexual transformation surgery.
Sexual Dysfunction	You are not covered for services or supplies related to sexual dysfunction, regardless of cause. This includes, but is not limited to, penile implants.
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.
Travel Immunizations	You are not covered for travel immunizations.
Thoracic Electric Bioimpedance (Outpatient/Office)	You are not covered for outpatient thoracic electric bioimpedance in an outpatient setting which includes in 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, except as described in *Chapter 4: Description of Benefits* under *Miscellaneous Medical Treatments, Inter-island Transportation.*
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 *Prescription 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 prescription drugs and supplies.
Wigs	You are not covered for wigs and artificial hairpieces.

CHAPTER 7

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- How to File Claims 57
- What Information You Must File 57
- Other Claim Filing Information 58

When to File Claims

Submit within 90 Days

Most providers in Hawaii file claims for you. If your provider does not file for you, please submit an itemized bill or receipt. The bill or receipt must be submitted within 90 days of the last day on which you received services. It must list the services you received. No payment will be made on any claim 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 are listed in *Chapter 1: Important Information.*

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.

Telephone 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 Physician claims, send to:
HPH – HCFA 1500 claims
P.O. Box 44500
Honolulu, Hawaii 96804-4500

For Facility claims, send to:
HPH – UB92 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, we will send you a report explaining your benefits not later than 30 days after we get a claim you submit. 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 require more information to make a decision about your claim or are unable to make a decision due to circumstances beyond our control, we will extend the time for an additional 15 days. We will let you know within the initial 30-day period why we are extending the time and when you can expect our decision. If we require more information, you will have at least 45 days to provide us the information.

If your claims are denied, our report will explain the denial.

If, for any reason, you believe we wrongly denied a claim or coverage request, please call our phone numbers listed in *Chapter 1: Important Information*. If you are not satisfied with the information you receive, 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

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- If You Disagree with Our Appeal Decision and You are Enrolled in an Employer Sponsored Group Plan 60
- If You Disagree with Our Appeal Decision and You are Enrolled In an Employer Sponsored Group Plan Not Subject to ERISA 61

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 receive 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 limit of your claim, or of the denial of coverage for any requested service or supply.

Send written requests to:

HPH
Attn: Appeals Coordinator
P.O. Box 1958
Honolulu, HI 96805-1958

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

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 receive your appeal.

Appeal of Any Other Decision or Action

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

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.
- 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 You Disagree with Our Appeal Decision and You are Enrolled in an Employer Sponsored Group Plan

If you are enrolled in an employer sponsored group plan subject to the Employee Retirement Income Security Act (ERISA) and you would like to appeal HMSA's decision, you must do one of the following:

- Request a review by an independent review organization, if the service requested was determined to not meet HMSA's Payment Determination Criteria,
- Request arbitration before a mutually selected arbitrator,
- Request federal external review in accord with standards to be developed by the U.S. Departments of Health and Human Services, Treasury and Labor, or
- File a lawsuit against HMSA under section 502(a) of ERISA.

Request Review by Independent Review Organization

If you request review by an Independent Review Organization, the review will be at no cost to you. You must submit your written request within 180 days of the date of HMSA's appeal decision to:

HMSA
Attn: Appeals Coordinator
P.O. Box 1958
Honolulu, Hawaii 96805-1958

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

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 issues. 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 on.

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.

Request Federal External Review

Federal external review by an independent review organization will be available to you at a future date. The review will meet standards yet to be developed by the U.S. Departments of Health and Human Services, Treasury and Labor. Contact Customer Service at the phone number on the back cover of this Guide for more information.

If You Disagree with Our Appeal Decision and You are Enrolled In an Employer Sponsored Group Plan Not Subject to ERISA

If you are enrolled in an employer sponsored group plan not subject to ERISA, in addition to the reviews described above, you may select review by a panel selected by the Hawaii Insurance Commissioner. At a future date, this option may be replaced by federal external review. The Insurance Commissioner will decide whether federal external review will be available to you instead of review by the Insurance Commissioner.

