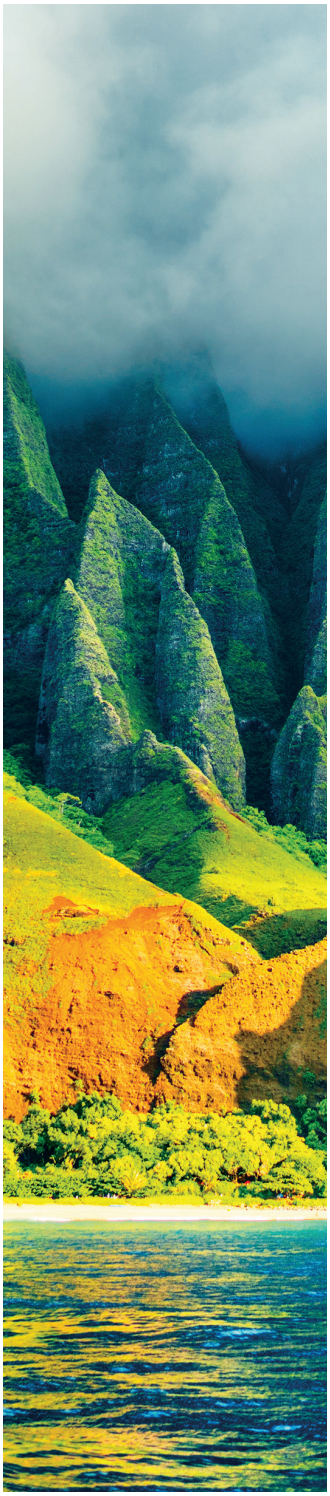
Guide to Benefits



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January 2019

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An Independent Licensee of the Blue Cross and Blue Shield Association

Federal law requires HMSA to provide you with this notice.

HMSA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HMSA does not exclude people or treat them differently because of things like race, color, national origin, age, disability, or sex.

Services that HMSA provides

Provides aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages
- If you need these services, please call 1 (800) 776-4672 toll-free; TTY 711

How to file a discrimination-related grievance or complaint

If you believe that we've failed to provide these services or discriminated against you in some way, you can file a grievance in any of the following ways:

- Phone: 1 (800) 776-4672 toll-free
- TTY: 711
- Email: Compliance_Ethics@hmsa.com
- Fax: (808) 948-6414 on Oahu
- Mail: 818 Keeaumoku St., Honolulu, HI 96814

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, in any of the following ways:

- Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1 (800) 368-1019 toll-free; TDD users, call 1 (800) 537-7697 toll-free
- Mail: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201

For complaint forms, please go to hhs.gov/ocr/office/file/index.html.

Hawaiian: E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻŌlelo Hawaiʻi, loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā 1 (800) 776-4672. TTY 711.

Bisaya: ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1 (800) 776-4672 nga walay toll. TTY 711.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 776-4672。TTY 711.

Ilocano: PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1 (800) 776-4672 toll-free. TTY 711.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (800) 776-4672 をご利用ください。TTY 711.まで、お電話にてご連絡ください.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 776-4672번으로 연락해 주시기 바랍 니다. TTY 711 번으로 전화해 주십시오.

Laotian: ກະລຸນາສັງເກດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາ, ບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ແມ່ນມີໃຫ້ທ່ານ. ໂທ 1 (800) 776-4672 ຟຣີ. TTY 711.

Marshallese: LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1 (800) 776-4672 tollfree, enaj ejjelok wonaan. TTY 711.

Pohnpeian: Ma ke kin lokaian Pohnpei, ke kak ale sawas in sohte pweine. Kahlda nempe wet 1 (800) 776-4672. Me sohte kak rong call TTY 711.

Samoan: MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1 (800) 776-4672 e leai se totogi o lenei ʻau'aunaga. TTY 711.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 776-4672. TTY 711.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 776-4672 toll-free. TTY 711.

Tongan: FAKATOKANGA'I: Kapau ʻoku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea ʻoku nau fai atu ha tokoni ta'etotongi, pea teke lava ʻo ma'u ia. Telefoni mai 1 (800) 776-4672. TTY 711.

Trukese: MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1 (800) 776-4672, ese kamo. TTY 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 776-4672. TTY 711.

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CHAPTER 1

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What You Should Know about this Guide to Benefits

About Your Comprehensive Medical Plan

Your health care coverage is a Comprehensive Medical plan. This means you have medical benefits for your health care needs including office visits, inpatient facility services, outpatient facility services, and other provider services. This coverage offers you flexibility in the way you get medical benefits. Your opportunity to take an active role in your health care decisions makes this coverage special. In general, to get the lowest out-of-pocket costs possible, you should seek services from ***HMSA Participating Providers.***

To keep pace with change, HMSA's New Technology Assessment Committee uses scientific evidence to evaluate new developments in technology and new applications of existing technologies. The Committee's recommendations are a critical factor in our decisions to cover new technologies and applications. HMSA's Pharmacy and Therapeutics Advisory Committee, composed of practicing physicians and pharmacists from the community, meet quarterly to assess drugs, including new drugs, for inclusion in HMSA's plans. Drugs that meet the Committee's standards for safety, efficacy, ease of use, and value are included in various plan formularies. For more details on coverage under this plan, see *Chapter 4: Description of Benefits* and *Chapter 6: Services Not Covered*.

Terminology

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

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

Definitions

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

Questions

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

Summary of Provider Categories

This chart shows how the various provider categories impact your benefits.

	Provider Category			
	HMSA Participating Provider	**BlueCard Participating Provider**	**Contracting Provider**	**Nonparticipating Provider (in or out of state)**
Does your provider contract with HMSA?	Yes	No, contracts with the BlueCard Program.	Yes, contracts with HMSA for transplant services.	No, does not contract with HMSA or the BlueCard program.
Does your provider always file claims for you?	Yes	Yes	Yes	No, you may have to file your own claims.
Does your provider accept eligible charge as payment in full? If so, you do not pay for any difference between actual charge and eligible charge.	Yes	Yes	Yes	No, you pay any difference between the actual charge and the eligible charge. See *From What Provider Category Did You Receive Care?* in the section labeled *Questions We Ask When You Receive Care* later in this chapter.
Do you pay the provider copayments? If so, we send benefit payment directly to the provider.	Yes	Yes	Yes	No, you pay provider in full. We send benefit payments to you.
Does your provider get precertification approvals for you?	Yes	No, you are responsible for getting approval.	Yes	No, you are responsible for getting approval.

Care While You are Away from Home

Medical Care Outside of Hawaii (BlueCard® Program)

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Participating Medical Providers

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

When you receive covered medical services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered medical services is calculated based on the lower of:

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

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

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

Inter-Plan Programs: Federal/State Taxes/ Surcharges/Fees

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

Nonparticipating Providers Outside Hawaii

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

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

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

Blue Cross Blue Shield Global Core

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

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

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

Finding BlueCard Participating Providers

The Host Blue in the area where you need services can provide you with information on participating providers in the area. You can also visit the BlueCard Doctor and Hospital Finder web site (www.BCBS.com) or call 1-800-810-BLUE (2583).

Carry Your Member Card

Always carry your HMSA Member Card. Your member card ensures that you get all the conveniences you're used to when you get medical services at home in Hawaii. The card tells participating providers which independent Blue Plan you belong to. It also includes information the provider needs to file your claim for you.

Questions We Ask When You Receive Care

Is the Care Covered?

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

Does the Care Meet Payment Determination Criteria?

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

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

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

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

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

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

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

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

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

Is the Care Consistent with HMSA's Medical Policies?

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

From What Provider Category Did You Receive Care?

Your benefits may be different depending on the category of provider that you get care from. In general, you will get the maximum benefits possible when you get services from an HMSA participating provider.

When you see a nonparticipating provider you will owe any copayment that applies to the service plus the difference between HMSA's eligible charge and the provider's actual charge. Also, nonparticipating providers have not agreed to HMSA's payment policies and can bill you for services or other charges that HMSA does not cover. Participating providers have agreed not to charge you for these services. These amounts will be included in the nonparticipating provider's actual charge.

For more details on provider categories see the sections *Summary of Provider Categories* and *Care While You are Away from Home* earlier in this chapter.

Please note: Your participating provider may refer services to a nonparticipating provider and you may incur a greater out-of-pocket expense.

For example, your participating provider may send a blood sample to a nonparticipating lab to analyze. Or, your participating provider may send you to a nonparticipating specialist for added care.

Is the Service or Supply Subject to a Benefit Maximum?

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

Is the Service or Supply Subject to Precertification?

Certain services require our prior approval. HMSA participating providers get approval for you, but other providers may not. If you get services from a BlueCard or nonparticipating provider and approval for certain services is not obtained, benefits may be denied. In some cases, benefits are denied entirely. For services subject to approval, read *Chapter 5: Precertification.*

Did You Receive Care from a Provider Recognized by Us?

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

Did a Recognized Provider Order the Care?

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

What You Can Do to Maintain Good Health

Practice Good Health Habits

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

Be a Wise Consumer

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

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

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

Interpreting this Guide

Agreement

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

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

Our Rights to Interpret this Document

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

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

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

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

CHAPTER 2

This Chapter Covers

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- Copayment 9
- Annual Copayment Maximum 10
- Maximum Allowable Fee 10
- Benefit Maximum 11

Eligible Charge

Definition

For most medical services, except for emergency services provided by nonparticipating providers, the **Eligible Charge** is the lower of either the provider's *actual* charge or the amount we establish as the *maximum allowable fee*. HMSA's payment, and your copayment, are based on the eligible charge. Exceptions: For services from participating facilities, HMSA's payment is based on the maximum allowable fee and your copayment is based on the lower of the actual charge or the maximum allowable fee. Some services may be rendered by providers who accept monthly payments from HMSA to manage the care of a certain population of their patients.

The eligible charge for emergency services from nonparticipating providers is calculated in accord with federal law as described at 45 CFR § 147.138(b).

Participating providers agree to accept HMSA's payment plus your copayment as payment in full for covered services. Nonparticipating providers generally do not. If you get services from a nonparticipating provider, you are responsible for a copayment plus any difference between the actual charge and the eligible charge.

Please note: Eligible charge does not include excise or other tax. You are responsible for all taxes related to the medical care you receive. If your provider accepts monthly payments to manage your care, you may owe tax on your copayment.

Copayment

Definition

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

Please note: If you get services from a nonparticipating or noncontracting provider, you are responsible for the copayment ***plus*** any difference between *the actual charge and the eligible charge*.

Amount

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

Examples

Here are two examples of how the copayment works.

Let's say you have a sore throat and go to a participating physician to have it checked.

- The physician's bill or actual charge = $125.
- HMSA's eligible charge = $60.
- Your copayment = $14.

If you go to a nonparticipating physician, your out of pocket will be higher.

- The physician's bill or actual charge = $125.
- HMSA's eligible charge = $60.
- Your copayment = $14.
- The difference between the actual charge and the eligible charge = $65.
- You owe $79 (your copayment plus the difference between the actual charge and the eligible charge).

Annual Copayment Maximum

Definition

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

Amount

$2,500 per person

$7,500 (maximum) per family

When You Pay More

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

- Payments for services subject to a maximum once you reach the maximum. See *Benefit Maximum* later in this chapter.
- The difference between the actual charge and the eligible charge that you pay when you get services from a nonparticipating provider.
- Payments for noncovered services.
- Any amounts you owe in addition to your copayment for covered services.

