HMSA's

Health Plan Hawaii Plus

Health Maintenance Organization (HMO)

Guide to Benefits

January 2007

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™

NCQA Accreditation EXCELLENT

For Commercial HMO

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Table of Contents

CHAPTER 1

This Chapter Covers

About this Guide to Benefits

Your HMO Program

Your coverage provides you with medical benefits for treatment of an illness or injury, prevention of illness and injury, and promotion of good health. The Health Plan Hawaii Member Handbook provides further information about this plan including Member's Rights and Responsibilities, Care Connection programs and preventive health services. In the event the Handbook differs from this Guide to Benefits, the Guide takes precedence. You can obtain a copy of the Handbook by calling your nearest Customer Service office listed in *Chapter 1: Important Information*.

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 which 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*** 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 receive services, such as a hospital or skilled nursing facility. Additionally, 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 ***PCP (Personal Care Physician)*** 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. Additional information 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 receive 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

Except for emergency services, annual vision exams, annual gynecological exams, and mental health and substance abuse services, benefits are available only for care you receive from or arranged by your PCP.

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:

- You must choose a PCP from within your designated health center; and
- If your condition requires the skills of a specialist, your PCP will arrange for you to receive 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 available 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 physician that you want to remain with? Read through the ***Health Plan Hawaii Directory of Health Centers and Physicians*** to determine whether your current physician is available as a PCP.
- Decide what type of personal care physician specialty fits your needs (family practice, general practice, OB/GYN, internal medicine or pediatrics).
- 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 doctor, cultural issues and languages spoken).
- Call the physician's office for more information (what are the office hours, what hospital can the doctor practice at, what is their experience with certain diseases).
- Select a personal care physician (the personal care physician that you choose must be in your selected health center).

The Directory of Health Centers and Physicians 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.*

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 physician is responsible for providing and arranging all your medical care. Having a continuous relationship with your personal care physician allows you the best possible care. If you need to change your personal care physician, 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 receive a new member card indicating the name of your new personal care physician.

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 physician's agreement with HMSA ends, we will notify you of the need to select a new personal care physician from your health center. If you do not make a selection, you will be assigned a new personal care physician. 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.
- In rare circumstances, your PCP may need to refer you outside the Health Plan Hawaii network. This should happen only when a physician with the specialty designation or facility required for your condition is not available within the Health Plan Hawaii network of providers.

Once your PCP identifies an appropriate specialty physician or facility, he or she will send a referral to HMSA for non-network services.

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.

Authorization of Services

Except for emergency services, annual vision exams, annual gynecological exams, and mental health and substance abuse services, benefits are available only for care you receive from or arranged by your PCP.

If your PCP does not authorize care before you receive services, you are responsible for the cost of the medical services.

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

- The provider you are referred to contacts your PCP; and
- Your PCP authorizes the additional services.

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

Away From Home Care

To meet your health care needs while you are away from home, your coverage offers benefits for short trips and long-term stays outside your plan service area through a program called Away from Home Care. This program is sponsored by the Blue Cross and Blue Shield Association.

Please note: The Away from Home Care program uses BlueCard providers. While the participation of providers in this program is extensive, some service areas do not have participating BlueCard providers. Away from Home Care benefits are not available in these service areas.

- *For services outside your plan service area*, benefits are available through the BlueCard program for conditions that require urgent care. You should follow these steps:
  - Carry your current member card for easy reference and access to service.
  - In an emergency, go directly to the nearest provider.
  - 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 applicable 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 additional care you might require.
- *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 additional care you might require.

- *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 United States. 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 application. Application information can be taken by telephone or through the mail.
- Once the application is completed, the HPH coordinator will forward the application to the Away from Home Care Coordinator in the service area you will be visiting.
- Once the HMO host plan processes your application, 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 physicians (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:

- Appropriate and necessary for the symptoms, diagnosis, and direct care or treatment of your illness or injury.
- Consistent with professionally recognized standards of health care in the United States, and given at the right time and in the right setting.
- Not primarily for your convenience or the convenience of your provider.
- The most appropriate supply or level of service that can safely be provided.

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.

More than one procedure, service, or supply may be appropriate for the diagnosis and treatment of 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 determine whether the services you need meet our payment determination criteria before you receive the care.

Is the Care Consistent with HMSA's Medical Policies?

To be covered, the care you receive must be consistent with HMSA's medical policies. These are policies drafted by HMSA Medical Directors, many of whom are practicing physicians, in conjunction with community physicians and nationally recognized authorities. Each policy provides detailed coverage criteria for a specific service, drug, or supply. If you have questions about the policies or would like to obtain 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?

Except for emergency services, annual vision exams, annual gynecological exams, and mental health and substance abuse services, benefits are available only for care you receive from or arranged by your PCP.

Is the Service or Supply Subject to a Benefit Maximum?

Benefit Maximum means 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 physician is a network provider, refer to your Directory of Health Centers and Physicians. 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 medical 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 participant in your treatment. Talk with your provider and ask questions. Understand the treatment program and any risks, benefits, and alternatives associated with it.

Take time to read and understand your ***Report to Member***. This report shows how we applied benefits. You will receive 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 application 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 whether you meet our written eligibility requirements;
- to determine the amount and type of benefits payable to you or your dependents in accord with the terms of this Agreement; and
- to interpret the provisions of this Agreement as is necessary to determine benefits, including determinations of 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 disagree 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, limitations and exclusions of this Guide to Benefits, convey or void any coverage, or increase or reduce any benefits under this Agreement.

CHAPTER 2

This Chapter Covers

Eligible Charge

Definition

We calculate our payment and your copayment based on the eligible charge. The ***Eligible Charge*** is the lower of either the provider's *actual* charge or the amount we establish as the *maximum allowable fee*.

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

Copayment

Definition

Copayment applies to most covered services and is either a fixed percentage of the eligible charge or a fixed dollar amount.

Please note: When you receive multiple services from your health center on the same day, the following rules apply:

- Only one copayment applies for services received from the same provider, except where otherwise stated.
- More than one copayment may apply if you receive services from more than one provider.

Amount

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

Annual Copayment Maximum

Definition

The ***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

$1,500 per person, or

$4,500 (maximum) per family contract

When You Pay More

The following amounts do not apply toward meeting the copayment maximum. In addition, you continue to be responsible for these amounts even after you have met the copayment maximum.

- Copayments for Skilled Nursing Facility room and board, Blood and Blood Products, Contraceptives, Inter-island Transportation, Medical Foods, Diabetic Drugs and Supplies, and Insulin.
- 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.

Following 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 previous year;
  - the relative difficulty of the service compared to other services;
  - changes in technology; and
  - payment for the service under federal, state, and other private insurance programs.
- For *some facility-billed services* (not to include practitioner-billed facility services), we use a per case, per treatment, or per day fee (per diem) rather than an itemized amount (fee for service). 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. The negotiated price may be the actual charge less: a *simple discount*; *an estimate that factors in expected settlements, withholds, any other contingent payment arrangements and other non-claims transactions with your provider (or with a specified group of providers); or average expected savings.* Average prices may result in greater variation (more or less) from the actual price paid than will the estimated price. Estimated or average prices may be prospectively adjusted to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price. ***Please note:*** It is possible that states may enact or reenact laws that do not allow Blue Cross and/or Blue Shield Plans to calculate payment on the lower of the actual charge or the negotiated price, or that require a surcharge. When you receive covered services in one of those states, your liability would be calculated according to the laws of that state.
- For *prescription drugs*, 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 our charges upon which your copayments are based. Discounts and rebates are used to calculate the Other Brand Name Cost Share. We also apply discounts and rebates received to reduce prescription drug coverage rates.

Benefit Maximum

Definition

A ***Benefit Maximum*** is a limitation 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, outpatient mental health visits are limited to no more than 50 minutes per day.
- *Calendar year.* For example, you are eligible to receive benefits for up to 100 skilled nursing facility days each calendar year.
- *Lifetime.*

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 immediately prior to this coverage, any maximums you accrued under the previous coverage carry forward and 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

This Chapter Covers

Benefit and Payment Chart

About this Chart

This benefit and payment chart:

- is a summary listing 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 limitations or Precertification.
- provides you the page number where you can find additional 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 limitations may apply to a service or supply listed in this benefit and payment chart. Please read the detailed benefit information on the page referenced.