You must submit a request for review by the Insurance Commissioner within 60 days of the date of HMSA's appeal decision to the Insurance Commissioner. The address is:

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

If your request for review is accepted by the Commissioner, the Commissioner will appoint a three member panel. The panel will be made up of a representative from another health plan, a provider not involved in your care, and a representative from the Commissioner's office. A hearing will be conducted within 60 days. The panel will issue a decision within 30 days of the hearing. If the amount in controversy is less than $500, the Commissioner may conduct a review hearing without a review panel.

You may ask for an expedited review by the Insurance Commissioner if the above time frames 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.

If your request for review is not accepted by the Commissioner or if your appeal of HMSA's decision contains issues that are not within the scope of the Commissioner's jurisdiction, then disputes of these issues must be resolved by arbitration before a mutually selected arbitrator as described above.

If you need help in determining if you are a member of an ERISA plan, please call HMSA at (808) 948-5090 for assistance in determining if review is available in your case.

CHAPTER 9

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What Coordination of Benefits Means

Coverage that Provides Same or Similar Coverage

You may have other insurance 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 because of the primary plan's payment. 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. Additionally, when this plan is secondary, benefits will be paid only for those services or supplies covered under this plan.

If there is an applicable 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 tuberculin test per calendar year, if this plan is secondary and your primary plan covers one tuberculin test per calendar year, the test covered under the primary plan will count toward the yearly benefit maximum and this plan will not provide benefits for a second test within the calendar year. However, the first twenty days of confinement to a skilled nursing 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.

Chapter 9: Coordination of Benefits and Third Party Liability

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.

What We Will Do

Once we have the information 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:

(1) Custodial parent.
(2) Spouse of custodial parent.
(3) Non-custodial parent.
(4) 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.

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 any 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: (1) 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 (2) if you have or may have a right to recover damages or receive payment without regard to fault (other than coverage available under Hawaii Revised Statutes Chapter 431, Article 10C).

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 and 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 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, 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 are covered under both Medicare and this plan, and Medicare is allowed by law to be the primary payer, coverage under this plan will be reduced by the amount of benefits paid by Medicare. We will coordinate benefits under this plan 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 receive 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., 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 receive services at a facility or by a provider that is not eligible or entitled to receive 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 receive 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 the following:

- **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 arising 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 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.

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: (1) your knowledge of any potential claim against any third party or other source of recovery in connection with the injury or illness; (2) 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 (3) 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 right to be reimbursed 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 including liability insurance or your underinsured or uninsured motorist coverage;
- Workplace liability insurance;
- Property and casualty insurance;
- Medical malpractice coverage; or
- Other insurance.

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.

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 of set-off from any future payments payable on your behalf under this Guide to Benefits.

To the extent that we are not reimbursed for the total benefits we pay or have paid related to your illness or injury, we have a right of subrogation (substituting us to your rights of recovery) for all causes of action and all rights of recovery you have against any third party or other source of recovery in connection with the illness or injury.

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

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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 you show us to our satisfaction 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 are the only one covered.
- With family coverage, you, and your spouse, and each of your eligible, dependent children have coverage. Each covered family member must be listed on the employee'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.

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

Chapter 10: General Provisions

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.
- Your child is not married.
- Your child is enrolled with us under this coverage or another HMSA coverage and has had continuous health care coverage with us since before the child's 26th birthday.

You must provide this documentation to us within 31 days of the child's 26th birthday 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 birth date of a newborn adopted child, providing we receive 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 receive 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 which 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 request a copy of HMSA's procedures governing QMCSO determinations. A copy will be mailed to you without charge.

When Coverage Begins

When You are Eligible to Receive Benefits

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

- Your initial dues were paid.
- We accepted your enrollment form and gave you written notice of your effective date; and
- You are not in the hospital on the day coverage goes into effect.