Maximum Allowable Fee

Definition

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

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

- For most services, supplies, or procedures, we consider:
  - Increases in the cost of medical and non-medical services in Hawaii over the last year.
  - The relative difficulty of the service compared to other services.
  - Changes in technology.
  - Payment for the service under federal, state, and other private insurance programs.
- For *some facility-billed services*, we use a per case, per treatment, or per day fee (per diem) rather than an itemized amount (fee for service). This does not include practitioner-billed facility services. For nonparticipating 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 participating providers outside of Hawaii*, we use the lower of the provider's actual charge or the negotiated price passed on to us by the on-site Blue Cross and/or Blue Shield Plan. For more details on HMSA's payment practices under the BlueCard Program, see *Care While You are Away from Home* in *Chapter 1: Important Information*.

- For *drugs and supplies*, we use nationally recognized pricing sources and other relevant information. The allowable fee includes a dispensing fee. Any discounts or rebates that we get will not reduce the charges that your copayments are based on. We apply discounts and rebates to reduce drugs and supplies coverage rates.

Benefit Maximum

Definition

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

- *Service.* For example, In Vitro Fertilization is limited to a one-time only benefit while you are an HPH or HMSA member.
- *Calendar year.* For example, you are eligible to get benefits for up to 120 skilled nursing facility days each calendar year.

Where to Look for Limitations

See *Chapter 4: Description of Benefits.*

CHAPTER 3

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Benefit and Payment Chart

About this Chart

This benefit and payment chart:

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

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

*** =** An asterisk next to a service or supply means either:

- A service dollar maximum may apply.
- You may owe amounts in addition to your copayment.

Please read the benefit details on the page referenced.

∗ = see page 13	more info. on page:	Copayment Is (Percentage copayments are based on eligible charges)	
		Participating	**Nonparticipating**
Hospital and Facility Services			
Ambulatory Surgical Center (ASC)	24	20%	20%
Hospital Ancillary Services	24	20%	20%
∗ Hospital Room and Board	24	20%∗	20%∗
Intensive Care Unit/Coronary Care Unit	24	20%	20%
Intermediate Care Unit	24	20%	20%
Isolation Care Unit	25	20%	20%
Operating Room	25	20%	20%
Outpatient Facility	25	20%	20%
Skilled Nursing Facility	25	20%	20%
Emergency Services			
Emergency Room	25	20%	20%
All Other Services and Supplies	Varies	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.	Same as participating copayment for the service or supply plus the difference between the actual charge and HMSA's payment
Online Care			
Online Care	25	None	Not Covered
Telehealth			
Telehealth	26	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.	
Physician Services			
Anesthesia	26	20%	20%
Consultation Services	26	$20	$20
Physician Visits – Emergency Room	26	$20	$20
Physician Visits - Home, Office, and Skilled Nursing Facility	27	$14	$14
Physician Visits – Hospital	27	$20	$20

∗ = see page 13	more info. on page:	Copayment Is (Percentage copayments are based on eligible charges)	
		Participating	**Nonparticipating**
Surgical Services			
Assistant Surgeon Services	27	20%	20%
Bariatric Surgery	27	20%	20%
Cutting Surgery	27	20%	20%
Newborn Circumcision	28	10%	10%
Non-cutting Surgery	28	20%	20%
Oral Surgery	28	20%	20%
Reconstructive Surgery	28	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.	
Surgical Supplies	28	20%	20%
Testing, Laboratory and Radiology			
Allergy Testing	28	20%	20%
Allergy Treatment Materials	28	20%	20%
Diagnostic Testing – Inpatient	28	20%	20%
Diagnostic Testing – Outpatient	28	20%	20%
Genetic Testing, Screening, and Counseling	28	20%	20%
Laboratory and Pathology – Inpatient	28	20%	20%
Laboratory and Pathology – Outpatient	28	None	None
Radiology – Inpatient	28	20%	20%
Radiology – Outpatient	28	20%	20%
Chemotherapy and Radiation Therapy			
Chemotherapy – Infusion/Injections	29	20%	20%
Radiation Therapy – Inpatient	29	20%	20%
Radiation Therapy – Outpatient	29	20%	20%

∗ = see page 13	more info. on page:	Copayment Is (Percentage copayments are based on eligible charges)	
		Participating	**Nonparticipating**
Other Medical Services and Supplies			
Advance Care Planning	29	None	None
Ambulance (air)	29	20%	20%
Ambulance (ground)	29	20%	20%
Applied Behavior Analysis rendered by a Behavior Analyst Recognized by Us	29	$14	$14
Blood and Blood Products	30	20%	20%
Dialysis and Supplies	30	20%	20%
Durable Medical Equipment and Supplies	30	20%	20%
Evaluations for Hearing Aids	30	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.	
Gender Identity Services	30	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.	
Growth Hormone Therapy	31	20%	20%
Inhalation Therapy	31	20%	20%
Injections – Other than Self-Administered	31	20%	20%
Injections – Self-Administered	31	20%	20%
Medical Foods	31	20%	20%
Nutritional Counseling	31	$14	$14
∗ Orthodontic Services to treat Orofacial Anomalies	31	None∗	None∗
Orthotics and External Prosthetics	32	20%	20%
Outpatient IV Therapy	32	20%	20%
Private Duty Nursing	53	Not Covered	Not Covered
Vision and Hearing Appliances	32	20%	20%

* = see page 13	more info. on page:	Copayment Is (Percentage copayments are based on eligible charges)	
		Participating	**Nonparticipating**
Rehabilitation Therapy			
Dr. Ornish's Program for Reversing Heart Disease™	32	$20 when received from a provider that meets the requirements of the Dr. Ornish Program described in Chapter 4 under *Rehabilitation Therapy*.	
Physical and Occupational Therapy - Inpatient	33	20%	20%
Physical and Occupational Therapy - Outpatient	33	20%	20%
Pulmonary Rehabilitation - Outpatient	33	20%	20%
Speech Therapy Services - Inpatient	34	20%	20%
Speech Therapy Services - Outpatient	34	20%	20%
Special Benefits – Disease Management and Preventive Services			
Annual Preventive Health Evaluation (preventive visit)	34	None	None
Chlamydia (screening)	34	None	None
Colonoscopy (screening)	34	None	None
Diabetes Prevention Program	34	None when received from a provider that meets the requirements of the Diabetes Prevention Program as described in Chapter 4 under *Special Benefits – Disease Management and Preventive Service*	
Disease Management and Preventive Services Programs	34	None	Not Covered
Fecal Occult Blood Test (FOBT) (screening)	35	None	None
Gonorrhea (screening)	35	None	None
Immunizations	35	None	None
Mammography (screening)	35	None	None
Pap Smears (screening)	35	None	None
Prostate Specific Antigen (PSA) Test (screening)	35	None	None
Screening Services, Preventive Counseling, and Preventive Services	35	None	None
Sigmoidoscopy (screening)	36	None	None
Well-Being Services	36	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.	

* = see page 13	more info. on page:	Copayment Is (Percentage copayments are based on eligible charges)	
		Participating	**Nonparticipating**
Special Benefits – Disease Management and Preventive Services (continued)			
Well Child Care Immunizations	36	None	None
Well Child Care Laboratory Tests	36	None	None
Well Child Care Physician Office Visits	36	None	None
Well Woman Exam	36	None	None
Special Benefits for Men			
Erectile Dysfunction	36	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.	
Vasectomy	37	20%	20%
Special Benefits for Women			
Breast Pump	37	None	None
Contraceptive Implants	37	None	None
Contraceptive Injectables	37	None	None
Contraceptive IUD	37	None	None
In Vitro Fertilization	37	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.	
Maternity Care	37	10%	10%
Tubal Ligation	38	None	None
Special Benefits for Homebound, Terminal, or Long-Term Care			
Home Health Care	38	20%	20%
Hospice Services	38	None	None
Supportive Care	38	None	Not Covered

∗ = **see page 13**	more info. on page:	Copayment Is (Percentage copayments are based on eligible charges)	
		Participating	**Nonparticipating**
Behavioral Health – Mental Health and Substance Abuse			
∗ Hospital and Facility Services – Inpatient	39	20%∗	20%∗
Hospital and Facility Services – Outpatient	39	20%	20%
Physician Services – Inpatient	39	None	None
Physician Services – Outpatient	39	$14	$14
Psychological Testing – Inpatient	39	20%	20%
Psychological Testing – Outpatient	39	20%	20%
Organ and Tissue Transplants			
Corneal Transplant Surgery	40	20%	20%
Kidney Transplant Surgery	40	20%	20%
Organ Donor Services	40	20%	20%
Transplant Evaluation	40	None	None
Other Organ and Tissue Transplants			
Heart Transplants	40	None	None
Heart and Lung Transplants	40	None	None
Liver Transplants	40	None	None
Lung Transplants	40	None	None
Pancreas Transplants	40	None	None
Simultaneous Kidney/Pancreas Transplant	40	None	None
Small Bowel and Multivisceral Transplants	40	None	None
Stem-Cell Transplants (including Bone Marrow Transplants)	40	None	None

Drugs and Supplies

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

∗ = **see page 13**	more info. on page:	Copayment Is (Percentage copayments are based on eligible charges)	
		Participating	**Nonparticipating**
Autism Spectrum Disorders Drugs		***If you have an HMSA drug plan with benefits for drugs to treat autism spectrum disorders, the HMSA drug plan benefits will apply and not the benefits of this plan.***	
Generic Drugs	41	20%	20%
Preferred Formulary Drugs	41	20%	20%
Non-Preferred Formulary Drugs	41	30%	30%
Mail Order Generic Drugs	43	20%	Not Covered
Mail Order Preferred Formulary Drugs	43	20%	Not Covered
Mail Order Non-Preferred Formulary Drugs	43	30%	Not Covered
Chemotherapy – Oral Drugs		***If you have an HMSA drug plan with benefits for oral chemotherapy drugs, the HMSA drug plan benefits will apply and not the benefits of this plan.***	
Chemotherapy – Oral	41	None	None
Mail Order Chemotherapy – Oral	43	None	Not Covered
Contraceptives		***If you have an HMSA drug plan with benefits for contraceptives, the HMSA drug plan benefits will apply and not the benefits of this plan.***	
Contraceptive Diaphragms/Cervical Caps	41	None	None
Contraceptive Oral (Generic Drugs)	41	None	None
Contraceptive Oral (Preferred Formulary Drugs)	41	20%	20%
Contraceptive Oral (Non-Preferred Formulary Drugs)	41	30%	30%
Contraceptive – Other Methods (Generic Drugs)	41	None	None
Contraceptive – Other Methods (Preferred Formulary Drugs)	41	20%	20%
Contraceptive – Other Methods (Non-Preferred Formulary Drugs)	41	30%	30%
Contraceptive – Over-the-counter (OTC)	41	None	None