Remember, except for emergency services, annual vision exams, annual gynecological exams, and mental health and substance abuse services, benefits are available only for care you receive from or arranged by your PCP.

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

☎ = approval required	more info. on page:	Your Copayment Amount Is:
Routine and Preventive		
Gynecological Exam	21	None
Disease Management and Preventive Services Programs	21	None
Immunizations	22	None
Mammography (screening)	22	None
Physical Examinations (routine annual checkup)	22	None
Screening Services	21	None
Vision Exam	22	$14
Well-Child Care (age five and younger)	22	None
Physician Visits		
Away from Home Care	22	$14 (urgent care) Host Plan Copayments Apply (guest membership)
Home	22	$14
Inpatient Hospital	22	None
Office	23	$14
Outpatient Hospital	23	$14
Skilled Nursing Facility	23	None
Surgical Center	23	$14

☎ = approval required		more info. on page:	Your Copayment Amount Is:
Test, Laboratory and X-Rays			
	Allergy Testing	23	$14 (office visit) $14 (hospital outpatient) None (hospital inpatient)
	Diagnostic Tests	23	None (office visit) None (hospital outpatient) None (hospital inpatient)
	Evaluation for the Use of Hearing Aids	23	None (office visit)
☎	Genetic Testing	23	None (office visit) None (hospital outpatient) None (hospital inpatient)
	Laboratory and Pathology	23	None (office visit) None (hospital outpatient) None (hospital inpatient)
☎	X-ray and Other Radiology	23	10% of eligible charge (office visit) 10% of eligible charge (hospital outpatient) None (hospital inpatient)
Surgery			
	Anesthesia	23	$14 (outpatient professional charges) None (inpatient professional charges)
	Assistant Surgeon Services	24	$14 (outpatient professional charges) None (inpatient professional charges)
	Oral Surgery	24	$14 (outpatient professional charges) None (inpatient professional charges)
☎	Surgical Procedures	24	None (outpatient surgical center) $14 (outpatient professional charges) None (hospital operating room) None (inpatient professional charges)

☎ = approval required	more info. on page:	Your Copayment Amount Is:
Maternity		
Artificial Insemination	24	$14
☎ In Vitro Fertilization	24	20% of eligible charge
Routine Pre/Post Natal Care and Delivery	25	None
Nurse Midwives	25	None
Inpatient Care and Services		
Ancillary Services	25	None
Hospital Room and Board	25	None (You may owe amounts in addition to your copayment. Please see page 25 for more information.)
Skilled Nursing Facility	26	None
Private Duty Nursing	26	50% of eligible charge
Emergency Services		
Emergency Room Facility Services	27	$25 (in-state) $25 (BlueCard provider) 20% of eligible charge (worldwide)
Emergency Room Physician Visits	27	None (in-state) None (BlueCard provider) 20% of eligible charge (worldwide)
Air Ambulance	27	20% of eligible charge
Ground Ambulance	27	20% of eligible charge
Rehabilitation Therapy Services		
Physical and Occupational Therapy	29	$14 (office visit) $14 (hospital-outpatient) None (hospital-inpatient)
Speech Therapy	29	$14 (outpatient) None (inpatient)
Home Health Care and Hospice		
Home Health Care	29	None
Hospice Services	30	None

☎ = approval required	more info. on page:	Your Copayment Amount Is:

Miscellaneous Medical Treatments

	Blood and Blood Products	30	20% of eligible charge
	Chemotherapy and Radiation Therapy	30	$14 (office visit) $14 (hospital outpatient) None (hospital inpatient)
	Contraceptive Diaphragms/Cervical Caps	30	$5 per device
	Contraceptive Implants	31	$200
	Contraceptive Injectables	31	$5 times the number of months the drug is effective (Plus the office visit copayment or the maximum allowable fee for administration of the injectable, whichever is lower. Call HMSA for the current maximum allowable fee.)
	Contraceptive IUD	31	$60
	Contraceptives--Oral	31	$5 per one-month supply or cycle
	Contraceptives - Other Methods	31	**Network Pharmacy** $15 copayment plus a $35 Other Brand Name Cost Share **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 100% of the remaining eligible charge after deducting a $15 copayment plus a $35 Other Brand Name Cost Share
	Dialysis and Supplies	31	$14 (hospital outpatient) None (hospital inpatient)
☎	Growth Hormone Therapy	31	$14 (office visit) $14 (hospital outpatient) None (hospital inpatient)
☎	Home IV Therapy	32	None
	Inhalation Therapy	32	$14(office visit) $14 (hospital outpatient) None (hospital inpatient)
	Injections	32	$14 (office visit) None (hospital outpatient) None (hospital inpatient)
	Inter-island Transportation	32	None
	Medical Equipment, Appliances, and Supplies	32	50% of eligible charge
	Medical Foods	33	20% of eligible charge

☎ = approval required	more info. on page:	Your Copayment Amount Is:
Diabetic Drugs, Supplies, and Insulin		
Diabetic Drugs	33	**Network Pharmacy** $5 (Generic) $15 (Preferred Brand Name) $15 copayment plus a $35 Other Brand Name Cost Share (Other Brand Name) **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 100% of the remaining eligible charge after deducting: $5 (Generic) $15 (Preferred Brand Name) $15 copayment plus a $35 Other Brand Name Cost Share (Other Brand Name) **Mail Order Pharmacy** $10 (Generic) $35 (Preferred Brand Name)
Diabetic Supplies	33	**Network Pharmacy** None (Preferred Brand Name) $15 (Other Brand Name) **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 100% of the remaining eligible charge after deducting: None (Preferred Brand Name) $15 (Other Brand Name) **Mail Order Pharmacy** None (Preferred Brand Name)
Insulin	33	**Network Pharmacy** $5 (Preferred Brand Name) $15 (Other Brand Name) **Non-Network Pharmacy** You owe the entire charge and HMSA reimburses you 100% of the remaining eligible charge after deducting: $5 (Preferred Brand Name) $15 (Other Brand Name) **Mail Order Pharmacy** $10 (Preferred Brand Name)
Behavioral Health - Mental Health and Substance Abuse		
Hospital/Facility Charges	35	None
Physician Visits	34	$14 (outpatient) 20% of eligible charge (inpatient)
Psychological Testing	35	$20

☎ = approval required		more info. on page:	Your Copayment Amount Is:
Transplants			
☎	Organ and Tissue Transplants	36	$14 (office visit) None (hospital outpatient) None (hospital inpatient)
	Organ Donations	37	$14 (office visit) None (hospital outpatient) None (hospital inpatient)

CHAPTER 4

This Chapter Covers

Chapter 4: Description of Benefits describes covered services. Except for emergency services, annual vision exams, annual gynecological exams, and mental health and substance abuse services, benefits are available only for care you receive from or arranged by your PCP. Be sure to read *Chapter 1: Important Information*. All information within *Chapter 1: Important Information* applies to accessing the services described in this chapter. This chapter is divided into the following categories:

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

Routine and Preventive

Gynecological Exam

Covered, for a routine gynecological exam. You may receive a routine gynecological exam from a gynecologist or nurse midwife who practices at your designated health center. A referral from your PCP is not necessary. However, follow-up care or care unrelated to the annual exam must be received from or arranged by your PCP (if your gynecologist is not your PCP).

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 a combination of member and physician education.

You may be automatically enrolled in some of these disease management programs and may elect not to participate by contacting us. HMSA reserves the right to, at any time, add other programs or terminate programs currently in place. 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 preventive services programs and may elect not to participate by contacting us. HMSA reserves the right to, at any time, add other programs or terminate programs currently in place. Check with Customer Service for more information. Our phone numbers are listed in *Chapter 1: Important Information*.

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). For information about standard immunizations for children age 5 and younger, see *Well-Child Care* in this section.

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

Mammography

Covered, for mammography, including screening mammography.