If you are an inpatient when this coverage begins, and you had no other insurance or coverage immediately prior, then coverage for services related to the hospitalization begins on the effective date of this coverage. If you had other insurance or coverage immediately prior, then coverage for any services related to the hospitalization either a) begins on the effective date of this coverage, or b) does not begin until the day after your discharge from the hospital or other inpatient facility. We will work with your prior insurer or coverage to determine which option applies to you. This limit does not apply to you if you had medical coverage with us immediately prior to the effective date of this coverage. Please call us if this limit applies to you so that we can help you determine your rights to coverage.

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 the following takes 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 in 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 information 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.

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 get 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 are 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 that 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 that applies) 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, U.S. 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, U.S. Code.
- A public health plan as defined in government regulations.
- A health benefit plan under section 5(e) of the Peace Corps Act.

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 in *Chapter 1: Important Information.*

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 purposes 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.

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 get 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 provided that we give 30 days prior written notice to your employer or group sponsor.

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.

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.

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 U.S. 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 telephone 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

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

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

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 a medical, surgical, or obstetric care.

Agreement
The document made up of:
- This Guide to Benefits;
- Any riders or amendments;
- The enrollment form submitted to us; and
- The Agreement between HMSA 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 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
Local air or ground emergency transport to a hospital in the surrounding area where your transport began.

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 amount you pay for most covered services in a benefit period. The copayment maximum is reached from copayment amounts you pay in any given calendar year.

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

Chapter 11: Glossary

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 — The maximum benefit amount allowed for certain covered services A benefit maximum may limit the dollar amount, the duration, or the number of visits for covered services.

Benefit Period — A benefit period begins on the first day you are admitted to an inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you have not been inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital or SNF after one benefit period has ended, a new benefit period begins.

Benefits — Those medically necessary services and supplies that 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 in the treatment of the condition. The purpose of treatment is to exert control over that physiological function.

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.

Bionic Device — Electronic or electromechanical devices that replace missing body parts and/or enhance one's existing strength and ability.

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.

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

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.

Carryover of Benefits — The provision that if you were covered by HMSA under a different employer group coverage just prior to this coverage, any maximums you accrued under the previous coverage may carry forward to meet the maximum amounts under this program. Carryover of benefits includes any amounts you paid toward meeting your copayment maximum.

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 - 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.

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.

Contraceptives — Any oral medicine or device that prevents pregnancy.

Contraceptive Services — Services that promote the use of prescription contraceptives supplies or devices to prevent pregnancy.

Coordination of Benefits (COB) — Applies when you are covered by more than one group coverage or commercial 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.

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, U.S. 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, U.S. Code; or a public health plan as defined in government regulations health benefit plan under section 5(e) of the Peace Corps Act.

Covered Services — Services or supplies that meet payment determination criteria and are listed in this guide in *Chapter 4: Description of Benefits.*

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 staff.

Chapter 11: Glossary

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.

Dependent

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

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.

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 causes 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:

- It is durable enough to withstand repeated use.
- It is primarily and customarily made to serve a medical purpose; and
- It is not useful in the absence of illness or injury.

Examples include wheelchairs, walkers, and crutches.

ERISA

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

Effective Date

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

Eligible Charge

For most medical services, 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 provided by 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: 1) serious risk to the health of the person (or, with respect to a pregnant woman, the health of the woman and her unborn child); 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ part.

Facility

Examples include hospitals, skilled nursing facilities, and ambulatory surgical facilities.

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.
Frame	An eyeglass frame or similar frame into which two lenses are fitted.
Generic Drug	A drug that is prescribed or dispensed under its commonly used generic name rather than a brand name, 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 provides a written description of your health care coverage.
HMSA	Hawaii 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.
HealthPass	A health promotion and prevention program offered 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.
Homebound	Due to an illness or injury, you are unable to leave home, or leaving your home, requires a considerable and taxing effort.
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.
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.