* = see page 13	more info.	Copayment Is (Percentage copayments are based on eligible charges)	
Contraceptives (continued)		***If you have an HMSA drug plan with benefits for contraceptives, the HMSA drug plan benefits will apply and not the benefits of this plan.***	
Mail Order Contraceptive Diaphragms/Cervical Caps	43	None	Not Covered
Mail Order Contraceptive Oral (Generic Drugs)	43	None	Not Covered
Mail Order Contraceptive Oral (Preferred Formulary Drugs)	43	20%	Not Covered
Mail Order Contraceptive Oral (Non-Preferred Formulary Drugs)	43	30%	Not Covered
Mail Order Contraceptive – Other Contraceptive Methods (Generic Drugs)	43	None	Not Covered
Mail Order Contraceptive – Other Contraceptive Methods (Preferred Formulary Drugs)	43	20%	Not Covered
Mail Order Contraceptive – Other Contraceptive Methods (Non-Preferred Formulary Drugs)	43	30%	Not Covered
Mail Order Contraceptive – Over-the-counter (OTC)	43	None	Not Covered
Diabetic Drugs, Supplies, and Insulin		***If you have an HMSA drug plan with benefits for diabetic drugs, supplies, and insulin, the HMSA drug plan benefits will apply and not the benefits of this plan.***	
Diabetic Supplies – Preferred Formulary	41	None	None
Diabetic Supplies – Non-Preferred Formulary	41	20%	20%
Diabetic Drugs – Generic Drugs	41	20%	20%
Diabetic Drugs – Preferred Formulary Drugs	41	20%	20%
Diabetic Drugs – Non-Preferred Formulary Drugs	41	30%	30%
Insulin – Generic Drugs	41	20%	20%
Insulin – Preferred Formulary Drugs	41	20%	20%
Insulin – Non-Preferred Formulary Drugs	41	30%	30%
Mail Order Diabetic Supplies – Preferred Formulary	43	None	Not Covered
Mail Order Diabetic Supplies – Non-Preferred Formulary	43	20%	Not Covered
Mail Order Diabetic Drugs – Generic Drugs	43	20%	Not Covered
Mail Order Diabetic Drugs – Preferred Formulary Drugs	43	20%	Not Covered
Mail Order Diabetic Drugs – Non-Preferred Formulary Drugs	43	30%	Not Covered

* = see page 13	more info.	Copayment Is (Percentage copayments are based on eligible charges)	
Diabetic Drugs, Supplies, and Insulin (continued)		***If you have an HMSA drug plan with benefits for diabetic drugs, supplies, and insulin, the HMSA drug plan benefits will apply and not the benefits of this plan.***	
Mail Order Insulin – Generic Drugs	43	20%	Not Covered
Mail Order Insulin – Preferred Formulary Drugs	43	20%	Not Covered
Mail Order Insulin – Non-Preferred Formulary Drugs	43	30%	Not Covered
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs		***If you have an HMSA drug plan with benefits for U.S. Preventive Services Task Force recommended drugs, the HMSA drug plan benefits will apply and not the benefits of this plan.***	
USPSTF recommended drugs	41	None	None
Mail Order – USPSTF recommended drugs	43	None	Not Covered

CHAPTER 4

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About this Chapter

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

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.

Hospital and Facility Services

Review of Inpatient Hospital Care

When your condition requires you to be an inpatient, we may work with your provider to review your medical records to determine if payment determination criteria are met. Inpatient reviews take place after admission and at set intervals thereafter, until you are discharged from the facility. We also review discharge plans for after-hospital care.

If payment determination criteria are not met, our nurse reviewer will discuss your case with a physician consultant. If more details are needed, our nurse or physician consultant may contact your attending physician.

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

Ambulatory Surgical Center (ASC)

Covered, including operating rooms, surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics, blood transfusion services, routine lab and x-ray related to surgery. ***Ambulatory Surgical Center*** is an outpatient facility that provides surgical services without an overnight stay. This facility may be in a hospital or it may be a separate independent facility.

Hospital Ancillary Services

Covered, including:
- surgical supplies,
- hospital anesthesia services and supplies,
- diagnostic and therapy services,
- drugs,
- dressings,
- oxygen,
- antibiotics, and
- hospital blood transfusion services.

For hospital ancillary services associated with maternity-related services, see *Special Benefits for Women* in the section *Maternity Care*.

Hospital Room and Board

Covered, including:
- Semi-Private Rooms. If you are hospitalized at a participating facility, your copayment is based on the facility's medical/surgical semi-private room rate. If you are hospitalized at a nonparticipating facility, your copayment is based on HMSA's maximum allowable fee for semi-private rooms. Also, you owe the difference between the nonparticipating hospital's room charge and HMSA's maximum allowable fee for semi-private rooms.
- Private Rooms.
  At Participating Hospitals:
  - If you are hospitalized in a participating facility with private rooms only, your copayment is based on HMSA's maximum allowable fee for semi-private rooms.
  - If you are hospitalized in a participating facility with semi-private and private rooms or a BlueCard facility, your copayment is based on the facility's medical/surgical semi-private room rate. Also, you owe the difference between the facility's charges for private and semi-private rooms. ***Exception:*** If you are hospitalized for conditions identified by HMSA as conditions that require a private room, your copayment is based on the facility's medical/surgical private room rate. You may call HMSA for a list of these conditions.

  At Nonparticipating Hospitals:
  - If you are hospitalized in a nonparticipating facility, your copayment is based on HMSA's maximum allowable fee for semi-private rooms. Also, you owe the difference between the facility's private room charge and HMSA's maximum allowable fee for semi-private rooms.
    Exception: If you are hospitalized for conditions identified by HMSA as conditions that require a private room, your copayment is based on HMSA's maximum allowable fee for private rooms. Also, you owe the difference between the facility's private room charge and HMSA's maximum allowable fee for private rooms. You may call HMSA for a list of these conditions.

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

For hospital room and board services associated with maternity-related services, see *Special Benefits for Women* in the section *Maternity Care*.

Intensive Care Unit/Coronary Care Unit

Covered.

Intermediate Care Unit

Covered.

Isolation Care Unit

Covered.

Operating Room

Covered.

Outpatient Facility

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

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

Skilled Nursing Facility

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

Room and board is covered, but only for semi-private rooms when all of the following are true:

- You are admitted by your physician.
- Care is ordered and certified by your physician.
- Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care.
- The confinement is not longer than 120 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 services.

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

Emergency Services

Emergency Services

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

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

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

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

Please note: If you are admitted as an inpatient after a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits.

Online Care

Online Care

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

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

Telehealth

Telehealth

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

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

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

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

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

Physician Services

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.

Consultation Services

Covered, as needed for surgical, obstetrical, pathological, radiological, or other medical conditions when all of these statements are true:

- The attending physician must require the consultation.
- If the consultation is for inpatient services, you must be confined as a registered bed patient.
- If the consultation is for inpatient services, the consultant's report must be acceptable to us. It must also be included as a part of the record kept by the hospital or skilled nursing facility.
- The consultation must be for reasons other than to comply with requirements by the hospital or skilled nursing facility.

Physician Visits - Emergency Room

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

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

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

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

Please note: If you are admitted to the hospital as an inpatient after a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits.

Physician Visits – Home, Office, and Skilled Nursing Facility

Covered, when you are an inpatient in a skilled nursing facility or outpatient. A physician visit may be received in the physician's office, your home, a skilled nursing facility or outpatient hospital setting. You are also covered for family planning counseling.

Please note: Routine preventive care is described under *Special Benefits – Disease Management and Preventive Services*.

Physician Visits – Hospital

Covered, when you are an inpatient in a hospital. Newborn care is covered in accord with the time periods specified later in this chapter under *Maternity and Newborn Length of Stay*.

Surgical Services

Participating Providers have agreed to comply with HMSA's payment policies and so will not bill you for services or added charges that HMSA does not cover. When you see a nonparticipating provider you will owe any copayment that applies to the service plus the difference between HMSA's eligible charge and the provider's actual charge. This may include services or added charges not covered by HMSA.

Approval for Certain Surgical Procedures

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

Please note: This list of procedures changes periodically. To ensure your surgical procedure is covered, call us and we will check if it requires approval before you get the surgery.

If you are under the care of a:
- *Participating* physician, the physician will get approval for you.
- *Nonparticipating* physician, the physician may not get approval for you. Getting approval is your responsibility. See *Chapter 5: Precertification.*

Assistant Surgeon Services

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

Bariatric Surgery

Covered, but only if you meet HMSA's criteria.

***Please note*:** This service must have precertification. See *Chapter 5: Precertification.*

Cutting Surgery

Covered, including preoperative and postoperative care.

Please note: Nonparticipating providers may bill separately for preoperative care, the surgical procedure and postoperative care. In such cases, the total charge is often more than the eligible charge. You are responsible for any amount that exceeds the eligible charge.

Newborn Circumcision	Covered.
Non-Cutting Surgery	Covered. Examples of non-cutting surgical procedures include: ▪ diagnostic endoscopic procedures; ▪ diagnostic and therapeutic injections including catheters injections into joints, muscles, and tendons. ▪ orthopedic castings; ▪ destruction of localized lesions by chemotherapy (excluding silver nitrate), cryotherapy or electrosurgery, and ▪ acne treatment.
Oral Surgery	Covered, but only when the dentist performs surgery that could be performed by a physician or a dentist. Coverage is limited to: the removal of tumors and cysts; surgery to correct injuries; cutting and draining of cellulitis; cutting of sinuses, salivary glands, or ducts; reduction of dislocations and removal of jawbone joint; and major oral surgery for augmentation (building up) of the gum ridge.
Reconstructive Surgery	Covered, but only for corrective surgery required to restore, reconstruct or correct: ▪ Any bodily function that was lost, impaired, or damaged as a result of an illness or injury. ▪ Developmental abnormalities when present from birth and that severely impair or impede normal, essential bodily functions. ▪ The breast on which a mastectomy was performed, and surgery for the reconstruction of the other breast to produce a symmetrical appearance (including prostheses). Treatment for complications of mastectomy and reconstruction, including lymphedema, is also covered. Complications of a non-covered cosmetic reconstructive surgery are not covered.
Surgical Supplies	Covered.

Testing, Laboratory, and Radiology

Allergy Testing	Covered.
Allergy Treatment Materials	Covered.
Diagnostic Testing	Covered when related to an injury or illness. Examples of diagnostic tests include: ▪ Electroencephalograms (EEG). ▪ Electrocardiograms (EKG or ECG). ▪ Holter Monitoring. ▪ Stress Tests.
Genetic Testing, Screening, and Counseling	Covered, but only if you meet HMSA's criteria. Call us for more details. Our phone number is listed on the back cover of this Guide. ***Please note*:** Certain services must have precertification. See *Chapter 5: Precertification.* Other services identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations are described under *Special Benefits – Disease Management, Screening Services, Preventive Counseling, and Preventive Services.*
Laboratory and Pathology	Covered, when related to an illness or injury. For other routine and preventive lab services, see later in this chapter in the *Special Benefits – Disease Management and Preventive Services* section.
Radiology	Covered. Examples of radiology include: ▪ Computerized Tomography Scan (CT Scan). ▪ Diagnostic mammography. ▪ Nuclear Medicine. ▪ Ultrasound. ▪ X-rays.

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

Chemotherapy and Radiation Therapy

High-Dose Limitation

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

Chemotherapy - Infusion/Injections

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

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

Please note: For high-dose chemotherapy, see limitation above.

Radiation Therapy

Covered.

Please note: For high-dose radiation therapy, see limitation above.