Physical Examination

Covered, for routine examination only when provided or arranged by your PCP. Routine examinations not provided or arranged by your PCP are not a covered benefit and you are responsible for payment. Routine physical examinations, checkups, or related services received solely for the purpose of employment or obtaining insurance are also not a covered benefit.

Vision Exam

Covered. Your HMO medical plan provides benefits for one routine vision exam per calendar year. If you belong to a health center that has an ophthalmologist or optometrist, you must receive your vision exam from these providers. If you don't go to your health center vision provider for your vision exam, the vision exam will not be a covered benefit and you will be responsible for payment.

If your health center does not have an ophthalmologist or optometrist, you may receive your vision exam from any provider listed under the HMO Vision Network. 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 age 5 and under. Well-child care includes office visits for history, physical examinations, developmental assessments, anticipatory guidance, laboratory tests, and standard immunizations. Check with your PCP for the recommended immunization schedule.

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:*** some of these services require precertification. See *Chapter 5: Precertification.*
Laboratory Tests	Covered. Some examples of laboratory 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 Some radiological procedures may require precertification. See *Chapter 5: Precertification.*

Surgery

Certain surgical procedures must receive 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 which severely impair or impede normal, essential bodily functions, or
- the breast on which a mastectomy for cancer or the prevention of cancer 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. Additionally, 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 associated with one or more of the following 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 require 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 which may relate to this benefit are described in *Chapter 6: Services Not Covered* in the section labeled *Fertility and Infertility*.

Nurse Midwives

Covered.

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 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*, Inpatient Care and Service - Hospital Room and Board) following birth.

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

Total Maternity Care

You have benefits for prenatal, false labor, delivery, and postnatal services. Benefit payment occurs following delivery and includes the treatment of routine gynecological conditions during scheduled prenatal visits. If benefit payments are made separately prior to delivery, payments will be considered an advance and we will deduct the amount from the benefit payment for total maternity care.

Inpatient Care and Services

Ancillary Services

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

Hospital Rooms

Covered. Your plan may include a copayment for hospital rooms. See *Chapter 3: Summary of Benefits and Your Payment Obligations*, under *Inpatient Care and Services*, to find out if you owe a copayment under this plan. In addition, 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. In addition, 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 which 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 current 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. In addition, 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 which 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 current list of these conditions.
- Intensive care or coronary units.
- Intermediate care units.
- Isolation units.
- Operating rooms.

Skilled Nursing Facility

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

Limiting conditions:

- 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 additional days at the end of each 30-day period.
- The confinement is not longer than 100 days in any one calendar year.
- 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 Room

Covered, including room charges and physician visits, if a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy 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; or
- Serious dysfunction of any bodily organ or part.

Examples of an emergency include chest pain or other heart attack signs, poisoning, loss of consciousness, convulsions or seizures, broken back or neck, heavy bleeding, sudden weakness on one side, severe pain, breathing problems, drug overdose, severe allergic reaction, severe burns, and broken bones. Examples of non-emergencies are colds, flu, earaches, sore throats, and using the emergency room for your convenience or during normal physician office hours for medical conditions that are treatable in a physician's office.

If you require emergency services, call 911 or go to the nearest emergency room for treatment. Pre-authorization is not required.

Please note: If you are admitted to the hospital directly from the emergency room, hospital inpatient benefits will apply to your emergency room services.

You will not receive benefits if you use an emergency room for any of the following 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 the following statements are true:

- Your condition requires emergency treatment.
- 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 treatment, the transportation must begin at the place where the injury or illness occurred or first required 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 treatment 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 regarding the emergency situation. Your PCP (or a physician 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 treatment.

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 treatment 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, the following 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 receive emergency services, you (or someone acting on your behalf) should contact your PCP to:

- advise him or her of your condition; and
- receive 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 the following are true:

- The therapy is ordered by a physician under an individual treatment plan.
- The therapy is received from a licensed physical or occupational therapist.
- The therapy is necessary to restore neurological or musculoskeletal function that was lost or impaired due to an illness or injury.
- The therapy and diagnosis are described as covered in HMSA's medical policies on physical and occupational therapy.

Benefit maximums apply. Visits are covered up to the number of visits necessary to restore sufficient neurological or musculoskeletal function but not more than the maximum number of visits defined in HMSA's medical policies on physical and occupational therapy. If you are receiving occupational and physical therapy for the same injury, the total number of visits covered is limited to the maximum number of visits for either occupational therapy or physical therapy but not both combined. Neurological or musculoskeletal function is sufficient when one of the following first occurs:

- Neurological or musculoskeletal function is the level of the average healthy person of the same age, or
- When further significant functional gain is unlikely.

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

Speech Therapy

Covered, when the following statements are true:

- The therapy is necessary to restore speech function that was lost or impaired by illness or injury.
- The therapy is short term (long-term maintenance and group speech therapy programs are not covered).
- The therapy is not for developmental learning disabilities, or developmental delay.

Home Health Care and Hospice Services

Home Health Care

Covered, when all of the following statements are true:
Services are prescribed in writing by a physician for the treatment of 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 required.
- Services are not more costly than alternate services that would be effective for diagnosis and treatment of your condition.
- Without home health care, you would require 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 additional visits are required and provide a continuing 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 in determining benefits, level of care and eligibility for hospice services. In addition, 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 eventually 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 *Bone Marrow Transplants.*

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

Chemotherapy and Radiation Therapy (for malignancy)

Covered, subject to the following limitation:

- The chemotherapy or radiation therapy is not for high-dose radiation therapy, or related services and supplies except for those conditions described in the section *Organ and Tissue Transplants, Bone Marrow Transplants* later in this chapter.

Contraceptive Diaphragms/Cervical Caps

Covered, only when approved by the FDA and prescribed by your provider.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. If you have an HPH or HMSA drug plan with a similar benefit, there shall be no duplication or coordination of benefits between this plan and your HPH or HMSA drug plan.

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

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.

Contraceptive-Oral

Covered, for selected brands determined by HMSA in accord with Hawaii law.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. If you have an HPH or HMSA drug plan with a similar benefit, there shall be no duplication or coordination of benefits between this plan and your HPH or HMSA drug plan.

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

Contraceptives - Other Methods

Covered, only when approved by the FDA, under federal control, and prescribed by your provider.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. If you have an HPH or HMSA drug plan with a similar benefit, there shall be no duplication or coordination of benefits between this plan and your HPH or HMSA drug plan.

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 human 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 due to growth hormone deficiency.
- Neonatal hypoglycemia secondary to growth hormone deficiency.
- Prader-Willi Syndrome.

***Please note*:** these services require 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 required for primary diet, including home infusion services and self administered injectable medication from a contracted provider.

Please note: certain services require 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, biological therapeutics and biopharmaceuticals, and travel immunizations in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP). 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 require 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, 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. Vision appliances, which includes 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 durable 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.

Medical equipment and durable medical equipment must meet all of the following criteria:

- The item meets the definition of durable medical equipment. ***Durable Medical Equipment*** means that equipment 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 equipment require precertification. See *Chapter 5: Precertification.*

Benefit Limitation. Benefits for the medical appliance hearing aids are limited to one hearing aid per ear every five years.

Benefits for the rental or purchase of medical equipment or durable 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.

Medical Foods

Covered, for the treatment of 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.*

Diabetic Drugs, Supplies, and Insulin

Covered, only when:

- prescribed by a health care professional authorized to prescribe the drug, supply, or insulin, and
- you do not have an HPH or HMSA drug plan or your HPH or HMSA drug plan does not cover diabetic drugs, supplies, or insulin.

Diabetic drugs can be generic, preferred, or other brand name drugs. Diabetic supplies and insulin can be preferred or other brand name.

- *Generic drugs* are drugs prescribed or dispensed under their commonly used generic (chemical) name rather than a brand name and which are not protected by patent, or drugs identified by HMSA as "generic".
- *Preferred drugs, supplies, and insulin* are brand name drugs, supplies, or insulin identified as preferred on the HMSA Select Prescription Drug Formulary.
- *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.

Copayments for diabetic drugs, supplies, and insulin do not apply toward meeting the Annual Copayment Maximum.

