



Guide to Benefits



EUTF HMO (HMSA)

For Active EUTF State, City and County Employees

January 2026



An Independent Licensee of the Blue Cross and Blue Shield Association

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 - Qualified interpreters.
 - Information written in other languages.

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- Phone: 1 (800) 462-2085
- TTY: 711
- Email: appeals@hmsa.com
- Fax: (808) 952-7546
- Mail: HMSA Member Advocacy and Appeals
P.O. Box 1958
Honolulu, HI 96805-1958

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1 (800) 368-1019, 1 (800) 537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

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ATTENTION: If you don't speak English, language assistance services are available to you at no cost. Auxiliary aids and services are also available to give you information in accessible formats at no cost. QUEST members, call 1 (800) 440-0640 toll-free, TTY 1 (877) 447-5990, or speak to your provider. Medicare Advantage and commercial plan members, call 1 (800) 776-4672 or TDD/TTY 1 (877) 447-5990.

'Ōlelo Hawai'i

NĀ MEA: Inā 'a'ole 'oe 'ōlelo Pelekania, loa'a nā lawelawe kōkua 'ōlelo iā 'oe me ka uku 'ole. Loa'a nā kōkua kōkua a me nā lawelawe no ka hā'awi 'ana iā 'oe i ka 'ike ma nā 'ano like 'ole me ka uku 'ole. Nā lālā QUEST, e kelepona iā 1 (800) 440-0640 me ka uku 'ole, TTY 1 (877) 447-5990, a i 'ole e kama'ilio me kāu mea ho'olako. 'O nā lālā Medicare Advantage a me nā lālā ho'olālā kalepa, e kelepona iā 1 (800) 776-4672 a i 'ole TDD/TTY 1 (877) 447-5990.

Bisaya

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繁體中文

請注意：如果你不諳英文，我們將為您提供免費的語言協助服務。輔助支援和服務也能免費以無障礙的方式為您提供資訊。QUEST 會員請致電免費熱線 1 (800) 440-0640、聽障熱線 (TTY) 1 (877) 447-5990 或與您的服務提供者聯絡。Medicare Advantage 及商業計劃會員請致電 1 (800) 776-4672 或聽障／語障熱線 (TDD/TTY) 1 (877) 447-5990。

简体中文

注意：如果您不会说英语，我们可以免费为您提供语言协助服务。同时，我们还配备辅助工具和相关服务，免费为您提供无障碍格式的信息。QUEST 会员请拨打免费电话 1 (800) 440-0640, TTY 1 (877) 447-5990, 或咨询您的医疗服务提供者。Medicare Advantage 和商业计划会员请致电 1 (800) 776-4672 或 TDD/TTY 1 (877) 447-5990。

Ilokano

BASAEN: No saanka nga agsasao iti Ingles, mabalinmo a magun-odan ti libre a serbisio a tulong iti lengguah. Adda met dagiti kanayonan a tulong ken serbisio a makaited kenka iti libre nga impormasion iti nalaka a maawatan a pormat. Dagiti miembro ti QUEST, tawaganyo ti 1 (800) 440-0640 a libre iti toll, TTY 1 (877) 447-5990, weno makisaritaka iti provider-yo. Dagiti miembro ti Medicare Advantage ken plano a pang-komersio, tawaganyo ti 1 (800) 776-4672 weno TDD/TTY 1 (877) 447-5990.

日本語

注意：英語を話されない方には、無料で言語支援サービスをご利用いただけます。また、情報をアクセシブルな形式で提供するための補助ツールやサービスも無料でご利用いただけます。QUESTプログラムの加入者の方は、フリーダイヤル1 (800) 440-0640までお電話ください。TTYをご利用の場合は1 (877) 447-5990までお電話いただかず、担当医療機関にご相談ください。Medicare Advantageプランおよび民間保険プランの加入者の方は、1 (800) 776-4672までお電話いただかず、TDD/TTYをご利用の場合は1 (877) 447-5990までお電話ください。

한국어

주의: 영어를 사용하지 않는 경우, 무료로 언어 지원 서비스를 이용할 수 있습니다. 무료로 접근 가능한 형식으로 정보를 받기 위해 보조 지원 및 서비스 역시 이용할 수 있습니다. QUEST 가입자는 수신자 부담 전화 1 (800) 440-0640, TTY 1 (877) 447-5990 번으로 전화하거나 서비스 제공자와 상의하십시오. Medicare Advantage 및 민간 플랜 가입자는 1 (800) 776-4672 또는 TDD/TTY 1 (877) 447-5990 번으로 전화하십시오.