Chapter 11: Glossary

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.
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.
Inpatient Admission	A stay in an inpatient facility, usually involving overnight care.
Integrated Case Management	A program that addresses the specialized care needs of patients with severe or chronic illnesses or injuries.
Intravenous Injection	An injection made into the vein.
In Vitro Fertilization	A way to treat infertility in women.
Laboratory Services	Services used to help diagnose, prevent, or treat disease.
Limited Services	Those covered services that are limited per service, per episode, per calendar year or per lifetime.
Lenses	Ophthalmic corrective lenses ground as prescribed by a physician or optometrist for fitting into a frame.
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 Services	Services for prenatal and postnatal care, complications, delivery, and to end a pregnancy.
Maximum Allowable Fee	The amount we establish as the maximum amount HMSA will pay for covered services and supplies.
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 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 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.
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.
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, telephone 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.
Osteopathy	Medicine that specializes in diseases of the bone.
Other Brand Name Drug, Supply, or Insulin	A brand name drug, supply, or insulin that is not listed as preferred on the HMSA Select Prescription Drug Formulary.
Other Providers	Those 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.
Outpatient	Care received in a practitioner's office, the home, the outpatient department of a hospital or ambulatory surgery center.

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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 Services	Professional services necessarily and directly performed by a doctor to treat an injury or illness.
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.
Plan	This 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.
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 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.
Personal Care Provider (PCP)	The provider you choose within your health center to act as your personal health care manager.
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.

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 skilled nursing facility as an inpatient for an illness or injury covered by this guide.

Report to Member

The report you receive in the mail from us that notes how we applied benefits to a claim.

Service Area

The island or islands of Hawaii where the health center operates its facilities (excluding Hana, Maui) and where you reside.

Single Coverage

Coverage for the member only.

Skilled Nursing Facility

A facility that provides ongoing skilled nursing services as ordered and certified by your attending Provider.

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.

Subscriber Number

The number that appears on your HPH member card.

Substance Abuse Services

Providing medical, psychological, nursing, counseling, or therapeutic services as part of a treatment plan for alcohol or drug dependence or both. Services may include aftercare and individual, group and family counseling services.

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.

Chapter 11: Glossary

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.
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.
You and Your Family	You and your family members eligible for coverage under this guide.

HAWAII MEDICAL SERVICE ASSOCIATION
www.HMSA.com

HONOLULU • 818 Keeaumoku St. • 96814
Phone: 948-6372

HILO, HAWAII • 670 Ponahawai St., Suite 121 • 96720 • Phone: 935-5441

KAILUA-KONA, HAWAII • 75-1029 Henry St., Suite 301 • 96740 • Phone: 329-5291

KAHULUI, MAUI • 33 Lono Ave., Suite 350 • 96732 • Phone: 871-6295

LIHUE, KAUAI • 4366 Kukui Grove St., Suite 103 • 96766 • Phone: 245-3393

If you are calling from the U.S. Mainland, please call 1 (800) 776-4672. If you need to call a local Hawaii telephone number from the Mainland, the area code is 808.

HMSA is a Hawaii-based health care services organization dedicated, for over 70 years, to improving the health and wellness of individuals and our community. We will provide our customers real value and security by creating a broad range of products that gives them choices of health care plans, provider networks, prices, and other health care services, with a commitment to superior customer service.

(00) 1000-2214 10:09 LE
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HAWAII MEDICAL SERVICE ASSOCIATION

Health Plan Hawaii - HPH Plus
Prescription Drug Benefits Rider

I. ELIGIBILITY

This Rider provides coverage that supplements the coverage provided under the Health Plan Hawaii Guide to Benefits. Your coverage under this Rider starts and ends on the same dates as your Health Plan Hawaii Guide to Benefits coverage.

II. PROVISIONS OF THE MEDICAL PLAN APPLICABLE

All definitions, provisions, exclusions, and conditions of the Health Plan Hawaii Guide to Benefits shall apply to this Rider. Exceptions are specifically modified in this Rider.

III. DEFINITIONS

When used in this Rider:

A. **"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.

B. **"Eligible Charge"** is the charge HMSA uses to calculate a benefit payment for a covered service or drug. It is the lesser of the following charges:

1. The actual charge as shown on the claim, or
2. HMSA's Allowable Fee. This includes an allowance for dispensing the drug.