Mail Order Providers

Benefits for mail order diabetic drugs, supplies, and insulin are only available through contracted providers. Contact your nearest Customer Service office listed in *Chapter 1: Important Information* for a list of contracted providers.

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 psychiatrist, psychologist, clinical social worker, 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.

You are not covered for educational programs or other services performed by mutual self-help groups, even if you are referred to such a group by the judicial system.

Serious Mental Illness

Services for serious mental illness, as defined by Hawaii law such as schizophrenia, schizo-affective disorder, and bi-polar types I and II, and services for delusional disorder, dissociative disorder, major depressive disorder, and obsessive-compulsive disorder are not subject to the mental health inpatient and outpatient benefit limitations described below.

How to Access Services

You may receive 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 Physicians. A referral from your PCP is not necessary. Your plan does not provide benefits for mental health or substance abuse services rendered by out-of-network providers. Copies of the Health Plan Hawaii Directory of Health Centers and Physicians are available by contacting Customer Service. Our phone numbers are listed in *Chapter 1: Important Information.*

Benefit Limitations

- **Outpatient Sessions.** Benefits for outpatient mental health and/or substance abuse services by a psychiatrist, psychologist, clinical social worker, or advanced practice registered nurse. Sessions are limited to no more than 50 minutes per day for individual sessions and 90 minutes per day for group sessions. ***Please note****:* Except for serious mental illness, mental health sessions are limited to 24 outpatient sessions per calendar year. Each outpatient psychological testing session counts as one session against the outpatient mental health session maximum.

- **Inpatient Sessions.** Benefits for inpatient mental health and/or substance abuse sessions by a psychiatrist, psychologist, clinical social worker, or advanced practice registered nurse. Sessions are limited to no more than 50 minutes per day. ***Please note:*** Except for serious mental illness, mental health sessions are limited to 30 inpatient sessions per calendar year. Each inpatient psychological testing session counts as one session against the inpatient mental health session maximum.
- **Inpatient Days.** Benefits for inpatient mental health and/or substance abuse services are limited to room and care and inpatient ancillary service charges. No additional benefits are available for intensive or special-care psychiatric units. ***Please note:*** Except for serious mental illness, mental health conditions are limited to 30 inpatient days per calendar year.
- **Psychological Testing.** Benefits for psychological testing are limited to one series of psychological tests per calendar year. ***Please note****:* Each outpatient psychological testing session counts as one session against the outpatient mental health session maximum. Each inpatient psychological testing session counts as one session against the 30-day inpatient mental health session maximum.

Inpatient Mental Health Benefit Substitutions

Each inpatient mental health hospital day may be exchanged for:

- Two days of *nonhospital residential services*
- Two days of partial hospitalization.
- Two days of day treatment services in a qualified treatment facility, but only if the care includes three or more hours of treatment per day. A physician, clinical social worker, registered nurse, or licensed psychologist must prescribe and supervise day treatment services. Services require a minimum of three hours of care in any one day but less than 24 hours of care.
- *Two outpatient visits*. You may only exchange two outpatient visits for one inpatient hospital day if outpatient services would reasonably preclude hospitalization.

Definitions

Alcohol Dependence means any use of alcohol that produces a pattern of pathological use causing impairment in social or occupational functioning or produces physiological dependency evidenced by physical tolerance or withdrawal.

Day Treatment Services means that treatment services are provided by a hospital, mental health outpatient facility, or nonhospital facility to patients who, because of their conditions, require more than periodic hourly service

Drug Dependence means any pattern of pathological use of drugs causing impairment in social or occupational functioning and producing psychological or physiological dependency or both, evidenced by physical tolerance or withdrawal.

Nonhospital Residential Services mean the provision of medical, psychological, nursing, counseling, or therapeutic services by a nonhospital residential facility to patients suffering from alcohol dependence, drug dependence, or mental illness, according to individualized treatment plans.

Psychological Testing means a standardized task used to assess some aspect of a person's cognitive, emotional, or adaptive functioning.

Substance Abuse Services means medical, psychological, nursing, counseling, or therapeutic services in response to a treatment plan for alcohol or drug dependence or both. Services include, as appropriate, a combination of aftercare and individual, group and family counseling services.

Organ and Tissue Transplants

Organ and Tissue Transplants

Covered, as follows:

- Organ transplant services are limited to those 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 the section *Questions We Ask When You Receive Care.*
- The transplant you require (with the exception of corneal, kidney, small bowel and multivisceral transplants) meets all of the following criteria:
  - The transplant procedure receives our approval. Without approval for the specified transplant(s), benefits are not available. Your PCP will obtain approval for you.
  - You are accepted as a transplant candidate at a facility under contract with us for the type of transplant you require.
  - The transplant is received at a facility that is under contract with us for the type of transplant you require.
- Small bowel and multivisceral transplants must receive our approval. See *Chapter 5: Precertification*. Your PCP will obtain approval for you.

Benefit Limitation: Benefits are not available for any of the following:

- Artificial (mechanical) organs.
- Non-human organs.
- Organ or tissue transplants not listed in this section.

Transplant Evaluations

Covered, for bone marrow, heart, heart-lung, liver, lung, simultaneous kidney/pancreas, or small bowel and multivisceral transplants, only with our approval. ***Transplant Evaluation*** means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations, that a facility uses in evaluating a potential transplant candidate. For information about donor screening benefits, see the section *Organ Donations* later in this chapter.

Bone Marrow Transplants

Covered, only with our approval. See *Chapter 5: Precertification*. Also, benefits for bone marrow transplants are limited to autologous and allogeneic bone marrow transplants for the specified diseases or conditions described in this section. Benefits are not available for autologous and allogeneic bone marrow transplants for any other diseases or conditions.

The limited benefits specified below for allogeneic and autologous bone marrow transplants are an exception to the exclusion for experimental or investigative procedures. This limited exception is not intended to, and does not operate as, a waiver of the exclusion for experimental or investigative procedures. The limited benefit is subject to all other conditions and provisions of this plan.

Important Bone Marrow Transplant Definitions

Allogeneic and ***Autologous Bone Marrow Transplants*** mean medical and/or surgical procedures composed of several steps or stages including, without limitation:

- The harvest of stem cells from the blood or bone marrow of a third-party donor (“allogeneic”) or from the patient (“autologous”)
- Processing and/or storage of harvested stem cells.
- The administration of high dose chemotherapy and/or high dose radiation therapy. ***High Dose Chemotherapy*** and ***High Dose Radiation Therapy*** are forms of 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 bone marrow transplant is required or warranted.

- The infusion of harvested stem cells.
- Hospitalization, observation, and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities, and low blood counts.

This definition specifically includes transplants when the transplant component is derived from circulating blood instead of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, high dose chemotherapy and/or high dose radiation therapy.

Allogeneic Bone Marrow Transplants

Allogeneic bone marrow transplants are covered only with our approval. See *Chapter 5: Precertification.* Allogeneic bone marrow transplants are available only for treatment prescribed for the following conditions:

- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia.
- Advanced stage Hodgkin's disease.
- Advanced stage, intermediate-grade, or high-grade non-Hodgkin's lymphoma.
- Advanced stage neuroblastoma.
- Chronic myelogenous leukemia that is in blast crisis or chronic phase.
- Gonadal germ cell tumors.
- Homozygous beta-thalassemia.
- Infantile malignant osteopetrosis.
- Lysomal storage diseases.
- Myelodysplastic syndrome.
- Severe aplastic anemia.
- Severe combined immunodeficiency syndrome.
- Wilm's tumor.
- Wiskott-Aldrich syndrome.

***Please note*:** Also see the benefit description for *Organ Donations* later in this section.

Autologous Bone Marrow Transplants

Autologous bone marrow transplants are covered, only with our approval. See *Chapter 5: Precertification.* Also, benefits for autologous bone marrow transplants are limited to treatment prescribed for the following conditions:

- Acute lymphocytic and non-lymphocytic (i.e., myelogenous) leukemia.
- Advanced stage intermediate-grade or high-grade non-Hodgkin's lymphoma.
- Advanced stage Hodgkin's disease.
- Advanced stage neuroblastoma.
- Breast cancer.
- Gonadal germ cell tumors.
- Multiple myeloma if in accord with our criteria, the disease is newly diagnosed or responsive to previous treatment for multiple myeloma.
- Wilms' tumor.