ພາສາລາວ

ເຊື່ອງຊັບ: ຖ້າທ່ານບໍ່ເວົ້າພາສາອ້າງກິດແມ່ນມີບໍລິການ ຂ່ອຍເຫຼືອດູ້ນພາສາໄດ້ລັບມືຄ່າໃຊ້ລາຍເງື່ອມໃຫ້ທ່ານ. ນອກຈາກນັບປຸງລົງມີການຂ່ອງລາຍເຫຼືອ ແລະ ກ່າວປໍລິການ ດີເລີມເຜືອໃຫ້ຂໍມູນແກ່ທ່ານໃນຮັບແບບທີ່ເຊິ່ງທີ່ໄດ້ດູລຸ ບໍ່ມີຄ່າໃຊ້ລ່າຍ. ສະມາຊຸກ QUEST ແລ້ວໂທບໍ່ສະລັກຄ່າໄດ້ທີ່ເປີ 1 (800) 440-0640, TTY 1 (877) 447-5990 ຫຼື ປຶກສາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. ສະມາຊຸກແກ້ໄຂ ປະກັນ Medicare Advantage ແລະ ຊັນທຸວະກຳດ, ໂທ 1 (800) 776-4672 ຫຼື TDD/TTY 1 (877) 447-5990.

Kajin Majōi

KŌJELLA: Ņe kwōjab jelā kenono kajin Belle, ewōr jibañ in ukok ñan kwe im ejellok wonnen. Ewōr kein roñjak im jibañ ko jet ñan wāween ko kwōmaron ebōk melele im ejellok wonnen. Armej ro rej kōjralb QUEST, kall e 1 (800) 440-0640 ejellok wonnen, TTY 1 (877) 447-5990, ñe ejab kenono ibben taktō eo am. Medicare Advantage im ro rej kōjeralb injuran ko rej make wia, kall e 1 (800) 776-4672 ñe ejab TDD/TYY 1 (877) 447-5990.

Lokaiahn Pohnpei

Kohdo: Ma ke mwahu en kaiahn Pohnpei, me mwengei en kaiahn Pohnpei. Me mwengei en kaiahn Pohnpei, me mwengei en kaiahn Pohnpei. QUEST mwengei, kohdo mwengei 1 (800) 440-0640, TTY 1 (877) 447-5990, me mwengei en kaiahn Pohnpei, kohdo mwengei 1 (800) 776-4672 me TDD/TYY 1 (877) 447-5990.

Gagana Sāmoa

FAASILASILAGA: Afai e te lē tautala le faa-Igilisi, o loo avanoa mo oe e aunoa ma se totogi auaunaga fesoasoani i le gagana. O loo maua fo'i fesoasoani faaopo'opo ma auaunaga e tuuina atu ai iā te oe faamatalaga i auala eseese lea e maua e aunoa ma se totogi. Sui auai o le QUEST, valaau aunoa ma se totogi i le 1 (800) 440-0640, TTY 1 (877) 447-5990, pe talanoa i lē e saunia lau tausiga. Sui auai o le Medicare Advantage ma sui auai o peleni inisiua tumaoti, valaau i le 1 (800) 776-4672 po o le TDD/TYY 1 (877) 447-5990.

Español

ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia con el idioma. También están disponibles ayuda y servicios auxiliares para brindarle información en formatos accesibles sin costo alguno. Los miembros de QUEST deben llamar al número gratuito 1 (800) 440-0640, TTY 1 (877) 447-5990 o hablar con su proveedor. Los miembros de Medicare Advantage y de planes comerciales deben llamar al 1 (800) 776-4672 o TDD/TYY 1 (877) 447-5990.

Tagalog

PAUNAWA: Kung hindi ka nakapagsasalita ng Ingles, mayroon kang makukuhang mga serbisyo sa tulong sa wika nang libre. Mayroon ding mga auxiliary na tulong at serbisyo para bigyan ka ng impormasyon sa mga naa-access na format nang libre. Sa mga miyembro ng QUEST, tumawag sa 1 (800) 440-0640 nang toll-free, TTY 1 (877) 447-5990, o makipag-usap sa iyong provider. Sa mga miyembro ng Medicare Advantage at commercial plan, tumawag sa 1 (800) 776-4672 o TDD/TYY 1 (877) 447-5990.