Other Medical Services and Supplies

Advance Care Planning

Covered.

Ambulance

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

We will cover your ambulance transportation if the following apply:

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

Please note: Air ambulance is limited to intra-island or inter-island transportation within the state of Hawaii.

Autism Spectrum Disorders – Diagnosis and Treatment

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

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

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

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

Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us

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

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

Blood and Blood Products

Covered, including blood costs, blood bank services, blood processing.

You are not covered for peripheral stem-cell transplants except as described in this chapter under Stem-Cell Transplants (including Bone Marrow Transplants).

Dialysis and Supplies

Covered.

Durable Medical Equipment and Supplies

Covered, but only when prescribed by your treating provider.

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

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

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

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

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

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

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

Evaluations for Hearing Aids

Covered, but only when you get the evaluation for the use of a hearing aid in the office of a physician or audiologist.

Gender Identity Services

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

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

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

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

Growth Hormone Therapy

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

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

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

Inhalation Therapy

Covered.

Injections – Other than Self-Administered

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

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

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

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

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

Injections – Self-Administered

Covered, for FDA approved injectable drugs.

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

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

Medical Foods

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

Nutritional Counseling

Covered to treat eating disorders in accord with Hawaii law and HMSA's medical policy and only if:

- You are diagnosed with an eating disorder by a qualified provider; and
- Counseling is rendered by a recognized licensed dietitian.

Other counseling services identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations are described in other sections of this chapter. See *Special Benefits – Disease Management and Preventive Services, Screening Services, Preventive Counseling, and Preventive Services.*

Orthodontic Services to treat Orofacial Anomalies

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

Benefit Limitation: Benefits are limited to a maximum of $5,500 per treatment phase.

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

Orthotics and External Prosthetics

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

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

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

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

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

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

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

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

Please note: Certain prosthetics and orthotics must have precertification. See *Chapter 5: Precertification*.

Outpatient IV Therapy

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

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

Routine Care Associated With Clinical Trials

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

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

Vision and Hearing Appliances

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

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

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

Rehabilitation Therapy

Dr. Ornish's Program for Reversing Heart Disease™

Covered in accord with HMSA's then current policy available at www.hmsa.com and when all of the following are true:
- Program services are provided by practitioners who contract with HMSA to provide program services, and

- Services are received in the State of Hawaii at an accredited Ornish Reversal Program.

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

- Supervised exercise
- Yoga and meditation
- Support group
- Experiential education session with group meal.

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

Physical and Occupational Therapy

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

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

Please note: Precertification is required after the first visit for outpatient services. See *Chapter 5: Precertification*.

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

Pulmonary Rehabilitation

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

Benefits are not provided for maintenance programs.

Participants must meet HMSA's eligibility criteria and guidelines.

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

Speech Therapy Services

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

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

Speech therapy services include speech/language therapy, swallow/feeding therapy, aural rehabilitation therapy and augmentative/alternative communication therapy.

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

Special Benefits – Disease Management and Preventive Services

Annual Preventive Health Evaluation (preventive visit)

Covered, for one annual preventive health evaluation for members who are 22 and older when received from their primary care provider, including an assessment of any other preventive screenings you might need. See *Preventive Services Programs, Immunizations and Screening Services* for other screenings covered by this plan. ***Please note:*** Similar services for members under age 22 are covered as set forth in *Well-Child Care.*

Chlamydia (screening)

Covered.

Colonoscopy (screening)

Covered in accord with HMSA's medical policies.

Diabetes Prevention Program

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

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

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

Disease Management Programs

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

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

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

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

Preventive Services Programs

Covered, for programs available through HMSA's Health and Well-Being services such as the prenatal care program that helps expectant couples through normal and at-risk pregnancies with information and support services.

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

Fecal Occult Blood Test (FOBT) (screening)

Covered in accord with HMSA's medical policies.

Gonorrhea (screening)

Covered.

Immunizations

Covered, but only vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).

Please note: The list of ACIP recommended immunizations may change. If you would like information about the ACIP recommended immunizations, please visit our website at www.hmsa.com or call us at one of the phone numbers listed on the back cover of this Guide.

Mammography (screening)

Covered, but only one screening mammography per calendar year for women ages 40 and older.

Please note: A woman of any age may receive the screening more often if she has a history of breast cancer or if her mother or sister has a history of breast cancer. For diagnostic mammography benefits, see earlier in this chapter under *Testing, Laboratory, and Radiology.*

Pap Smears (screening)

Covered, but only one screening Pap smear every three years for women ages 21 to 65.

Prostate Specific Antigen (PSA) Screening Test

Covered, for men age 50 or older. Benefits are limited to one prostate specific antigen screening test per calendar year. For diagnostic PSA tests, see earlier in this chapter under *Testing, Laboratory, and Radiology.*

Screening Services, Preventive Counseling, and Preventive Services

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

- Preventive Counseling
- Preventive Services
- Screening Laboratory Services:
  - Screening for Lipid Disorders in Adults
  - Screening for Asymptomatic Bacteriuria in Adults
  - Screening for Hepatitis B Virus Infection
  - Screening for HIV
  - Screening for Syphilis Infection
  - Screening for Type 2 Diabetes Mellitus in Adults
  - Screening for Iron Deficiency Anemia
  - Screening for Rh (D) Incompatibility
  - Screening for Congenital Hypothyroidism
  - Screening for Phenylketonuria (PKU)
  - Screening for Sickle Cell Disease in Newborns
  - Screening for Tuberculosis
- Screening Radiology Services:
  - Screening for Abdominal Aortic Aneurysm
  - Screening for Osteoporosis in Postmenopausal Women

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

Please note: The list of U.S. Preventive Services Task Force (USPSTF) recommended screenings may change. If you need more details about the USPSTF recommended screenings, including a current list of recommendations, please visit our website at www.hmsa.com or call us at one of the phone numbers listed on the back of this Guide.

Please Note: Benefits for other U.S. Preventive Services Task Force (USPSTF) Grade A and B recommended screenings may be found in other sections of this chapter under *Surgical Services* and *Testing, Laboratory, and Radiology*.

Covered for recommended preventive services for women developed by the Institute of Medicine (IOM) and supported by the Health Resources and Services Administration (HRSA), such as the following:

- Breastfeeding Support and Counseling – but only from a trained physician or midwife during pregnancy and/or in the postpartum period.
- Contraceptive Counseling.
- Gestational Diabetes Screening.
- Human Papillomavirus (HPV) DNA Testing.
- Interpersonal and Domestic Violence Screening and Counseling.

Please Note: Benefits for other IOM recommended preventive services for women may be found in this section and under other sections of this chapter under *Special Benefits for Women* and *Drugs and Supplies.*

Sigmoidoscopy (screening)

Covered in accord with HMSA's medical policies.

Well-Being Services

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

Well-Child Care

Covered, from birth through age twenty-one including office visits for history, physical exams, sensory screenings, developmental/behavioral assessments, anticipatory guidance, lab tests, and immunizations. ***Well Child Care*** means routine and preventive care for children through age twenty-one. If your child needs medical care as the result of an illness or injury, physician visit benefits apply (and not well-child care benefits). See Physician Services earlier in this chapter.

Well Child Care Immunizations

Covered, in accord with Hawaii law and the guidelines set by the Advisory Committee on Immunization Practices (ACIP).

Well Child Care Laboratory Tests

Covered, in conjunction with office visits, from birth through age twenty-one. Laboratory tests are covered during the well-child care period as identified on the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care, in addition to one urinalysis through age five.

Well Child Care Physician Office Visits

Covered, including routine sensory screening, and developmental/behavioral assessments according to the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care:

- Birth to one year: seven visits
- Age one year: three visits
- Age two years: two visits
- Age three years through twenty-one years: one visit per year

Well Woman Exam

Covered, for one gynecological exam per calendar year. The well woman exam includes a pelvic exam, the collection of a specimen for Pap smear screening and a clinical breast exam.

Special Benefits for Men

Erectile Dysfunction

Services, supplies, prosthetic devices, and injectables approved by us are covered to treat erectile dysfunction due to organic cause as defined by HMSA or as described in this chapter under *Other Medical Services and Supplies, Gender Identity Services*.

Vasectomy

Covered, but only the initial surgery for a vasectomy. Benefits do not include the reversal of a vasectomy.

Special Benefits for Women

Breast Pump

Covered, for purchase of one device including attachments per pregnancy.

Covered, for the rental of a hospital-grade breast pump if the infant is unable to nurse directly on the breast due to a medical condition, such as prematurity, congenital anomaly and/or an infant is hospitalized.

Contraceptive Implants

Covered.

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

Contraceptive Injectables

Covered.

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

Contraceptive IUD

Covered.

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

In Vitro Fertilization

Covered. Coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are an HMSA member. If you get benefits for in vitro fertilization services under an HMSA plan, you will not be eligible for in vitro fertilization benefits under any other HMSA plan. In vitro fertilization services are not covered when a surrogate is used. The in vitro procedures must be performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine's minimal standards for programs of in vitro fertilization.

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

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

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

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

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

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

Maternity Care

Covered, for:

- ***Maternity Care.*** Covered, including prenatal, false labor, delivery, and postnatal services. HMSA pays physicians a global fee related to a bundle of maternity care. If benefit payments are made separately before delivery, payments will be considered an advance and we will deduct the amount from the global benefit payment for maternity care.
- Nursery care following birth.
- Pregnancy Termination.
- Complications of pregnancy, except physician visits.
- Hospital room and care and ancillary services associated with maternity-related services.

Please note: All plan limitations apply to services associated with maternity care. See *Chapter 4: Description of Benefits* for limitations on a specific service.

Physician visits for complications of pregnancy, newborn physician visits, emergency room, emergency room visits, outpatient radiology, and outpatient laboratory and pathology are not included in this Maternity Care benefit. See *Physician Visits - Hospital, Emergency Services, Radiology – Outpatient, and Laboratory and Pathology – Outpatient* for benefits.

Newborn care is covered for the baby's non-surgical physician services and nursery care following birth in accord with the time periods specified under *Maternity and Newborn Length of Stay.*

Maternity and Newborn Length of Stay

Covered, for up to:
- 48 hours from time of delivery for normal labor and delivery; or
- 96 hours from time of delivery for a cesarean birth.

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

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

Tubal Ligation

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

Special Benefits for Homebound, Terminal, or Long-Term Care

Home Health Care

Covered, but only when all of these statements are true:
- Services are prescribed in writing by a physician to treat an illness or injury when you are homebound. ***Homebound*** means that due to an illness or injury, you are unable to leave home, or if you do leave home, doing so requires a considerable and taxing effort.
- Part-time skilled health services are needed.
- Services are not more costly than alternate services that would be effective to diagnose and treat your condition.
- Without home health care, you would need inpatient hospital or skilled nursing facility care.
- If you need home health care services for more than 30 days, a physician must certify that there is further need for the services and provide an ongoing plan of treatment at the end of each 30-day period of care.
- Services do not exceed 150 visits per calendar year.

Hospice Services

Covered. A ***Hospice Program*** provides care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. We follow Medicare guidelines to determine benefits, level of care and eligibility for hospice services. Also, we cover:
- Residential hospice room and board expenses directly related to the hospice care being provided, and
- Hospice referral visits during which a patient is advised of hospice care options, regardless of whether the referred patient is later admitted to hospice care.