***Please note*:** Also see the benefit description for *Organ Donations* later in this section.

Corneal Transplants

Covered.

Heart Transplants

Covered, only with our approval. See *Chapter 5: Precertification.*

Heart and Lung Transplants

Covered, only with our approval. See *Chapter 5: Precertification.*

Kidney Transplants

Covered.

Liver Transplants

Covered, only:
- With our approval; and
- if contraindicators used by HMSA are not present; and
- for patient's with end-stage liver disease due to any of the following:
  - Intrinsic disease of the liver.
  - Diseases caused by external agents.
  - Systemic disease.

Lung Transplants

Covered, only with our approval. See *Chapter 5: Precertification*.

Simultaneous Kidney/Pancreas Transplants

Covered, only with our approval. 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 with our approval. See *Chapter 5: Precertification.*

Organ Donations

Organ Donor Services

Covered, but only when you are the person in need of the transplant (i.e., the recipient of the organ).

***Please note*:** Benefits are not available under your coverage for organ donation if you are the organ donor (i.e., you are donating one of your organs to someone else). If you are donating an organ, all claims related to your donor expenses should be submitted under the recipient's coverage.

Please note: Your organ donor benefits are secondary and the donor's benefits are primary when both of the following are true:
- You are the person in need of the transplant (i.e. the recipient of the organ).
- The donor's health coverage includes donor benefits for organ donations.

Benefit Limitation. 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, including donor searches.

Integrated Case Management

Integrated Case Management

Covered, when approved by us. ***Integrated Case Management*** is a special program to assist members with certain medical conditions that require costly, long-term care and when a hospital may not be the most appropriate setting for your treatment. If you meet HMSA's criteria, your coverage provides you with alternate benefits to help meet health care needs resulting 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.

CHAPTER

5

This Chapter Covers

Definition

Precertification is a special approval process to ensure that certain medical treatments, procedures, or devices meet payment determination criteria prior to the service being 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 listing treatments, procedures and devices which require precertification appears later in this chapter.

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

From time to time, it is necessary to change the list of services and supplies which require precertification. Changes are necessary so that your plan benefits remain current with changes to the way therapies are delivered and 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 appropriate to the medical circumstances of your case but not later than 15 days after receipt of your request. We may extend the time once for 15 days if we cannot respond to your request within the initial 15 days and it is due to circumstances beyond our control. If this happens, we will let you 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 additional information from you, we will let you know and provide you with at least 45 days to provide the information.

Our Response to Your Request for Precertification of Urgent Care

Your care is urgent if application of the time periods applicable to non-urgent care:

- Could seriously jeopardize 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 but not later than 72 hours after our receipt of the request.

If you do not provide sufficient information for us to determine whether or to what extent the care you request is covered, we will notify you within 24 hours of our receipt of your request. We will let you know what information we need to respond to your request and provide you a reasonable time but not less than 48 hours to provide the information.

Appeal of Our Precertification Decision

If you disagree with our precertification decision, you may appeal our decision. See *Chapter 8: Dispute Resolution.*

Approval Required For:	Your Action Required:	Result:
Specific Types of Care		
Autologous Chondrocyte Implants **Biological Therapeutics and Biopharmaceuticals** (for first year of its FDA-approved release date) **Blepharoplasty** **Bone Density Test** **Carotid Artery Stenting** **Computed Tomography (CT) - Outpatient** (not required for emergency room) **Durable Medical Equipment** **Genetic Testing - if predictive in asymptomatic individuals with the following:** ▪ Family history of breast cancer ▪ Family history of ovarian cancer ▪ Familial adenomatous polyposis ▪ Hereditary nonpolyposis colorectal cancer **Growth Hormone Therapy** **Home IV Therapy:** ▪ Albumin Therapy ▪ Inotropic Therapy ▪ Intravenous Immune Gamma Globulin (IVIG) Therapy ▪ Pain Management Infusion Therapy ▪ Parenteral Nutrition Therapy **Hyperbaric Oxygen Therapy** (for diabetic wounds and profound anemia) **In Vitro Fertilization** **Injectable Drugs:** ▪ Actimmune ▪ Alimta ▪ Amevive ▪ Avastin ▪ Byetta ▪ Enbrel (for treatment of psoriasis) ▪ Erbitux ▪ Forteo ▪ Lupron (for treatment exceeding 3 months for anemia caused by fibroids or 6 months for management of endometriosis) ▪ Raptiva ▪ Remicade ▪ Synagis ▪ Velcade ▪ Xolair ▪ Zevalin	None. Your provider will contact HMSA for you.	If services do not meet payment determination criteria, no benefits are available. Appropriate referral authorization is necessary if services are to be rendered outside of your health center.

Approval Required For:	Your Action Required:	Result:
Intensity Modulated Radiation Therapy (IMRT) **Intrastromal Corneal Ring Segments for Keratoconus (INTACS)** **Kyphoplasty** **Lung Volume Reduction Surgery** **Magnetic Resonance Angiography (MRA) - Outpatient** (not required for emergency room) **Magnetic Resonance Imaging (MRI) - Outpatient** (not required for emergency room) **Non-Coronary Brachytherapy** **Nuclear Cardiology - Outpatient** (not required for emergency room) **Off Label Drug Use** **Panniculectomy** **Photochemotherapy** **Positron Emission Tomography (PET)** **Reduction Mammoplasty** **Routine Care Associated With Clinical Trials** **Stereotactic Radiosurgery Utilizing Particle Beams (Gamma-knife Surgery)** **Surgery for Hyperhidrosis** **Surgery to Correct Morbid Obesity** **Surgeries, therapies or procedures employing new technology or representing a new application of existing technology** **Treatment of Hepatitis C with combined Interferon (including Peginterferon) and Ribavirin Therapy** **Treatment of Varicose Veins**	None. Your provider will contact HMSA for you.	If services do not meet payment determination criteria, no benefits are available. Appropriate referral authorization is necessary if services are to be rendered outside of your health center.
Organ and Tissue Transplants		
Transplant Evaluations **Allogeneic Bone Marrow Transplant** **Autologous Bone Marrow Transplant** **Heart Transplant** **Heart/Lung Transplant** **Liver Transplant** **Lung Transplant** **Simultaneous Kidney/Pancreas Transplant** **Small Bowel and Multivisceral Transplant**	None. Your provider will contact HMSA for you.	If services do not meet payment determination criteria, no benefits are available.

CHAPTER 6

This Chapter Covers

About this Chapter

Your health care coverage does not provide benefits for procedures, services or supplies that are listed in this chapter. For your convenience, we divided this chapter with category headings. These category headings will help you find the information 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, it will not be covered unless it is described in *Chapter 4: Description of Benefits*, and it meets all of the criteria described in *Chapter 1: Important Information* under *Questions We Ask When You Receive Care.*

If you are unsure if a specific procedure, service or supply is covered or not covered, please call Customer Service, and we will assist 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.

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.

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 illness or injury related to military service when you receive treatment in a hospital operated by an agency of the United States government. You are not covered for services or supplies that are required 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 receive payment or recover damages in connection with the illness or injury; or an illness or injury for which you may recover damages or receive 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 office visit for diagnosis.

Drugs

You are not covered for prescription drugs except as stated in *Chapter 4: Description of Benefits*.

Eyeglasses and Contacts

You are not covered for the following:

- 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.

Experimental or Investigative

Experimental or Investigative Treatment

You are not covered for medical treatments, procedures, drugs, devices, or care, and all related services or supplies (except for routine care described as covered in Chapter 4 of this Guide) that are experimental or investigational. A medical treatment, procedure, drug, device, or care is experimental or investigative if:

- The drug or device *cannot be lawfully marketed without approval* of the U.S. Food and Drug Administration (FDA) and FDA approval for marketing for the proposed use has not been given at the time the drug or device is furnished, unless the off-label use is listed as an approved/accepted indication in the USPDI (United States Pharmacopeial Drug Information), AHFS (American Hospital Formulary Service Drug Information), or the member demonstrates that the weight of the scientific evidence establishes the medical necessity of the drug for treatment of the member's condition; or
- The drug, device, medical treatment, or procedure, or the *patient informed consent document* utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
- *Reliable evidence* shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is for the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only:

- published reports and articles in authoritative medical and scientific literature;
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

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*.
- 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 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*** means 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.