ไทย

โปรดให้ความสนใจ: หากท่านไม่พูดภาษาอังกฤษ เราขอ บริการให้ความช่วยเหลือทางภาษาแก่ท่านโดยไม่มีค่าใช้จ่าย และยังมีความช่วยเหลือและบริการเสริมเพื่อให้ข้อมูลแก่ท่านในรูปแบบที่เข้าถึงได้โดยไม่มีค่าใช้จ่าย สำหรับสมาชิก QUEST โปรดโทรไปที่หมายเลขโทรศัพท์ที่หมายเลข 1 (800) 440-0640, TTY 1 (877) 447-5990 หรือพูดคุยกับผู้ให้บริการของคุณ สำหรับสมาชิก Medicare Advantage และแผนเพิ่มพานิชย์ โปรดโทรไปที่หมายเลข 1 (800) 776-4672 หรือ TDD/TYY 1 (877) 447-5990

Tonga

FAKATOKANGA: Kapau óku íkai keke lea Faka-Pilitania, óku í ai e tokotaha fakatonulea óku í ai ke tokonií koe íkai ha totongi. Óku í ai mo e kulupu tokoni ken au óatu e ngaahi fakamatala mo e tokoni íkai ha totongi. Kau memipa QUEST, ta ki he 1 (800) 440-0640 taé totongi, TTY 1 (877) 447-5990, pe talanoa ki hoó kautaha. Ko kinautolu óku Medicare Advantage mo e palani fakakomesiale, ta ki he 1 (800) 776-4672 or TDD/TYY 1 (877) 447-5990.

Foosun Chuuk

ESINESIN: Ika kese sine Fosun Merika, mei wor aninisin fosun fonu ese kamo mi kawor ngonuk. Mei pwan wor pisekin aninisin mi kawor an epwe esinei ngonuk porous non och wewe ika nikinik epwe mecheres me weweoch ngonuk ese kamo. Chon apach non QUEST, kekeri 1 (800) 440-0640 namba ese kamo, TTY 1 (877) 447-5990, ika fos ngeni noumw ewe chon awora aninisin. Medicare Advantage ika chon apach non ekoch otot, kekeri 1 (800) 776-4672 ika TDD/TYY 1 (877) 447-5990.

Tiếng Việt

CHÚ Ý: Nếu quý vị không nói được tiếng Anh, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Các phương tiện và dịch vụ hỗ trợ cũng có sẵn để cung cấp cho quý vị thông tin ở các định dạng dễ tiếp cận mà không mất phí. Hội viên QUEST, xin gọi số miễn cước 1 (800) 440-0640, TTY 1 (877) 447-5990, hoặc nói chuyện với nhà cung cấp dịch vụ của quý vị. Hội viên Medicare Advantage và chương trình thương mại, xin gọi số 1 (800) 776-4672 hoặc TDD/TYY 1 (877) 447-5990.

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CHAPTER 1

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About this Guide to Benefits

Your HMO Program

The Trust Fund has contracted with us to administer a health benefits plan as described in this Guide to Benefits.* The type of health coverage provided by the Plan is called a **Health Maintenance Organization**. If you enroll in our **Health Maintenance Organization**, you will have medical benefits for treatment of an illness or injury, prevention of illness and injury, and promotion of good health. The Health Plan Hawaii Member Handbook provides further information about this Plan including Member's Rights and Responsibilities, Well-Being Services and preventive health services. In the event the Handbook differs from this Guide to Benefits, the Guide takes precedence. You can get a copy of the Handbook by calling your nearest Customer Service office listed on the back cover of this Guide or visit our web site at www.hmsa.com.

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

*EUTF Administrative Rules

Please refer to the Hawaii Employer-Union Health Benefits Trust Fund Administrative Rules for complete information on your Plan. In the case of a discrepancy between this Guide to Benefits and the information contained in the Administrative Rules, the Administrative Rules shall take precedence to the extent allowed by law. The Administrative Rules can be found at eutf.hawaii.gov in the bottom left corner under "Administrative Rules and Statutes".

Terminology

The terms You and Your mean you and your family members enrolled in this plan and eligible for this coverage. We, Us, and Our refer to HMSA. **Trust Fund** means the Hawaii Employer Union Health Benefits Trust Fund (EUTF).