HMSA negotiates the cost of covered drugs from drug manufacturers or suppliers. This may include discounts, rebates, or other cost reductions. Any discounts or rebates received by HMSA will not reduce the charges that your copayments are based on. Discounts and rebates are used to calculate your Other Brand Name Cost Share. HMSA also applies discounts and rebates to reduce prescription drug coverage rates for all prescription drug plans.

Participating Providers agree to accept the eligible charge as payment in full for covered drugs or supplies. Nonparticipating providers generally do not. Therefore, if you receive drugs or supplies from a nonparticipating provider, you are responsible for a Copayment plus an Other Brand Name Cost Share, if any, plus the difference between the actual charge and the eligible charge.

C. **"Generic Drug"** is a drug 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."

D. **"HMSA Select Prescription Drug Formulary"** is a list of drugs by therapeutic category published by HMSA.

E. "**Oral Chemotherapy Drug**" " is an FDA-approved oral cancer treatment that may be delivered for self-administration under the direction or supervision of a Provider outside of a hospital, medical office, or other clinical setting.

F. "**Other Brand Name Cost Share**" is a share of the cost of Other Brand Name drugs or devices which you must pay in addition to a Copayment. When you choose Other Brand Name drugs, your Copayment plus Other Brand Name Cost Share may exceed HMSA's payment to the provider.

G. "**Other Brand Name Drug**" is a Brand Name Drug, supply, or insulin that is not identified as preferred on the HMSA Select Prescription Drug Formulary. Except for insulin, when you choose Other Brand Name drugs, your Copayment plus Other Brand Name Cost Share may exceed HMSA's payment to the provider.

H. "**Over-the-Counter Drugs**" are drugs that may be purchased without a prescription.

I. **"Participating Provider"** is a provider of services who, when rendering most services covered by this Rider to you, agrees with HMSA to collect not more than (a) a specified amount paid by HMSA, and (b) your Copayment as specified in this Rider. Participating Pharmacies are listed in HMSA's Directory of Participating Pharmacies for HMSA's PPO and HMO Plans.

J. **"Preferred Drug"** is a Brand Name Drug, supply, or insulin identified as preferred on the HMSA Select Prescription Drug Formulary.

K. **"Prescription Drug"** is a medication that is under Federal control. By Federal law, prescription drugs can only be dispensed with a prescription. Medications that are available as both a Prescription Drug and a nonprescription drug are not covered as a Prescription Drug under this Rider.

IV. DRUG BENEFITS

You are eligible to receive the following benefits when covered drugs are obtained with a prescription. Covered drugs must be from your Health Center Personal Care Provider (PCP) or Authorized Provider, and dispensed by a licensed Provider. The use of such drugs must be necessary for the diagnosis and treatment of an injury or illness:

A. **Covered Drugs.**

1. Prescription Drugs (including contraceptives).
2. Oral Chemotherapy Drugs.
3. Insulin.
4. The following diabetic supplies: syringes, needles, lancets, lancet devices, test strips, acetone test tablets, insulin tubing, and calibration solutions.
5. Diaphragms and Cervical Caps.
6. Drugs Recommended by the U.S. Preventive Services Task Force (USPSTF).

B. **Benefits for Covered Drugs.**

1. **Generic Drugs.**

a) When obtained from a Participating Provider, you owe a $7 Copayment per drug to the Participating Provider. HMSA pays the Participating Provider 100% of the remaining Eligible Charge.

b) When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $7 Copayment per drug when the claim is submitted.

2. **Oral Chemotherapy Drugs.**

a) When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment.

b) When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 100% of Eligible Charge when the claim is submitted.

3. **Insulin.**

a) **Preferred.**

(1) When obtained from a Participating Provider, you owe a $7 Copayment per drug to the Participating Provider. HMSA pays the Participating Provider 100% of the remaining Eligible Charge.

(2) When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $7 Copayment per drug when the claim is submitted.

b) **Other Brand Name.**

(1) When obtained from a Participating Provider, you owe a $30 Copayment per drug to the Participating Provider. HMSA pays the Participating Provider 100% of the remaining Eligible Charge.

(2) When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $30 Copayment per drug when the claim is submitted.