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

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

Supportive Care Services

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

Supportive Care is a comprehensive approach to care for members with a serious or advanced illness including Stage 3 or 4 cancer, advanced Congestive Heart Failure (CHF), advanced Chronic Obstructive Pulmonary Disease (COPD), or any advanced illness that meets the requirements of the Supportive Care policy. Members receive comfort-directed care, along with curative treatment from an interdisciplinary team of practitioners. Supportive Care is only available in Hawaii and when a member is referred by his or her physician.

Please note:

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

Case Management Services

Covered, for a chronic condition, a serious illness or complex health care needs which may include the following:

(1) Assessment of individual/family needs related to the understanding of health status and physician treatment plans, self-care and compliance capability and continuum of care.
(2) Education of individual/family on disease, treatment compliance and self-care techniques.
(3) Help with organization of care, including arranging for needed services and supplies.
(4) Assistance in arranging for a primary care provider to deliver and coordinate the care and/or consultation with physician specialists; and
(5) Referrals to community resources.

Behavioral Health – Mental Health and Substance Abuse

Covered, if:

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

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

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

Please note: Nonparticipating and out-of-state post-acute and residential treatment facilities must have precertification. See *Chapter 5: Precertification*.

Alcohol or Drug Dependence Treatment

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

Organ and Tissue Transplants

Organ and Tissue Transplants

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

Also, all transplants (with the exception of corneal and kidney transplant surgeries) must receive our approval. Without approval for the specified transplants, benefits are not available. See *Chapter 5: Precertification*.

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

Transplant Evaluations

Covered, if we approve, for heart, heart-lung, liver, lung, pancreas, simultaneous kidney/pancreas, small bowel and multivisceral, or stem-cell transplants. See *Chapter 5: Precertification*. ***Transplant Evaluation*** means those procedures, including lab and diagnostic tests, consultations, and psychological evaluations that a facility uses in evaluating a potential transplant candidate. This coverage is limited to one evaluation per transplant request. For details about donor screening benefits, see in this chapter under *Organ Donor Services*.

Organ Donor Services

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

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

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

Corneal Transplant Surgery

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

Heart Transplants

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

Heart and Lung Transplants

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

Kidney Transplant Surgery

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

Liver Transplants

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

Lung Transplants

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

Pancreas Transplants

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

Simultaneous Kidney/Pancreas Transplants

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

Small Bowel and Multivisceral Transplants

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

Stem-Cell Transplants (including Bone Marrow Transplants)

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

Drugs and Supplies

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

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

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

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

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

Definitions

Biological products

- Biological products, or biologics, are medical products. Many products are made from a variety of natural sources (i.e., human, animal, or microorganism). It may be produced by biotechnology methods and other cutting-edge technologies. Like drugs, some biologics are intended to treat diseases and medical conditions. Other products are used to prevent or diagnose diseases. Examples may include:
  - Vaccines.
  - Blood and blood products for transfusion and /or manufacturing into other products.
  - Allergenic extracts, that are used for both diagnosis and treatment, i.e., allergy shots.
  - Human cells and tissues used for transplantation (e.g., tendons, ligaments and bones).
  - Gene therapies.
  - Cellular therapies.
  - Tests to screen potential blood donors for infectious agents such as HIV.
- ***Reference product*** refers to the original FDA-approved biologic product that a biosimilar is based.
- ***Biosimilar product*** – A biological product that is FDA-approved based on a showing that it is highly similar to an already FDA-approved reference product. It has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Only minor differences in clinically inactive components are allowable in biosimilar products.
- ***Interchangeable biologic product*** – An FDA-approved biologic product that meets the additional standards for interchangeability to an FDA-approved reference product included in:
  - The Hawaii list of equivalent generic drugs and biological products.
  - The Orange Book.
  - The Purple Book.
  - Other published findings and approvals of the United States Food and Drug Administration.

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

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

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

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

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

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

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

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

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

Benefit Limitations

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

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

Diabetic supplies are limited to coverage for:

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

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

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

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

Drug Benefit Management

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

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

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

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

Additional Amounts You May Owe When There is a Generic Equivalent

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

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

Refills

Except for certain drugs managed under Drug Benefit Management, refills will be paid if indicated on your original prescription and only after two-thirds of your prescription has already been used.

Mail Order Providers

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

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

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

- You are prescribed a 30-day supply of a drug that is packaged in less than 30-day quantity, for example, a 28-day supply. The pharmacy will fill the prescription by providing you a 28-day supply. You owe the 90-day copayment. If you are prescribed a 90-day supply, the pharmacy would fill the prescription by giving you three packages each containing a 28-day supply of the drug. Again, you would owe a 90-day copayment for the 84-day supply.

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

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

CHAPTER 5

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Definition

Precertification is a special approval process to make sure that certain medical treatments, procedures, or devices meet payment determination criteria before the service is rendered.

Services and Supplies Which Require Precertification

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

Lab, X-ray and Other Diagnostic Tests such as genetic testing, polysomnography and sleep studies, computed tomography (CT), and functional MRI.

Surgeries such as organ and tissue transplants, bariatric surgery, and varicose veins treatment.

Treatment Therapies such as applied behavior analysis, physical, occupational and speech therapies, chiropractic services, in vitro fertilization, growth hormone therapy, home IV therapy, drugs such as oral chemotherapy agents, infusibles and injectables, new drug to market (specialty medical drugs), and off-label drug use.

Durable Medical Equipment and Orthotics and Prosthetic Devices such as wheelchairs, positive airway pressure and oral devices to treat obstructive sleep apnea.

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

When to Request Precertification

If you are under the care of:

- An HMSA participating physician or contracting physician, he or she will:
  - Get approval for you; and
  - Accept any penalties for failure to get approval.
- A BlueCard participating or nonparticipating provider you are responsible for getting the approval. If you do not get approval and get any of the services described in this chapter, benefits may be denied.

How to Request Precertification

Ask for precertification by writing or faxing us at:

HMSA
P.O. Box 2001
Honolulu, HI 96805-2001
(808) 944-5611

If you would like to check on the status of the precertification, call your nearest HMSA office listed on the back cover of this Guide.

Our Response to Your Non-Urgent Precertification Request

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

Our Response to Your Urgent Precertification Request

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

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

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

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

Appeal of Our Precertification Decision

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

CHAPTER 6

This Chapter Covers

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About this Chapter

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

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

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

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

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

Counseling Services

Bereavement Counseling

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

Genetic Counseling

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

Marriage or Family Counseling

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

Nutritional Counseling

You are not covered for nutritional counseling, except as described in *Chapter 4: Description of Benefits*. See *Other Medical Services and Supplies, Nutritional Counseling* or *Special Benefits – Disease Management and Preventive Services, Screening Services, Preventive Counseling, and Preventive Services*.

Sexual Orientation Counseling

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

Coverage Under Other Programs or Laws

Payment Responsibility

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

Military

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

Third Party Reimbursement

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

Dental, Drug, and Vision

Dental Care

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

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

Drugs

You are not covered for:

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

Eyeglasses and Contacts

You are not covered for:

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

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

Vision Services

You are not covered for:
- Refractive eye surgery to correct visual acuity problems.
- Replacement of lost, stolen or broken lenses, contact lenses or frames.
- Vision training.
- Aniseikonic studies and prescriptions.
- Reading problem studies or other procedures determined to be special or unusual.

Fertility and Infertility

Contraceptives

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

Infertility Diagnosis

You are not covered for services or supplies related to the diagnosis of infertility.

Infertility Treatment

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

Sterilization Reversal

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

Preventive and Routine

Health Appraisal

You are not covered for Health Appraisal services except as stated in *Chapter 4: Description of Benefits.*

Immunizations

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

Physical Exams (routine annual check-up)

Physical exams and any associated screening procedures in connection with third party requests or requirements, such as those for: employment, participation in employee programs, sports, camp, insurance, disability licensing, or on court order or for parole or probation are not covered. This limitation is not intended to affect coverage of physical exams or associated screening procedures that would otherwise have been covered, and that have separately and incidentally been requested or required by a third party.

Routine Circumcision

You are not covered for routine circumcision except as stated in *Chapter 4: Description of Benefits* under the *Surgical Services* section.

Routine Foot Care

You are not covered for services or supplies related to routine foot care.

Provider Type

Provider Nondiscrimination

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

Complementary and Alternative Medicine Provider

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

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

Dietitian

You are not covered for nutritional counseling services, except as described in *Chapter 4: Description of Benefits*. See *Other Medical Services and Supplies, Nutritional Counseling* or *Special Benefits – Disease Management and Preventive Services, Screening Services, Preventive Counseling, and Preventive Services*.

Provider is an Immediate Family Member

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

Social Worker

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

Please note: Social workers are not Participating Providers under this plan except as noted above. You will be responsible for your copayment, if any, plus the difference between HMSA's eligible charge and the social worker's billed charge.

Transplants

Living Donor Transport

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

Living Organ Donor Services

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

Mechanical or Non-Human Organs

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

Organ Purchase

You are not covered for the purchase of any organ.

Transplant Services or Supplies

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

Transportation Related to Organ and Tissue Transplants	You are not covered for transportation for organ or tissue transplant services or transportation of organs or tissues.

Miscellaneous Exclusions

Act of War	To the extent allowed by law, you are not covered for services needed to treat an injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists.
Acupuncture	You are not covered for services or supplies related to acupuncture.
Airline Oxygen	You are not covered for airline oxygen.
Biofeedback	You are not covered for biofeedback and any related tests.
Blood	You are not covered for blood except as described in *Chapter 4: Description of Benefits.*
Carcinoembryonic Antigen (CEA)	You are not covered for carcinoembryonic antigen when used as a screening test.
Cardiac Rehabilitation	You are not covered for cardiac rehabilitation services except as described in *Chapter 4: Description of Benefits* under *Dr. Ornish's Program for Reversing Heart Disease™*.
Chemotherapy (High-Dose)	You are not covered for high-dose chemotherapy except when provided in conjunction with stem-cell transplants described in *Chapter 4: Description of Benefits* under *Stem-Cell Transplants (including Bone Marrow Transplants).*
Complementary and Alternative Medicine Services	You are not covered for complementary and alternative medicine services or supplies including, but not limited to: ▪ botanical medicine, ▪ aromatherapy, ▪ herbal/nutritional supplements, ▪ medication techniques, ▪ relaxation techniques, ▪ movement therapies, ▪ energy therapies, and ▪ massage therapy when not part of rehabilitative therapy.
Complications of a Non-Covered Procedure	You are not covered for complications of a non-covered procedure, including complications of recent or past cosmetic surgeries, services or supplies.
Convenience Treatments, Services or Supplies	You are not covered for treatments, services or supplies that are prescribed, ordered or recommended primarily for your comfort or convenience, or the comfort or convenience of your provider or caregiver. Such items may include ramps, home remodeling, hot tubs, swimming pools, deluxe/upgraded items, or personal supplies such as surgical stockings and disposable underpads.
Cosmetic Services, Surgery or Supplies	You are not covered for cosmetic services or supplies that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function. You are not covered for complications of recent or past cosmetic surgeries, services or supplies.
Custodial Care	You are not covered for custodial care, sanatorium care, or rest cures. ***Custodial Care*** consists of training in personal hygiene, routine nursing services, and other forms of personal care, such as help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Also excluded are supervising services by a physician or nurse for a person who is not under specific medical, surgical, or psychiatric care to improve that person's condition and to enable that person to live outside a facility providing this care.
Developmental Delay	You are not covered for treatment of developmental delay or services related to developmental delay that are available through government programs or agencies.