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 limitation, all forms of bone marrow or peripheral stem cell transplants.

Miscellaneous Exclusions

Act of War

To the extent permitted by law, you are not covered for services required in the treatment of 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 testing.

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 as described in *Chapter 4: Description of Benefits* under *Bone Marrow Transplants.*

Complications of a Non-Covered Procedure

You are not covered for complications of a non-covered procedure.

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 treatment 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 receive 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 and only 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 false statement or other misrepresentation that you made in an application for membership or in any claims for benefits. If we pay benefits to you or your provider before learning of any false statement, you are responsible for reimbursing us.
Foot Orthotics	You are not covered for foot orthotics except for specific diabetic conditions.
Genetic Testing and Screening	You are not covered for genetic testing and screening except as stated in *Chapter 4: Description of Benefits* under *Testing, Laboratory, and Radiology.*
Growth Hormone Therapy	You are not covered for human growth hormone therapy except as stated in *Chapter 4: Description of Benefits.*
Hair Loss	You are not covered for services or supplies, including hair transplants and topical medications, related to the treatment of baldness or hair loss regardless of condition.
Intradiscal Electro Thermal Therapy (IDET)	You are not covered for intradiscal electro thermal therapy.
Motor Vehicles	This plan does not cover the cost of purchase or rental of motor vehicles such as cars and vans. You are also not covered for equipment and costs associated with 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 examinations that are performed solely for the purpose of insurance or employment. You are also not covered for physical examinations that are not provided or arranged by your PCP.
Radiation (Nonionizing)	You are not covered for treatment with nonionizing radiation.
Radiation (High-dose)	You are not covered for high-dose radiotherapy except as described in *Chapter 4: Description of Benefits* under *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.
Thoracic Electric Bioimpedance (Outpatient)	You are not covered for outpatient thoracic electric bioimpedance.
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 and Food Supplements	You are not covered for vitamins, minerals or food supplements except as described in *Chapter 4: Description of Benefit* under *Miscellaneous Medical Treatments.*
Weight Reduction Programs	You are not covered for weight reduction programs and supplies (including dietary supplements, food, equipment, laboratory testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.
Wigs	You are not covered for wigs and artificial hairpieces.

CHAPTER 7

This Chapter Covers

When to File Claims

Submit within 90 Days

Most providers in the state of Hawaii file claims for you. If your provider does not file for you, please submit an itemized bill or receipt within 90 days of the last day on which you received services listing 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 which appears on your member card.

Provider Statement

The provider statement must be from your provider and all services provided 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 (or with accompanying English translation) on the stationery of the provider who performed the service.

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 beginning 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 provided to us for your records.

Information provided to us will not be returned to you.

Report to Member

Once we receive and process your claim, we will send you a report explaining your benefits not later than 30 days after we receive a claim you submit. The ***Report To Member*** tells you how we processed the claim including 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 additional 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 additional information, you will have at least 45 days to provide us the information.

If your claim is denied, our report will provide an explanation for the denial.

If, for any reason, you believe we wrongly denied a claim or coverage request, please call Customer Service for assistance. For your convenience, our phone numbers are 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, you will be assessed a service charge.

CHAPTER 8

This Chapter Covers

Your Request for an Appeal

Writing Us to Request an Appeal

If you wish to dispute a determination made by HMSA related to coverage, reimbursement, any other decision or action by HMSA, or any other matter related to this Agreement, you must request an appeal. Your request must be in writing unless you are requesting 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 limitation of your claim, or of the denial of coverage for any requested service or supply.

Address 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 which 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 regarding 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 but not later than 30 days after we receive your appeal.

Appeal of Any Other Decision or Action

We will respond to your appeal within 60 calendar days of our receipt of your appeal.

Expedited Appeal

You may request expedited appeal if application of the time periods for appeals above may:

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

You may request 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 but not later than 72 hours of our receipt of your request.

Who Can Request an Appeal

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

- Any person you authorize to act on your behalf provided you follow our procedures which include filing a form with us. To obtain 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 requesting 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 the following information:

- The date of your request.
- Your name.
- The date of the service we denied or date of the contested action or decision (or in the case of precertification for a service or supply, the date of our denial of coverage for such 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 information relating to your appeal including 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

If you disagree with HMSA's appeal decision, you must either 1) request arbitration before a mutually selected arbitrator, or 2) file a lawsuit against HMSA. If you are not enrolled in an employer sponsored group plan subject to ERISA, you have the additional option of requesting review by the Hawaii State Insurance Commissioner. If you are enrolled in an ERISA plan and wish review by the Commissioner or want help determining if you are enrolled in an ERISA plan, please call HMSA at (808) 948-5090 or the Insurance Commissioner at (808) 586-2804 for assistance in determining if review is available in your case.

Request for Arbitration

If you select 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 receive your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the disagreement. 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 actually 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 United States District Court for the District 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 questions for the arbitrator shall be whether we were in violation of law, or acted arbitrarily, capriciously, or in abuse of our discretion. The arbitration shall be conducted in accord with the Federal Arbitration Act, 9 U.S.C. §1 et seq., and such other arbitration rules as both parties agree upon.

The arbitrator will make a decision as quickly as possible and will give both parties a copy of this decision. The decision of the arbitrator is final and binding and 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 for Review by Insurance Commissioner

If you are not in an employer sponsored group plan subject to ERISA, you may request review by a panel selected by the Hawaii Insurance Commissioner by submitting a request for review within 60 days of the date of HMSA's appeal decision to the Insurance Commissioner at:

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

If your request for review is accepted by the Commissioner, the Commissioner will appoint a three member panel composed 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 and the panel will issue a decision within 30 days of the hearing.

You may request expedited review by the Insurance Commissioner if application of the above timeframes may:

- Seriously jeopardize your life or health,
- Seriously jeopardize 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 you are in an ERISA plan and wish review by the Commissioner or need help in determining if you are a member of an ERISA plan, please call HMSA at (808) 948-5090 or the Insurance Commissioner at (808) 586-2804 for assistance in determining if review is available in your case.

CHAPTER 9

This Chapter Covers

What Coordination of Benefits Means

Coverage that Provides Same or Similar Coverage

You may have other insurance coverage that provides benefits which are the same or similar to this plan. If so, the benefits payable under this plan, when combined with benefits paid under your other coverage, will not exceed the lesser of:

- 100 percent of eligible charge, or
- the amount payable by your other coverage plus any copayment you would owe if the other coverage were 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.

The method we use to calculate our eligible charge may be different from the methods of other plans. For a description of how we determine our eligible charge, see *Chapter 2: Payment Information.*

What You Should Do

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

To help us coordinate your benefits, you should:

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

Chapter 9: Coordination of Benefits and Third Party Liability

What We Will Do

Once we have the 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 upon 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.

Limitation On Benefits

After applying the coordination rules to determine which plan pays first and which plan pays second, if it is determined that this plan pays second, this plan's payment will not exceed the amount this plan would have paid if it had been your only coverage.

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 cost sharing payments.

Before we pay benefits under this coverage for an injury covered by motor vehicle insurance, you must provide 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 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. Upon our verification of exhaustion, you are eligible for covered services in accord with this Guide to Benefits.

Please note that in the following two situations, 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 for the same covered services. Except as provided below, we will cover any remaining Medicare copayments and deductibles. Benefits under this plan will be paid up to either the Medicare approved charge for services rendered by a Medicare participating provider, or the lesser of our eligible charge or the limiting charge (as defined by Medicare) for services rendered by a provider that does not participate with Medicare.

Exhaustion of Medicare Benefits

If you are entitled to Medicare benefits, we will begin paying benefits after all Medicare benefits (including all lifetime reserve days) are exhausted.