4. **Diabetic Supplies.**

a) **Preferred.**

(1) When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment for diabetic supplies.

(2) When obtained from a nonparticipating provider, you owe the entire charge for diabetic supplies. HMSA reimburses you 100% of Eligible Charge when the claim is submitted.

b) **Other Brand Name.**

(1) When obtained from a Participating Provider, you owe a $30 Copayment for diabetic supplies. HMSA pays 100% of the remaining Eligible Charge.

(2) When obtained from a nonparticipating provider, you owe the entire charge for diabetic supplies. HMSA reimburses you 100% of the remaining Eligible Charge after deducting a $30 Copayment when the claim is submitted.

5. **Diaphragms and Cervical Caps.**

a) When obtained from a Participating Provider, you owe a $10 Copayment per device to the Participating Provider. HMSA pays the Participating Provider 100% of the remaining Eligible Charge.

b) When obtained from a nonparticipating provider, you owe the entire charge for the device. HMSA reimburses you 100% of the remaining Eligible Charge after deducting a $10 Copayment per device when the claim is submitted.

6. **Drugs Recommended by the U.S. Preventive Services Task Force (USPSTF).** Contact HMSA for a list of drugs recommended by the USPSTF. Examples of drugs recommended include, but are not limited to, aspirin and folic acid.

a) When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no copayment.

b) When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the Eligible Charge when the claim is submitted.

7. **All Other Covered Drugs.**

a) **Preferred.**

(1) When obtained from a Participating Provider, you owe a $30 Copayment per drug to the Participating Provider. HMSA pays the Participating Provider 100% of the remaining Eligible Charge.

(2) When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $30 Copayment per drug when the claim is submitted.

b) **Other Brand Name.**

(1) When obtained from a Participating Provider, you owe a $30 Copayment per drug and a $35 Other Brand Name Cost Share per drug. HMSA pays 100% of the remaining Eligible Charge after deducting the Copayment and Other Brand Name Cost Share.

(2) When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $30 Copayment per drug and a $35 Other Brand Name Cost Share per drug when the claim is submitted.

8. **Omeprazole OTC.** Benefits for Omeprazole OTC are available when you receive a written prescription for Omeprazole OTC. Copayment amounts listed below are for any amount up to a 42-day supply. Benefits for Omeprazole OTC are not available through HMSA's Prescription Drug Mail Order Program.

a) When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment.

b) When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 100% of Eligible Charge when the claim is submitted.

9. The Copayment amounts shown in Sections B.1. through B.7. above are for a maximum 30-day supply or fraction thereof. As used in this Rider, 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 obtain more than a 30-day supply under one prescription:

a) You must pay an additional Copayment for each 30-day supply or fraction thereof, and

b) HMSA's maximum benefit payment shall be limited to benefits for two additional 30-day supplies or fractions thereof.

10. Drugs Dispensed in Manufacturer's Original Unbreakable Package: Except for insulin, copayments for prescription drugs that are dispensed in a manufacturer's original unbreakable package are determined by the number of calendar days that are covered by the prescription. Copayments for insulin are based on the lesser of the calendar days supply and the "discard after" date on the medication. You owe one copayment for each prescription for up to 59 days, two copayments for 60-89 days, and three copayments for 90-119 days. Examples of drugs that come in unbreakable packages are eye drops, inhalers, topical creams and ointments.

11. Other Brand Name Drug Copayment Exceptions. You may qualify to purchase Other Brand Name drugs at the lower Preferred Brand copayment if you have a chronic condition that lasts at least three months, and have tried and failed treatment with at least two comparable Generic or Preferred drugs (or one comparable drug if only one alternative is available), or all other comparable Generic or Preferred Brand drugs are contraindicated based on your diagnosis, other medical conditions, or other medication therapy. When prescription drugs become available as therapeutically equivalent over-the-counter drugs, they must also be considered before an Other Brand Name Drug Copayment Exception is approved. You have failed treatment if you meet a, b, or c below.