Ductal Lavage

You are not covered for ductal lavage.

Duplicate Item

You are not covered for duplicate items that are intended to be used as a back-up device, for multiple residences or for traveling including:

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

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

Effective Date

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

Electron Beam Computed Tomography (EBCT or Ultrafast CT)

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

Enzyme-potentiated Desensitization

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

Erectile Dysfunction

You are not covered for services and supplies (including prosthetic devices) related to erectile dysfunction except if due to an organic cause or to treat gender dysphoria as described in *Chapter 4: Description of Benefits* under *Other Medical Services and Supplies, Gender Identity Services*. This includes, but is not limited to, penile implants. You are not covered for drug therapies related to erectile dysfunction except certain injectables approved by us to treat erectile dysfunction due to an organic cause or to treat gender dysphoria as described in *Chapter 4: Description of Benefits* under *Other Medical Services and Supplies, Gender Identity Services*.

Extracorporeal Shock Wave Therapy

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

False Statements

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

Foot Orthotics

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

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

Genetic Testing and Screening

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

Growth Hormone Therapy

You are not covered for growth hormone therapy except as stated in *Chapter 4: Description of Benefits* under *Other Medical Services and Supplies*.

Hair Loss

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

Hypnotherapy

You are not covered for hypnotherapy.

Intradiscal Electro Thermal Therapy (IDET)

You are not covered for intradiscal electro thermal therapy.

Massage Therapy

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

Microprocessor (Upper/Lower Prostheses)

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

Motor Vehicles

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

Non-Medical Items

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

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

Non-Related Items Exclusion

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

Private Duty Nursing

You are not covered for private duty nursing.

Radiation (High-dose)

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

Radiation (Nonionizing)

You are not covered for treatment with nonionizing radiation.

Repair/Replacement

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

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

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

Reversal of Gender Reassignment Surgery

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

Self-Help or Self-Cure

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

Services Related to Employment

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

Stand-by Time

You are not covered for a provider's waiting or stand-by time.

Supplies

You are not covered for take home supplies or supplies billed separately by your provider when the supplies are integral to services being performed by your provider.

Thoracic Electric Bioimpedance (Outpatient/Office)

You are not covered for outpatient thoracic electric bioimpedance in an outpatient setting which includes a physician’s office.

Topical Hyperbaric Oxygen Therapy

You are not covered for topical hyperbaric oxygen therapy.

Travel or Lodging Cost

You are not covered for the cost of travel or lodging.

Vertebral Axial Decompression (VAX-D)

You are not covered for vertebral axial decompression.

Vitamins, Minerals, Medical Foods and Food Supplements

You are not covered for vitamins, minerals, medical foods, or food supplements except as described in *Chapter 4: Description of Benefits* under *Other Medical Services and Supplies* and *Drugs and Supplies.*

Weight Reduction Programs

You are not covered for weight reduction programs and supplies, whether or not weight reduction is medically appropriate. This includes:

- dietary supplements,
- food,
- equipment,
- lab tests,
- exams, and
- drugs and supplies.

Wigs

You are not covered for wigs and artificial hairpieces.

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When to File Claims

When to File Claims

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

How to File Claims

One Claim Per Person and Per Provider

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

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

What Information You Must File

Subscriber Number

The subscriber number that appears on your member card.

Provider Statement

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

The provider statement must include:

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

Phone Number

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

Signature

Make sure you sign the claim.

Other Claim Filing Information

Where to Send Claim

Send your claim to the address listed on the back cover of this Guide.

Keep a Copy

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

Information given to us will not be returned to you.

Report to Member

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

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

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

Cash or Deposit any Benefit Payment in a Timely Manner

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

CHAPTER 8

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Your Request for an Appeal

Writing Us to Request an Appeal

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

Send written requests to:

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

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

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

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

Appeal of Our Precertification Decision

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

Appeal of Any Other Decision or Action

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

Expedited Appeal

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

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

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

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

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

Who Can Request an Appeal

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

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

What Your Request Must Include

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

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

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

Information Available From Us

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

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

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

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

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

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

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

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

Your request must be in writing and include:

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

You must send the request to the Insurance Commissioner at:

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

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

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

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

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

Expedited IRO Review

You may request expedited IRO review if:

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

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

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

External Review of Decisions Regarding Experimental or Investigational Services

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

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

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

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

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

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

Request Arbitration

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

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

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

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

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

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

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

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

- Request review by an Independent Review Organization (IRO) selected by HMSA at random from a panel of three IROs;
- Request arbitration with your employer or group sponsor before a mutually selected arbitrator; or
- File a lawsuit against your employer or group sponsor under 29 USC 1132(a) unless your plan is one of the two bulleted types below in which case you must select review by an IRO or arbitration:
  - A church plan as defined in 29 USC 2002(33) and no selection has been made in accord with 26 USC 410(d), or
  - A government plan as defined in 29 USC 1002(32).

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

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

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

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

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

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

Expedited Review by an IRO Selected by HMSA

You may request expedited external review if:

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

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

Request Arbitration

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

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

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

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

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

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

CHAPTER 9

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- General Coordination Rules 64
- Dependent Children Coordination Rules 64
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What Coordination of Benefits Means

Coverage that Provides Same or Similar Coverage

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

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

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

What You Should Do

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

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

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

You will get a letter from us if we need more details. If you do not give us the details we need to coordinate your benefits, your claims may be delayed or denied.

To help us coordinate your benefits, you should:

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

What We Will Do

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

General Coordination Rules

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

No Coordination Rules

The coverage without coordination of benefits rules pays first.

Member Coverage

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

Active Employee Coverage

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

Earliest Effective Date

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

Dependent Children Coordination Rules

Birthday Rule

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

Court Decree Stipulates

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

Court Decree Does Not Stipulate

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

- Custodial parent.
- Spouse of custodial parent.
- Other parent.
- Spouse of other parent.

Earliest Effective Date

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

If You Are Hospitalized When Coverage Begins

If You are Hospitalized on the Effective Date of Coverage

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

Motor Vehicle Insurance Rules

Automobile Coverage

If your injuries or illness are due to a motor vehicle accident or other event for which we believe motor vehicle insurance coverage reasonably appears available under Hawaii Revised Statutes Chapter 431, Article 10C, then that motor vehicle

coverage will pay before this coverage. You are responsible for any cost sharing payments required under such motor vehicle insurance coverage. We do not cover such cost sharing payments. Before we pay benefits under this coverage for an injury covered by motor vehicle insurance, you must give us a list of medical expenses paid by the motor vehicle insurance. The list must show the date expenses were incurred, the provider of service, and the amount paid by the motor vehicle insurance. We will review the list of expenses to verify that the motor vehicle insurance coverage available under Hawaii Revised Statutes Chapter 431, Article 10C is exhausted. After it is verified, you are eligible for covered services in accord with this Guide to Benefits.

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

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

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

Medicare Coordination Rules

Medicare as Secondary Payer

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

If You are Age 65 or Older

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

If You are Under Age 65 with Disability

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

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

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

Dual Medicare Eligibility

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

This Plan Secondary Payer to Medicare

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

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

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

Facilities or Providers Not Eligible or Entitled to Medicare Payment

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

Third Party Liability Rules

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

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

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

What Third Party Liability Means

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

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

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

What You Need to Do

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

- **Give Us Timely Notice**. You must give us timely notice in writing of each of the following:
  - your knowledge of any potential claim against any third party or other source of recovery in connection with the injury or illness;
  - any written claim or demand (including legal proceeding) against any third party or against other source of recovery in connection with the injury or illness; and
  - any recovery of damages (including any settlement, judgment, award, insurance proceeds, or other payment) against any third party or other source of recovery in connection with the injury or illness.

  To give timely notice, your notice must be no later than 30 calendar days after the occurrence of each of the events stated above;
- **Sign Requested Documents**. You must promptly sign and deliver to us all liens, assignments, and other documents we deem necessary to secure our rights to recover payments. You hereby authorize and direct any person or entity making or receiving any payment on account of such injury or illness to pay to us so much of such payment as needed to discharge your reimbursement obligations described above;
- **Provide Us Information**. You must promptly provide us any and all information reasonably related to our investigation of our liability for coverage and our determination of our rights to recover payments. We may ask you to complete an Injury/Illness report form, and provide us medical records and other relevant information;

- **Do Not Release Claims Without Our Consent**. You must not release, extinguish, or otherwise impair our rights to recover our payments, without our express written consent; and
- **Cooperate With Us**. You must cooperate to help protect our rights under these rules. This includes giving notice of our lien as part of any written claim or demand made against any third party or other source of recovery in connection with the illness or injury.

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

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

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

Payment of Benefits Subject to Our Right to Recover Our Payments

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

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

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

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

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

By accepting benefits under this plan, you also specifically acknowledge the Plan's right of reimbursement. This right of reimbursement attaches when this plan has paid health care benefits for expenses incurred due to Third Party Injuries and you or your representative has recovered any amounts from a Third Party. By providing any benefit under this Guide to Benefits, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment

received by you to the extent of the full cost of all benefits provided by this plan. The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

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

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

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

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

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

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

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

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

CHAPTER 10

This Chapter Covers

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Eligibility for Coverage

When You are Eligible for Coverage

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

Categories of Coverage

There are different categories of coverage you may hold.

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

Enrollment Process

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

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

What You Should Know about Enrolling Your Child(ren)

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

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

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

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

Children with Special Needs

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

- Your child is incapable of self-sustaining support because of a physical or mental disability.
- Your child's disability existed before the child turned 26 years of age.
- Your child relies primarily on you for support and maintenance as a result of his or her disability.
- Your child is enrolled with us under this coverage or another HMSA coverage and has had continuous health care coverage with us since before the child's 26th birthday.

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

Children Who are Newborns or Adopted

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

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

Qualified Medical Child Support Order (QMCSO)

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

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

If you would like more information about how HMSA handles QMCSOs, you may call HMSA's Customer Service. Our phone number is listed on the back cover of this Guide.

When Coverage Begins

When You are Eligible to Receive Benefits

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

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

When Coverage Ends

Reasons for Coverage Termination

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

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

- We end our agreement with your employer or group sponsor, and we have given 10-days advance written notice to your employer and the Director of the Hawaii Department of Labor and Industrial Relations.
- For *the member*, upon your retirement, termination of employment, severance from the group, or termination of this Agreement.
- For *the member's spouse*, upon your termination of coverage or upon the dissolution of the marriage.
- For *the member's children*, when any of the following occurs:
  - The member's coverage ends; or
  - The child fails to meet the criteria outlined earlier in this chapter under *What You Should Know about Enrolling Your Child(ren).*

Notifying Us When Your Child's Eligibility Ends

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

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

Termination for Fraud

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

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

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

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

Continued Coverage

Continued Coverage Under Federal Law - COBRA Rights

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

Qualifying Events

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

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

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

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

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

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

Payment of COBRA Premiums

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

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

What You Must Do

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

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

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

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

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

Adding Your Child

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

Length of Coverage Under COBRA

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

- The last day of the 18-, 29-, or 36-month maximum coverage period, whichever is applicable. If you or any of your dependents who has elected COBRA coverage is determined to be disabled under the Social Security Act during the first 60 days of continuation coverage, your COBRA coverage may continue for up to 29 months. The 29-month period will apply to you and your eligible dependents who elected COBRA coverage. You must provide notice of the disability determination to your employer within 60 days after the determination.