If your inpatient hospital stay is extraordinarily long and costly and some or all of the stay is not covered by Medicare because your Medicare inpatient hospital benefits (including lifetime reserve days) are exhausted, we will pay the lesser of:

- the eligible charge for the entire confinement less Medicare inpatient hospital payments and Medicare Part B payments for inpatient lab, diagnostic and x-ray services on those days; or
- total hospital charges for inpatient days for which Medicare rules permit the hospital to bill you less Medicare Part B payments for inpatient lab, diagnostic and x-ray services on those days.

Medicare Part B Only

If you have coverage under Medicare Part B only, we will pay inpatient benefits based on our eligible charge less any Medicare Part B benefits for inpatient lab, diagnostic and x-ray services.

Facilities or Providers Not Eligible or Entitled to Medicare Payment

When services are rendered 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

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 situations, any payment made by us on your behalf in connection with such injury or illness will only be in accord with the following 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 applicable to your automobile coverage.

What You Need To Do

Your cooperation is necessary 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 accordance 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, and 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 necessary 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 in protecting 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, and 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 which rights are preserved and may be pursued at our option against you or any other appropriate person or entity.

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

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

CHAPTER 10

This Chapter Covers

Eligibility for Coverage

When You Are Eligible for Coverage

You may apply for this coverage when you are first eligible according to your employer's rules for eligibility. If you do not apply for coverage when you first become eligible or by the first day of the month immediately following the first four consecutive weeks of employment, your application will not be accepted 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 application 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 application.

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 application or added later as a new dependent.

Enrollment Process

You must enroll your spouse or child(ren) by naming him or her on the application form or other enrollment 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 the following requirements:

- The child is your natural child, your legally adopted child or a child placed with you for adoption, a stepchild, or a child for whom you are the court-appointed guardian.
- The child is under 19 years of age.
- The child is not married.

In addition, you may enroll children who meet all of the criteria in one of the following categories:

- Children Who Are Students
- Children with Special Needs
- Children Who Are Newborns or Adopted

Children Who Are Students

Your child may qualify to be enrolled as a student subject to your employer's arrangement with HMSA if all the following statements are true:

- Your child is enrolled in an educational institution (such as a high school, college, junior college, university, trade school, business school, or industrial educational center) for not less than the minimal number of credit hours required by such educational institution for full time students.
- Your child is not married.
- Your child is a legal resident of Hawaii.
- Your child is wholly dependent on you for support and maintenance.

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 19 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 the child's 19th birthday.

You must provide this documentation to us within 31 days of the child's 19th birthday and subsequently at our request but not more frequently than annually after the child reaches 21 years of age.

Children Who Are Newborns or Adopted

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

- The birth date of a newborn, providing you comply with our usual enrollment process within 31 days of the child's birth.
- The date 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, providing all of the following are met:

- Your initial dues were paid.
- We accepted your application by giving written notice to you of your effective date.
- You are not in the hospital on the day coverage goes into effect.

If you are confined in a hospital or other inpatient facility at the time 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. We will work with your prior insurer or coverage to determine which option applies to you. This limitation 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 limitation applies to you so that we can assist you in determining your rights to coverage.

When Coverage Ends

Reasons for Coverage Termination

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

- You choose to terminate this coverage. In this case, you must provide us 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 terminate 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 terminates; or
  - The child fails to meet the criteria outlined earlier in this chapter under *What You Should Know about Enrolling Your Child(ren).*

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

- You engage in conduct, such as the examples listed below, that, in our opinion, seriously jeopardizes our ability to provide plan benefit services:
  - Refusing to follow recommended treatment or medical procedure and the physician believes that no professionally acceptable alternative exists;
  - Refusing to follow prescribed Health Center provider's operational procedures; or
  - Engaging in repeated disruptive behavior or threatens infliction of bodily harm to others.
- You fail to pay copayments or other amounts owed to the Health Center provider.
- 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 graduates from college 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 terminate immediately if you use this coverage fraudulently or you misrepresent or conceal material facts in your application. If your coverage is terminated for fraud, 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 receive a COBRA election form within 44 days if the qualifying event is a termination of employment or reduction in hours. If the qualifying event is divorce, legal separation, or a child ceasing to be a dependent child, the form and notice must be provided to you within 14 days after you notify your employer of the event.

Please note: You or your spouse 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 which may be up to 102% of the full cost of the coverage. In the case of a disabled individual whose coverage is being continued for 29 months, you or your dependents may be required to pay up to 150% of the full cost of the coverage for any month after the 18th month.

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

What You Must Do

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

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

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

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

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

Chapter 10: General Provisions

Adding Your Child

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

Length of Coverage Under COBRA

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

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

  as the spouse of the covered employee; or

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

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

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

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 is confidential. HMSA does not use or disclose your medical information except as permitted or required by law. You may be required 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 premium following 30 days written notice to your employer or group sponsor.

Timely Payment

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

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

Terms of Coverage

By submitting the application, 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 terminate this coverage at any time. If your employer or group sponsor terminates 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 regarding the modification.

Governing Law

To the extent not superseded by the laws of the United States, 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 in the state or federal courts located 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.

Chapter 10: General Provisions

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 United States Department of Labor. You may examine these documents without charge at the plan administrator's office or at specified locations.
- obtain 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 obtaining 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 requires physician and nursing observations on a minute-to-minute, hour-to-hour basis.

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

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

Admission
The formal acceptance of a patient into a facility for a medical, surgical, or obstetrical condition.

Agreement
The document made up of all of the following:
- This Guide to Benefits.
- Any riders or amendments.
- The application form submitted to us.
- The Agreement between HMSA and your employer or group sponsor.

Alcohol Dependence
Any use of alcohol that produces a pattern of pathological use causing impairment in social or occupational functioning or produces physiological dependency evidenced by physical tolerance or withdrawal.

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

Ambulance Service
Local air or ground emergency transportation to a hospital or nursing facility in the surrounding area where your transportation began.

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

Anesthesia
The administration of anesthetics to produce loss of feeling or consciousness, usually in conjunction with forms of 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 applicable 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 disagreement.

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

Chapter 11: Glossary

Autologous Transplant — Transplant in which the tissue or organ for a transplant is procured 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 United States).

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.

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 — Biofeedback is 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 — Biological therapeutics and biopharmaceuticals are any biology-based therapeutics that structurally mimic compounds found within 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 which replace missing body parts and/or which 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 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 beginning 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 immediately 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.

Certified Substance Abuse Staff — Professionals and paraprofessionals with current full certification as substance abuse or program administrators under Hawaii state law; and/or physicians who hold a current American Society of Addiction Medicine (ASAM) certificate.

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.

Child	Means any of the following: your natural child, your legally adopted child, your stepchild, a child for whom the member or his or her spouse is the court-appointed guardian, a minor child who has been adopted or placed with the member for adoption.
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 (deliberation) 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 contraceptives or contraceptive devices that prevent impregnation.
Contraceptive Services	Services intended to promote the effective 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	Applies to most covered services and is either a fixed percentage of the eligible charge or a fixed dollar amount.The amount you pay to help share the costs of your medical care. Your copayment applies each time you receive most covered services.
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, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5, United States Code; or a public health plan as defined in government regulations health benefit plan under section 5(e) of the Peace Corps Act.
Covered Services	Services or supplies which meet payment determination criteria and are listed in this guide in *Chapter 4: Description of Benefits.*
Custodial Care	Helps you meet your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel.
Day Treatment Services	Treatment services provided by a hospital, mental health outpatient facility, or nonhospital facility to patients who, because of their condition, require more than periodic hourly service.
Detoxification Services	A process of detoxifying a person who is dependent on alcohol and/or drugs The process involves assisting a person through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug dependency factors.
Dependent	The member’s spouse and/or eligible child(ren).

Chapter 11: Glossary

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 Physicians — A complete listing of HPH health centers and network providers.

Drug — Any chemical compound that may be used on or administered as an aid in the diagnosis treatment, or prevention of disease or other abnormal condition, for the relief of pain or suffering, or to control or improve any physiologic or pathogenic condition.