a) Symptoms or signs are not resolved after completion of treatment with the Generic or Preferred drugs at recommended therapeutic dose and duration. If there is no recommended therapeutic time, you must have had a meaningful trial and sub-therapeutic response.

b) You experienced a recognized and repeated adverse reaction that is clearly associated with taking the comparable Generic or Preferred drugs. Adverse reactions may include but are not limited to vomiting, severe nausea, headaches, abdominal cramping or diarrhea.

c) You are allergic to the comparable Generic or Preferred drugs. An allergic reaction is a state of hypersensitivity caused by exposure to an antigen resulting in harmful immunologic reactions on subsequent exposures. Symptoms may include but are not limited to skin rash, anaphylaxis or immediate hypersensitivity reaction.

This benefit requires precertification. You or your Provider must provide legible medical records that substantiate the requirements of this section in accord with HMSA's policies and to HMSA's satisfaction.

This exception is not applicable to controlled substances, off label uses, Other Brand medications if there is an FDA approved A rated generic equivalent, or if HMSA has a drug specific policy which has criteria different from the criteria in this section. You can call HMSA Customer Service to find out if HMSA has a drug policy specific to the drug prescribed for you.

Lipid lowering agents are subject to slightly different Other Brand Name Drug Copayment exception criteria. These are described in HMSA's Medical Policy, Drug Tier Exception for Lipid Lowering Agents.

C. **Limitations on Covered Drugs.**

1. Limitations on Prescription Drugs.

a) Compound preparations are covered if they contain at least one Prescription Drug that is not a vitamin or mineral.

b) Coverage of vitamins and minerals that are Prescription Drugs is limited to:

(1) The treatment of an illness that in the absence of such vitamins and minerals could result in a serious threat to your life. For example, folic acid used to treat cancer.

(2) Sodium fluoride, if dispensed as a single drug (for example, without any additional drugs such as vitamins) to prevent tooth decay.

2. **Drug Benefit Management.** HMSA has arranged with Participating Providers to assist in managing the use of certain drugs. This includes drugs listed in the HMSA Select Prescription Drug Formulary.

a) HMSA has identified certain kinds of drugs in the HMSA Select Prescription Drug Formulary that require the preauthorization of HMSA. The criteria for preauthorization are that:

(1) the drug is being used as part of a treatment plan,

(2) there are no equally effective drug substitutes, and

(3) the drug meets the "payment determination" criteria and other criteria established by HMSA.

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

b) Participating Providers will dispense a maximum of a 30-day supply or fraction thereof for first time prescriptions of maintenance drugs. For subsequent refills, the Participating Provider may dispense a maximum 90-day supply or fraction thereof after confirming that:

(1) you have tolerated the drug without adverse side effects that may cause you to discontinue using the drug, and

(2) your Provider has determined that the drug is effective.

3. **Smoking Cessation Drugs.** Coverage of smoking cessation drugs is limited to 180 days of treatment per calendar year.

4. This Rider 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, HMSA will pay only the amount that would have been paid for the generic equivalent. This provision regarding reduced benefits shall apply even if the particular generic equivalent was out-of-stock or was not available at the pharmacy. You may seek other Participating Providers when purchasing a generic equivalent in cases when the particular generic equivalent is out-of-stock or not available at that pharmacy.

5. Except for certain drugs managed under Drug Benefit Management, refills are available if indicated on your original prescription. The refill prescription must be purchased only after two-thirds of your prescription has already been used. For example, for coverage under this Rider, if the previous supply was a 30-day supply, you may refill the prescription on the 21st day, but not earlier.

6. Spacers and peak flow meters are not a benefit under this Rider. However, HMSA has arranged with manufacturers to provide spacers and peak flow meters at special member rates.

7. There shall be no duplication or coordination between benefits of this drug plan and any other similar benefit of your HMSA medical plan.

