Prescription Drug Rider

P L A N C E R T I F I C A T E

Medical Loss Ratio Information

The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit www.HealthCare.gov."

HMSA's Prescription Drug Rider

This summary is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the plan certificate for complete information on benefits and provisions. In the case of a discrepancy between this summary and the language contained within the certificate, the latter will take precedence.

Important Information

All copayments shown are based on eligible charge. The eligible charge is the amount that HMSA's participating providers have agreed to accept as payment in full for services rendered. All services received from a nonparticipating provider will likely result in significantly higher out-of-pocket expenses since the member is responsible for any difference between HMSA's eligible charge and the nonparticipating provider's actual charge.

PRESCRIPTION DRUGS	DRUG 516	
	YOUR COPAYMENT	
	Participating Provider	Nonparticipating Provider
GENERIC	$7	$7 plus 20% of remaining eligible charge
PREFERRED BRAND NAME & SINGLE SOURCE GENERIC DRUGS	$30	$30 plus 20% of remaining eligible charge
OTHER BRAND NAME	$30 plus $45 Other Brand Name cost share	$30 plus $45 Other Brand Name cost share and 20% of remaining eligible charge
SPECIALTY DRUGS	$100[1]	Not covered
U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) RECOMMENDED DRUGS[2]	None	20%
ORAL CHEMOTHERAPY DRUGS	None	None
INSULIN		
Preferred Brand Name	$7	$7 plus 20% of remaining eligible charge
Other Brand Name	$30	$30 plus 20% of remaining eligible charge
DIABETIC SUPPLIES		
Preferred Brand Name	None	None
Other Brand Name	$30	$30
ADDITIONAL BENEFITS		
Oral Contraceptives & Other Contraceptive Methods (i.e. ring and patch)		
Generic	None	$7 plus 20% of remaining eligible charge
Preferred Brand	$30	$30 plus 20% of remaining eligible charge
Other Brand	$30 plus $45 Other Brand Name cost share	$30 plus $45 Other Brand Name cost share and 20% of remaining eligible charge
Diaphragms (per device)	None	$10
Smoking Cessation Drugs Treatment is limited to: 180 days per calendar year	None	20%
Spacers and Peak Flow Meters for Inhaled Drugs[3]	None	None
• **NOTE:** Each drug dispensed is limited to a 30-day supply. A 30-day supply is defined as a supply lasting the member for a period consisting of 30 consecutive days.		
MAIL SERVICE PRESCRIPTION PROGRAM (From an HMSA contracted provider -- 90 day supply)		
GENERIC[4]	$11	Not covered
PREFERRED BRAND NAME	$65	Not covered
OTHER BRAND NAME	$65 plus $135[5] Other Brand Name cost share	Not covered
SPECIALTY DRUGS	Not covered	Not covered
U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) RECOMMENDED DRUGS[2]	None	Not covered
ORAL CHEMOTHERAPY DRUGS	None	Not covered
INSULIN		
Preferred Brand Name	$11	Not covered
Other Brand Name	$65	Not covered
DIABETIC SUPPLIES		
Preferred Brand Name	None	Not covered
Other Brand Name	$65	Not covered
• **NOTE:** When a prescribed brand name drug has a generic equivalent that is listed on the Hawaii Drug Formulary of Equivalent Drug Products, you will be responsible for the appropriate copayment plus the difference between the generic and brand name cost. This procedure will apply regardless of whether you chose not to use the generic equivalent or the particular generic equivalent was not available at the pharmacy.		

(1) Benefit available at Par Specialty Pharmacies only
(2) USPSTF A & B Recommendations
(3) Limited to the items on HMSA's SELECT formulary
(4) Includes Single Source Generic Drugs
(5) $45 retail Other Brand Name cost share times 3 month supply

HAWAIʻI 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.

L. "**Single Source Generic Drug**" is a generic drug which is manufactured by a single pharmaceutical company.

M. "**Specialty Drugs**" are high cost drugs that are used to treat chronic, potentially life threatening diseases and are listed in the HMSA Select Prescription Drug Formulary.

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. Spacers and peak flow meters (limited to those listed in the HMSA Select Prescription Drug Formulary).
7. Specialty Drugs.
8. Drugs Recommended by the U.S. Preventive Services Task Force (USPSTF).

B. **Benefits for Covered Drugs.**

1. **Generic Drugs.** (For Single Source Generic drug benefits, refer to section IV.B.9.a).

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. For contraceptives, 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 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, HMSA pays 100% of Eligible Charge. You owe no Copayment.

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. **Spacers and Peak Flow Meters.**

a) When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment for spacers and peak flow meters.

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

7. **Specialty Drugs.** Specialty Drugs are covered only when purchased from select providers. Contact HMSA to get a list of these providers. When obtained from a provider on the list, you owe a $100 copayment per drug to the provider. HMSA pays the provider 100% of the remaining Eligible Charge.

8. **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.

9. **All Other Covered Drugs.**

a) **Preferred and Single Source Generic Drugs.**

(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 $45 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 $45 Other Brand Name Cost Share per drug when the claim is submitted.

10. **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.

11. The Copayment amounts shown in Sections B.1. through B.9. 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.

12. 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, and inhalers.

13. 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, Single Source Generic, or Preferred drugs (or one comparable drug if only one alternative is available), or all other comparable Generic, Single Source 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 have also been tried and failed 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, Single Source 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, Single Source 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, Single Source 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 Specialty Drugs, 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.

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. Subject to 1 and 2 below:

(1) Compound drugs that are available as similar commercially available prescription drug products are not covered.

(2) Compound drugs made with bulk chemicals are not covered.

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.

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. 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. Specialty Drugs are not available through HMSA's Mail Order Prescription Drug Program.

a) You owe the contracted mail order provider a $11 Copayment per Generic or Single Source Generic mail order drug, a $65 Copayment per Preferred mail order drug, and a $65 Copayment plus a $135 Other Brand Name Cost Share per Other Brand Name mail order drug. HMSA pays 100% of the remaining charges. For contraceptives (Generic), HMSA pays 100% of Eligible Charge. You owe no Copayment.

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) Spacers and Peak Flow Meters. You owe the contracted mail order provider no Copayment for mail order spacers and peak flow meters. HMSA pays 100% of the charges.

f) 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, and inhalers.

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 those designated as covered in the HMSA Select Prescription Drug Formulary; 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.

HMSA

HAWAI'I MEDICAL SERVICE ASSOCIATION

www.HMSA.com

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