- The first day (including grace periods, if applicable) on which timely payment is not made by you.
- The date on which the employer ceases to maintain any group health plan (including successor plans).
- The date the qualified beneficiary enrolls in Medicare benefits. ***Qualified Beneficiary*** means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan:
  - as the spouse of the covered employee; or
  - as the dependent child of the covered employee.
- The first day on which a beneficiary is actually covered by any other group health plan. However, if the new group health plan contains an exclusion or limitation relating to any preexisting condition of the beneficiary, then coverage will end on the earlier of the satisfaction of the waiting period for preexisting conditions contained in the new group health plan, or the occurrence of any one of the other events stated in this chapter.

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

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

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

Other Continuation Coverage

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

Continued Coverage if Member Dies

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

Continued Coverage if You have Medicare

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

Confidential Information

Your medical records and information about your care are confidential. HMSA does not use or disclose your medical information except as allowed or required by law. You may need to provide information to us about your medical treatment or condition. In accordance with law, we may use or disclose your medical information (including providing this information to third parties) for the purposes of payment activities and health care operations such as quality assurance, disease management, provider credentialing, administering the plan, complying with government requirements, and research or education.

Dues and Terms of Coverage

Dues

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

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

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

Timely Payment

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

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

Terms of Coverage

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

Authority to Terminate, Amend, or Modify Coverage

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

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

Governing Law

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

Payment in Error

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

Notice Address

You may send any notice required by this chapter to:

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

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

ERISA Information

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

- Examine all plan documents and copies of documents (such as annual reports) filed by the plan with the United States Department of Labor. You may examine these documents without charge at the plan administrator's office or at specified locations.
- Get copies of plan documents from the plan administrator upon written request. The plan administrator may request a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report if your employer or group sponsor has 100 or more participants in your plan. The plan administrator is required by law to furnish you with a copy of this summary annual report.

In addition to creating rights for you and other participants, ERISA imposes duties upon the people responsible for the operation of your employee benefit plan. The people responsible are called fiduciaries of the plan. Fiduciaries have a duty to operate your employee benefit plan prudently and in the interest of you and your family members. HMSA and the plan administrator (your employer or group sponsor), are fiduciaries under this Agreement; however, HMSA's duties are limited to those described in this Agreement, and the plan administrator is responsible for all other duties under ERISA. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from getting a covered benefit or exercising your rights under ERISA. In general, federal law prohibits health plans from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. Plans may require authorization for lengths of stay in excess of these time parameters. If your claim for a covered benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to request an appeal and reconsideration of your claim. Under ERISA, there are steps you can take to enforce the above rights.

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

If you have a claim for benefits that is denied or ignored (in whole or in part), you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person or entity you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator, i.e., your employer or group sponsor. If you have questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your phone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20010.

CHAPTER 11

Accidental Injury	An injury, separate from a disease or bodily infirmity of any other cause, that happens by chance and needs medical care right away.
Actual Charge	The amount a provider bills for a covered service or supply.
Acute Care	Inpatient 24-hour hospital care that needs physician and nursing care on a minute-to-minute, hour-to-hour basis.
Admission	The formal acceptance of a patient into a facility for medical, surgical, or obstetric care.
Advance Care Planning	Advance care planning (ACP) prepares members in the event they become very sick. Members discuss with their doctor what matters most to them and document the desired care. ACP becomes important when a member cannot communicate decisions.
Agreement	The document made up of: ▪ This Guide to Benefits; ▪ Any riders or amendments; ▪ The enrollment form submitted to us; and ▪ The Agreement between us and your employer or group sponsor.
Alcohol Dependence	Any use of alcohol that produces a pattern of pathological use that causes impairment in social or occupational functions or produces physiological dependence evidenced by physical tolerance or withdrawal.
Allogeneic Transplant	Transplant in which the tissue or organ for a transplant is obtained from someone other than the person receiving the transplant.
Ambulance Service	Local air or ground emergency transport to a hospital in the surrounding area where your transport began.
Ambulatory Surgical Center	A facility that provides surgical services on an outpatient basis for patients who do not need an inpatient, acute care hospital bed.
Ancillary Services	Facility charges other than room or board. For example, charges for inpatient drugs and biologicals, dressings, or medical supplies.
Anesthesia	The use of anesthetics to produce loss of feeling or consciousness, usually with medical treatment such as surgery.
Annual Copayment Maximum	The maximum amount you pay for most covered services in a benefit period. The copayment maximum is reached from deductible and copayment amounts you pay in any given calendar year.

Chapter 11: Glossary

Applied Behavior Analysis

The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

Arbitration

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

Assisting Surgeon

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

Autologous Transplant

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

Benefit Maximum

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

Benefits

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

Bereavement Services

Services that focus on healing from emotional loss.

Biofeedback

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

Biological Products

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

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

Biological Therapeutics and Biopharmaceuticals

Any biology-based therapeutics that structurally mimic compounds found in the body. This includes recombinant proteins, monoclonal and polyclonal antibodies, peptides, antisense oligonucleotides, therapeutic genes, and certain therapeutic vaccines.

Biosimilar Product

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

Birthing Center

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

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

BlueCard Participating Provider A provider that participates with the BlueCard Program. BlueCard participating providers file claims for you and accept the eligible charge as payment in full.

BlueCard Program The Blue Cross and Blue Shield Association program that gives HMSA members access to participating providers throughout the U.S.

Breast Prostheses (External) Artificial breast forms intended to simulate breasts for women who have uneven- or unequal-sized breasts who decide not to, or are waiting to, undergo surgical breast reconstruction after a covered mastectomy or lumpectomy. They include mastectomy bras (surgical bras), forms, garments and sleeves.

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

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

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

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

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

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

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

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

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

Contraceptives Any oral medicine or device that prevent impregnation.

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

Coordination of Benefits (COB) Applies when you are covered by more than one insurance policy providing benefits for like services.

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

Chapter 11: Glossary

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

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

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

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

Custom-Fabricated
Items that are individually made for a specific patient (no other patient would be able to use it) starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as vacuum forming, cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components but it involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

Dr. Ornish's Program for Reversing Heart Disease™
A comprehensive approach to cardiovascular disease management and overall well-being improvement that addresses modifiable risk factors under the supervision of a multidisciplinary team.

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

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

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

Diagnosis
The medical description of the disease or condition.

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

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

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

Dues
The monthly premium amount for HMSA membership.

Durable Medical Equipment

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

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

ERISA

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

Effective Date

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

Eligible Charge

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

Emergency

A medical condition accompanied by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:
- serious risk to the health of the person (or, with respect to a pregnant woman, the health of the woman and her unborn child);
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ part.

Facility

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

False Statement

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

Family Coverage

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

Family Member

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

Foot Orthotics

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

Frame

A standard plastic eyeglass frame or similar frame into which two lenses are fitted.

Gender Identity

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

Gender Dysphoria

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

Gender Transition	The process of a person changing the person's outward appearance, including sex characteristics, to accord with the person's gender identity.
Generic Drug	A drug, supply, or insulin that is prescribed or dispensed under its commonly used generic name rather than a brand name. A generic drug is not protected by patent, or is identified by HMSA as "generic".
Group	Those members who share a common relationship such as employment or membership. The group has executed the group plan agreement with us and by getting health coverage through the group, you designate the group as your administrator.
Guide to Benefits	This document, along with any riders or amendments that provide a written description of your health care coverage.
HMSA	Hawai'i Medical Service Association, an independent licensee of the Blue Cross and Blue Shield Association.
HMSA Directory of Participating Providers	A complete list of HMSA participating providers.
HMSA Participating Provider	A provider that contracts with HMSA, files claims for you, accepts the eligible charge as payment in full, and handles precertification for you.
HMSA Select Prescription Drug Formulary	A list of drugs by therapeutic category published by HMSA.
High-Dose Chemotherapy	A form of chemotherapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a stem-cell transplant is needed.
High-Dose Radiotherapy	A form of radiation therapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a stem-cell transplant is needed.
Homebound	Due to an illness or injury, you are unable to leave home, or leaving your home requires a large and taxing effort.
Home Health Agency (HHA)	An approved agency that provides skilled nursing care in your home.
Home Infusion Therapy	Treatment in the home that involves giving nutrients, antibiotics and other drugs and fluids intravenously or through a feeding tube. Drugs must be FDA approved.
Hospice Program	A program that provides care in a comfortable setting for patients who are terminally ill and have a life expectancy of six months or less. Care is normally provided in the patient's home.
Hospital	An institution that provides diagnostic and therapeutic services for surgical and medical diagnosis, treatment and care of injured or sick persons.
Illness or Injury	Any bodily disorder, injury, disease or condition, including pregnancy and its complications.
Immediate Family Member	Your child, spouse, parent, or yourself.
Immunization	An injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

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

Inhalation Therapy Therapy to treat conditions of the cardiopulmonary system.

Injection The introduction of a drug, biological therapeutic, biopharmaceutical, or vaccine into the body by using a syringe and needle. Injectable drugs must be FDA approved.

Inpatient Admission A stay in an inpatient facility, usually involving overnight care.

Integrated Case Management A program that addresses the specialized care needs of patients with severe or chronic illnesses or injuries.

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

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

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

Intravenous Injection An injection made into the vein.

In Vitro Fertilization A method used to treat infertility in women.

Laboratory Services Services used to help diagnose, prevent, or treat disease.

Lenses Ophthalmic corrective lenses ground as prescribed by a physician or optometrist for fitting into a frame.

Limited Services Those covered services that are limited per service, per episode, per calendar year or per lifetime.

Mammogram An x-ray exam of the breast using equipment dedicated specifically for mammography.

Mammography (screening) An x-ray film that screens for breast abnormalities.

Maximum Allowable Fee The amount we establish as the maximum amount HMSA will pay for covered services and supplies.

Medicaid A form of public assistance sponsored jointly by the federal and state governments providing medical assistance for eligible persons whose income falls below a certain level. The Hawaii Department of Human Services pursuant to Title XIX of the federal Social Security Act administers this program.

Medication The treatment of disease without surgery.

Medicine To diagnose and treat disease and to maintain health.

Member The person who meets eligibility requirements and who executes the enrollment form that is accepted in writing by us.