D. **HMSA's Mail Order Prescription Drug Program.**

1. HMSA has contracted with a limited number of providers to make prescription maintenance medications available by mail.

a) You owe the contracted mail order provider a $11 Copayment per Generic mail order drug, a $65 Copayment per Preferred mail order drug, and a $65 Copayment plus a $105 Other Brand Name Cost Share per Other Brand Name mail order drug. HMSA pays 100% of the remaining charges.

b) Oral Chemotherapy Drugs. You owe the contracted mail order provider no Copayment for oral chemotherapy mail order drugs. HMSA pays 100% of the charges.

c) Insulin. You owe the contracted mail order provider a $11 Copayment per Preferred mail order drug and a $65 Copayment per Other Brand Name mail order drug. HMSA pays 100% of the remaining charges.

d) Diabetic Supplies. You owe the contracted mail order provider no Copayment for Preferred mail order diabetic supplies and a $65 Copayment per Other Brand Name mail order diabetic supplies. HMSA pays 100% of the remaining charges.

e) USPSTF Recommended Drugs. You owe the contracted mail order provider no Copayment for USPSTF recommended mail order drugs. HMSA pays 100% of the charges.

2. **HMSA's Mail Order Prescription Drug Program Limitations.**

a) Mail Order Prescription Drugs are available only from contracted providers. Contact HMSA to get a list of providers. If you receive mail order prescription drugs from a provider that does not contract with HMSA, no benefits will be paid.

b) Mail Order Prescription Drugs are limited to prescribed maintenance medications taken on a regular or long-term basis.

c) Copayment amounts are for a maximum 90-day supply or fraction thereof. A 90-day supply is a supply that will last for 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:

(1) 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 15 pills, the number of pills you must take during a three-month period.

(2) 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.

(3) 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 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.

d) Drugs Dispensed in Manufacturer's Original Unbreakable Package: Except for insulin, copayments for prescription drugs dispensed in a manufacturer's original unbreakable package are determined by the number of calendar days covered by the prescription. Copayments for insulin are based on the lesser of the calendar days supply and the "discard after" date on the medication. You owe one copayment for each prescription for up to 119 days. Examples of drugs that come in unbreakable packages are eye drops, inhalers, topical creams and ointments.

e) Unless the prescribing Provider requires the use of a Brand Name Drug, your prescription will be filled with the generic equivalent when available and permissible by law. If a Brand Name Drug is required, it must be clearly indicated on the prescription.

f) Refills are available if indicated on your original prescription. The refill prescription must be purchased only after two-thirds of your prescription has already been used.

V. EXCLUSIONS

This Rider is subject to all exclusions in the Health Plan Hawaii Guide to Benefits. The Guide to Benefits describes the medical benefits plan that accompanies this Rider.

Except as otherwise stated in this Rider, no payment will be made for: Prescription Drugs and supplies prescribed by other than a Health Center PCP or Authorized Provider; immunization agents; agents used in skin tests to determine allergic sensitivity; all drugs to treat sexual dysfunction except suppositories listed in the HMSA Select Prescription Drug Formulary and used to treat sexual dysfunction due to an organic cause as defined by HMSA; appliances and other nondrug items; injectable drugs, except Imitrex, Glucagon, Epinephrine, Byetta, and Symlin; drugs dispensed to a registered bed patient; convenience packaged drugs; unit dose drugs; over-the-counter drugs that may be purchased without a prescription (except as specified in this Rider); replacements for lost, stolen, or destroyed prescriptions; and lifestyle drugs. Lifestyle drugs are pharmaceutical products that improve a way or style of living rather than alleviating a disease. Lifestyle drugs that are not covered include, but are not limited to: creams used to prevent skin aging, drugs for shift work sleep disorder, and drugs to enhance athletic performance.

VI. COORDINATION OF BENEFITS

The coordination of benefits described in Chapter 9 of the Health Plan Hawaii Guide to Benefits in the section labeled "Coverage that Provides Same or Similar Coverage" is modified as follows:

You may have other insurance 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 because of the primary plan's payment. 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.

Any Other Brand Name Cost Share you owe under this plan will first be subtracted from the benefit payment. You remain responsible for the Other Brand Name Cost Share owed under this plan, if any.

All other provisions of Chapter 9 of the Health Plan Hawaii Guide to Benefits remain unchanged.