Drug Dependence — Any pattern of pathological use of drugs causing impairment in social or occupational functioning and producing psychological or physiological dependency or both, evidenced by physical tolerance or withdrawal.

Dues — The monthly premium amount for HPH membership.

Durable Medical Equipment — An item that meets the following criteria:

- It is durable enough to withstand repeated use.
- It is primarily and customarily manufactured to serve a medical purpose.
- 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 upon which you are first eligible to receive benefits under this coverage.

Eligible Charge — The amount upon which your copayment is based. This amount is always the lower of the actual charge or the maximum allowable fee.

Emergency — When a prudent layperson could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual (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.

Experimental or Investigative Treatment — Services, supplies, devices, procedures, drugs or treatments that are not yet accepted as common medical practice. For a detailed definition, see *Chapter 6: Services Not Covered.*

Facility — Examples of facilities include hospitals, skilled nursing facilities, and ambulatory surgical facilities.

False Statement — Any misrepresentation that you made in an application for membership 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 which is prescribed or dispensed under its commonly used generic (chemical) name rather than a brand name and which is not protected by patent, or a drug 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 obtaining 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.

High-Dose Chemotherapy A form of chemotherapy in which the dose and/or manner of administration is expected to damage a persons bone marrow or suppress bone marrow function so that a bone marrow transplant is required or warranted.

High-Dose Radiotherapy A form of radiation therapy in which the dose and/or manner of administration is expected to damage a persons bone marrow or suppress bone marrow function so that a bone marrow transplant is required or warranted.

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.

Home Health Agency (HHA) An approved agency that provides skilled nursing care in your home.

Home Infusion Therapy Treatment provided in the home involving the administration of nutrients, antibiotics and other drugs and fluids intravenously or through a feeding tube.

Hospice Program A program that provides care in a comfortable setting (usually the home) for patients who are terminally ill and have a life expectancy of six months or less.

Hospital An institution that primarily provides diagnostic and therapeutic services for surgical and medical diagnosis treatment and care of injured or sick persons.

Illness or Injury Any bodily disorder, bodily injury, disease or condition (includes pregnancy and complications of pregnancy).

Immediate Family Member Your child, spouse, parent, or yourself.

Immunization An injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

Incidental Procedure A procedure that is an integral part of another procedure. Such procedures are not a separately reimbursable benefit.

Inhalation Therapy Therapy to treat conditions of the cardiopulmonary system.

Chapter 11: Glossary

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 emphasizes the specialized care needs of patients with severe or chronic illnesses or injuries.
Intravenous Injection	An injection made into the vein.
Investigative or Experimental Treatment	Services, supplies, devices, procedures, drugs or treatment that is not yet accepted as common medical practice. For a detailed definition, see *Chapter 6: Services Not Covered.*
In Vitro Fertilization	A method of treating 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.
Lifetime Maximum	The maximum benefit amount each member is eligible to receive during his or her lifetime. The lifetime maximum may accumulate from benefits received under this coverage and any other HMSA employer group coverage you have or had as a member or dependent, regardless of any interruptions in coverage.
Mammogram	The x-ray examination 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 termination of pregnancy.
Maximum Allowable Fee	The amount we establish as the maximum amount HMSA will pay toward covered services and supplies. HMSA uses various methods to determine the maximum allowable fee.
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 by non-surgical means.
Medicine	The diagnosis and treatment of disease and maintenance of health.
Member	The person who meets applicable eligibility requirements and who executes the application 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 receive services.

Mental Illness/Disorder — A syndrome of clinically significant psychological, biological, or behavioral abnormalities that result in personal distress or suffering, impairment of capacity for functioning, 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.

Mental Health Outpatient Facility — A mental health establishment, clinic, institution, center, or community mental health center that provides for the diagnosis treatment, care or rehabilitation of mentally ill persons.

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 hospitalization.

Non-Assignment — When benefits for covered services and supplies cannot be transferred or assigned to anyone for use.

Nonhospital Facility — A facility for the care or treatment of alcohol dependent, drug dependent, or mentally ill persons.

Nonhospital Residential Services — The provision of medical, psychological, nursing, counseling, or therapeutic services, by a nonhospital residential facility to patients suffering from alcohol dependence drug dependence or mental illness, according to individualized treatment plans.

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 rehabilitation therapy involving the treatment of neurological or musculoskeletal function through the use of specific tasks or goal-directed activities designed to improve the functional performance of an individual.

Ophthalmologist — A physician specializing in the diagnosis and treatment of diseases and defects of the eye.

Optometrist — A practitioner who specializes in the examination, diagnosis treatment and management of diseases and disorders of the visual system, the eye and associated structures.

Oral Surgeon — A dentist licensed as a doctor of dentistry (D.M.D.) or dental surgery (D.D.S.) to perform diagnosis and treatment of oral conditions requiring surgical intervention.

Organ Donor Services — Services related to the donation of an organ.

Osteopathy — Medicine that specializes in diseases of the bone.

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Other Brand Name Cost Share	A share of the cost of other brand name drugs or devices which you must pay in addition to a copayment.
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.
Other Brand Name Drug, Supply, or Insulin	A brand name drug, supply, or insulin which is not identified as preferred on the HMSA Select Prescription Drug Formulary
Partial Hospitalization	Treatment services provided by a hospital or mental health outpatient facility to patients who, because of their condition, require more than periodic hourly service. A physician or licensed psychologist must prescribe partial hospitalization services.
Payment Determination Criteria	Care, treatment, service, or supply which is all of the following: 1) appropriate and necessary for the symptoms, diagnosis, and direct care or treatment of your illness or injury; 2) consistent with professionally recognized standards of health care in the United States, and given at the right time and in the right setting; 3) not primarily for your convenience or the convenience of your provider; and 4) the most appropriate supply or level of service that can safely be provided.
Physical Therapy	Therapy that helps restore a neurological or musculoskeletal function that was lost or impaired by injury or illness.
Physician Services	Professional services necessarily and directly performed by a doctor in treatment of 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 following a surgical operation.
Postpartum	The period of time following childbirth.
Precertification	The process of obtaining approval for specified services and supplies. Failure to obtain our approval results in denial of benefits.
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 physician directing a pharmacist to dispense a particular drug in a specific dose.

Personal Care Physician (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.

Psychiatry — The medical study that specializes in treatment and prevention of disorders of the mind.

Psychological Testing — A standardized task used to assess some aspect of a person's cognitive, emotional, or adaptive functioning.

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.

Qualified Treatment Center — An accredited inpatient or outpatient facility for the treatment of mental illness.

Radiology — The use of radiant energy in the diagnosis and treatment of disease.

Referral — When your PCP determines that your condition requires the services of a specialist, he or she will arrange for you to receive 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 to benefits.

Report to Member — The report you receive in the mail from us that outlines how we applied benefits to a submitted claim.

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

Chapter 11: Glossary

Single Coverage	Coverage for the member only.
Skilled Nursing Facility	A facility that provides continuous skilled nursing services as ordered and certified by your attending physician.
Speech Therapy	Restoration of speech that was lost or impaired by injury or illness.
Spouse	Your husband or wife as the result of a marriage that is legally recognized in the state of Hawaii.
Subscriber Number	The number that appears on your HPH member card.
Substance Abuse Services	The provision of medical, psychological, nursing, counseling, or therapeutic services in response to a treatment plan for alcohol or drug dependence or both. Services include, as appropriate, a combination of 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 receive 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.
Transplant	The transfer of an organ or tissue for grafting into another area of the same body or into another individual.
Treatment	Management and care of the patient for the purpose of combating disease or disorder.
Tubal Ligation	A sterilization procedure for women.
Urgent Care	When you require medical care for an unexpected illness or injury which 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 to Benefits.

HAWAII MEDICAL SERVICE ASSOCIATION
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The Hawaii Medical Service Association is a nonprofit, mutual benefit association founded in Hawaii in 1938. It is the most experienced provider of health care coverage in the state. HMSA is a member of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

HMSA is dedicated to providing Hawaii's families with access to quality, affordable health care. We are also committed to improving the health and well-being of all HMSA members and the community at large through a variety of health education, promotion and prevention programs and other community services.