Member Card	Your member card issued to you by us. You must present this card to your provider at the time you get services.
Mental Health Outpatient Facility	A mental health clinic, institution, center, or community mental health center that provides for the diagnosis, treatment, care or rehabilitation of people who are mentally ill.
Mental Illness/Disorder	A syndrome of clinically significant psychological, biological, or behavioral abnormalities that result in personal distress or suffering, impairment of capacity to function, or both. Mental illness and disorder are used interchangeably in this Guide and as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or in the International Classification of Disease.
Microprocessor-Controlled Prosthetic Device	Prosthetic devices that use feedback from sensors to adjust joint movement on a real-time as-needed basis.
Myoelectric Prosthetic Device	Prosthetic devices powered by electric motors with an external power source. For example, the movement of an upper limb prosthesis (e.g., hand, wrist, and/or elbow) is driven by micro-chip-processed electrical activity in the muscles of the remaining limb stump.
Newborn	A recently born infant.
Newborn Care	All routine non-surgical physician services and nursery care provided to a newborn during the mother's initial hospital stay.
Non-Assignment	When benefits for covered services and supplies cannot be transferred or assigned to anyone for use.
Non-Preferred Formulary Drug, Supply, or Insulin	A brand name drug, supply, or insulin that is not listed as preferred on the HMSA Select Prescription Drug Formulary.
Nonparticipating Providers	Providers that are not under contract with HMSA or any other Blue Cross and/or Blue Shield Plan.
Nurse Midwife	A health care professional who provides services such as pre and post natal care, normal delivery services, routine gynecological services, and any other services within the scope of his or her certification.
Occupational Therapy	A form of therapy involving the treatment of neurological and musculoskeletal dysfunction through the use of specific tasks or goal-directed activities designed to improve the functional performance of an individual.
Online Care	Care provided by video conferencing, phone or web if obtained from HMSA Online.
Ophthalmologist	A physician specializing in the diagnosis and treatment of diseases and defects of the eye.
Optician	One who fits, adjusts and dispenses glasses and other optical devices, on the written prescription of a licensed physician or optometrist.
Optometrist	One who specializes in the examination, diagnosis, treatment and management of diseases and disorders of the visual system, the eye and related structures.
Oral Surgeon	A dentist licensed as a doctor of dentistry (D.M.D.) or dental surgery (D.D.S.) to diagnose and treat oral conditions that need surgery.

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

Orofacial Anomalies Cleft lip or cleft palate and other birth defects of the mouth and face affecting functions such as eating, chewing, speech, and respiration.

Orthodontic Services to treat Orofacial Anomalies Direct or consultative services from a licensed dentist with a certification in orthodontics by the American Board of Orthodontics.

Orthotics/Orthotic Devices/Orthoses Rigid or semi-rigid devices that are used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a diseased or injured part of the body. They must provide support and counterforce (i.e., a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace. An orthotic can be either prefabricated or custom-fabricated.

Osteopathy Medicine that specializes in diseases of the bone.

Osteoporosis The loss of minerals from the bone.

Other Providers Health care providers other than facilities and practitioners. Examples include hospice agencies, ambulance services, retail pharmacies, home medical equipment suppliers, and independent labs.

Our Reference to HMSA (Hawai‘i Medical Service Association).

Outpatient Care received in a practitioner's office, the home, an ambulatory infusion suite, the outpatient department of a hospital or ambulatory surgery center.

Participating Provider A provider that participates with us or a Blue Cross and/or Blue Shield Plan.

Physical Therapy A form of therapy involving treatment of disease, injury, congenital anomaly or prior therapeutic intervention through the use of therapeutic modalities and other interventions that focus on a person’s ability to go through the functional activities of daily living and on alleviating pain.

Physician A medical doctor (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.).

Physician Assistant A practitioner who provides care under the supervision of a physician.

Physician Services Professional services necessarily and directly performed by a doctor to treat an injury or illness.

Plan This hospital and health benefits program offered to you as an eligible employee for purposes of ERISA.

Plan Administrator Your employer or group sponsor for the purposes of ERISA.

Planned Admission An admission that can be scheduled in advance because the condition, illness or injury is not immediately life-threatening.

Podiatrist A health care professional who specializes in conditions of the feet.

Podiatry Care and study of the foot.

Post-Acute Care
Comprehensive inpatient care (medical or behavioral health) designed for an individual who has an acute illness, injury or exacerbation of a disease process. It is goal-oriented treatment rendered immediately after acute inpatient hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments. Post-acute care requires the coordinated services of an interdisciplinary team and is given as part of a specifically designed treatment plan.

Postoperative Care
Care given after a surgical operation.

Postpartum
The period of time after childbirth.

Precertification
The process of getting prior approval for specified services and devices. Failure to get our approval will result in a denial of benefits if the services or devices do not meet HMSA's payment determination criteria. HMSA participating providers agree to get approval for you. All other providers do not agree to get approval for you, therefore you are responsible.

Preferred Formulary Drug, Supply, or Insulin
A brand name drug, supply, or insulin identified as preferred on the HMSA Select Prescription Drug Formulary.

Preoperative Care
Care that occurs, is performed, or is administered before, and usually close to, a surgical operation.

Prescription
The instructions written by a provider with statutory authority to prescribe directing a pharmacist to dispense a particular drug in a specific dose.

Primary Care Provider (PCP)
The provider you choose to act as your personal health care manager, and who renders general medical care focusing on preventive care and treatment of routine injuries and illnesses.

Private Duty Nursing
24-hour nursing services by an approved nurse who is dedicated to one patient.

Prosthetic Appliances
Devices used as artificial substitutes to replace a missing natural part of the body and other devices to improve, aid, or increase the performance of a natural function.

Provider
An approved physician or other practitioner, facility, or other health care provider, such as an agency or program.

Psychologist
An approved provider who specializes in the treatment of mental health conditions.

Qualified Beneficiary
Qualified Beneficiary means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan:
- as the spouse of the covered employee; or
- as the dependent child of the covered employee.

Qualified Medical Child Support Order (QMCSO)
A Medical Child Support Order that creates or recognizes in the person specified in the order the existence of the right to enroll in the health benefit plan for which the plan member or his/her dependents are eligible. To be a Qualified Medical Child Support Order, the order cannot require a health benefit plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act with respect to a group plan.

Radiology
The use of radiant energy to diagnose and treat disease.

Reference Product
Refers to the original FDA-approved biologic product that a biosimilar is based.

Registered Bed Patient A person who is registered by a hospital or skilled nursing facility as an inpatient for an illness or injury covered by this Guide.

Report to Member The report you get from us that notes how we applied benefits to a claim. You may get copies of your report online through My Account on hmsa.com or by mail upon request.

Sexual Identification Counseling Psychotherapy for a person with gender dysphoria.

Sexual Orientation Counseling Treatment of an enduring pattern of emotional, romantic and/or sexual attractions to men, women or both sexes. Sexual orientation also refers to a person's sense of identity based on those attractions, related behaviors and membership in a community of others who share those attractions.

Single Coverage Coverage for the member only.

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

Specialist A provider who is specifically trained in a certain branch of medicine related to a service or procedure, body area or function, or disease.

Speech Therapy Services Services for the diagnosis, assessment and treatment of communication impairments and swallowing disorders.

Spouse Your husband or wife as the result of a marriage who is legally recognized in the state of Hawaii.

Stand by Time Any period of time that is used for waiting, or is idle.

Subcutaneous Implant A medication that is surgically placed beneath the skin to release the drug in the bloodstream. An example is the Norplant contraceptive.

Subscriber Number The number that appears on your HMSA member card.

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

Supportive Care Services A comprehensive approach to care for members with a serious or advanced illness including Stage 3 or 4 cancer, advanced Congestive Heart Failure (CHF), advanced Chronic Obstructive Pulmonary Disease (COPD), or any advanced illness that meets the requirements of the Supportive Care policy. Members get comfort-directed care, along with curative treatment from an interdisciplinary team of practitioners.

Surgical Services Cutting, suturing, diagnostic, and therapeutic endoscopic procedures; debridement of wounds, including burns; surgical management or reduction of fractures and dislocations; orthopedic casting manipulation of joints under general anesthesia or destruction of localized surface lesions by chemotherapy cryotherapy, or electrosurgery.

Third Party Liability Our rights to reimbursement when you or your family members get benefits under this coverage for an illness or injury and you have a lawful claim against another party or parties for compensation, damages, or other payment.

Transgender Person A person who has gender identity disorder or gender dysphoria, received health care services related to gender transition, adopts the appearance or behavior of the opposite sex, or otherwise identifies as a gender different from the gender assigned to that person at birth.

Transplant The transfer of an organ or tissue for grafting into another area of the same body or into another person.

Treatment Management and care of the patient to combat a disease or disorder.

Tubal Ligation A sterilization procedure for women.

Us HMSA (Hawai‘i Medical Service Association).

Vasectomy A sterilization procedure for men.

Vision Services Services that test eyes for visual acuity and identify and correct visual acuity problems with lenses and other equipment.

We HMSA (Hawai‘i Medical Service Association).

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

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

Serving you

Meet with knowledgeable, experienced health plan advisers. We'll answer questions about your health plan, give you general health and well-being information, and more. Visit hmsa.com for directions.

HMSA Center @ Honolulu
818 Keeaumoku St.
Monday through Friday, 8 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center @ Pearl City
Pearl City Gateway | 1132 Kuala St., Suite 400
Monday through Friday, 9 a.m.–7 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center @ Hilo
Waiakea Center | 303A E. Makaala St.
Monday through Friday, 9 a.m.–7 p.m. | Saturday, 9 a.m.–2 p.m.

Opening in 2019
HMSA Center @ Kahului
Puunene Shopping Center | 70 Hookele St.

Customer Relations representatives are also available in person at our Neighbor Island offices, Monday through Friday, 8 a.m. to 4 p.m.:

Kailua-Kona, Hawaii Island
75-1029 Henry St., Suite 301 | Phone: 329-5291

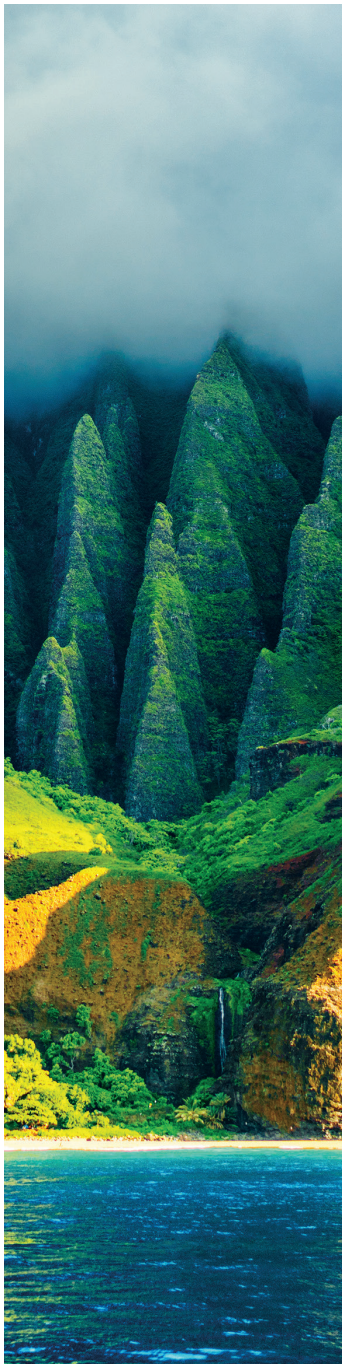
Kahului
33 Lono Ave., Suite 350 | Phone: 871-6295

Lihue
4366 Kukui Grove St., Suite 103 | Phone: 245-3393

Contact HMSA. We're here for you.

Call 948-6111 on Oahu or 1 (800) 776-4672 toll-free on the Neighbor Islands or Mainland.

hmsa.com myhmsa @askHMSA askhmsa



Together, we improve the lives of our members and the health of Hawaii.
Caring for our families, friends, and neighbors is our privilege.

hmsa