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

Chapter 1: Important Information

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

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

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

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

Definitions

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

Questions

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

Accessing Care

Your Member Card

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

Your PCP

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

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

Health Center and PCP

Health Center

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

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

PCP

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

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

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

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

Chapter 1: Important Information

Your Health Team

Choosing Your Health Team

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

- Your designated health center
- Your designated PCP

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

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

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

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

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

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

Changing Your Health Team

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

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

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

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

Chapter 1: Important Information

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

When We Must Assign a New PCP

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

Referrals

The Referral Process

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

The referral process is as follows:

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

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

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

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

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

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

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

Authorization of Services

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

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

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

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

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

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

Referral Limitations

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

Claim Filing and Copayments

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

Referrals to Another Island

If your PCP refers you to a specialist on another island you may be eligible for inter-island transportation. For more details, see the section *Miscellaneous Medical Treatments* in *Chapter 4: Description of Benefits*.

Care While You are Away from Home

Medical Care Outside of Hawaii (BlueCard® Program)

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

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

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

- For emergency and urgent care services outside of Hawaii, benefits are available through the BlueCard program. You should follow these steps:
 - Carry your current member card for easy reference and access to service.
 - If you experience a Medical Emergency while traveling outside Hawaii, go to the nearest Emergency facility.

Chapter 1: Important Information

- For urgent care, to find names and addresses of nearby providers, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard Access at 1-800-810-BLUE (2583). Call the provider to schedule an appointment.

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

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Participating Providers

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

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

Emergency Care Services

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

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

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

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

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

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

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Nonparticipating Medical Providers Outside Hawaii

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

Exceptions

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

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

Blue Cross Blue Shield Global Core

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

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

Chapter 1: Important Information

Care on Neighbor Islands	<p><i>For trips to the Neighbor Islands</i>, urgent care benefits are available by contacting the Customer Service office on the island you are visiting. Our phone numbers are listed on the back cover of this Guide. A customer service representative will arrange your appointment and advise you of your copayment responsibility. Benefits include one visit to a provider's office. Contact your PCP as soon as possible after receiving services so that he or she can update your file and provide or arrange any added care you might require.</p>
Guest Membership Program	<p>If you will be living away from your plan service area for longer than 90 days, benefits are available through the Guest Membership program within the U.S. You will need to prearrange care in the new service area through us. We will advise you of the HMO host plans that are available to you.</p> <ul style="list-style-type: none">• For members who are away from home, Guest Membership privileges are available for up to 180 days. If your absence from Hawaii exceeds 180 days, you may renew your Guest Membership privileges for up to an additional six months.• For dependents who are away from home, Guest Membership privileges must be renewed annually.
Process for Establishing Guest Membership	<p>How to Enroll in the Guest Membership Program. To enroll in the Guest Membership Program, call the HPH Away from Home Care Coordinator before you leave your plan service area. For a list of phone numbers by island, see the back cover of this Guide. The coordinator will research if a HMO host plan is available in the area you will be visiting.</p> <ul style="list-style-type: none">• If a provider is available, you will need to fill out an enrollment form. Enrollment information can be taken by phone or through the mail.• Once the enrollment is completed, the HPH coordinator will forward the enrollment form to the Away from Home Care Coordinator in the service area you will be visiting.• Once the HMO host plan processes your enrollment form, you will become a guest member of the HMO host plan while you are living in their service area. As a guest member, you are eligible for those benefits offered by the HMO host plan and must abide by the provisions of that plan. Your HPH plan benefits will not apply until you return to your HPH service area.• When you arrive at your destination, call the Away from Home Care Coordinator of the HMO host plan. The coordinator will provide you with a list of Providers (from which you can select a PCP) and a description of the host plan's benefits.

Questions We Ask When You Receive Care

Is the Care Covered?	To get benefits, the care you get must be a covered treatment, service, or supply. See <i>Chapter 4: Description of Benefits</i> 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: <ul style="list-style-type: none">• 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:<ul style="list-style-type: none">– 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 HMA's Customer Service Department.

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

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

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

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

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

Is the Care Consistent with HMSA's Medical Policies?

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

Did You Receive Care from Your PCP?

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

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

Is the Service or Supply Subject to a Benefit Maximum?

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

Is the Service or Supply Subject to Precertification?

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

Did You Receive Care from a Provider Recognized by Us?

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

Did a Recognized Provider Order the Care?

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

Chapter 1: Important Information

What You Can do to Maintain Good Health

Practice Good Health Habits

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

Routine and Preventive Services

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

Be a Wise Consumer

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

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

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

Interpreting this Guide

Our Rights to Interpret this Document

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

- To determine the amount and type of benefits payable to you or your dependents according to the terms of this Guide.
- To interpret the provisions of this Guide as needed to determine benefits, including decisions on medical necessity.

Our determinations and interpretations, and our decisions on these matters are subject to review by the Trust Fund. If you do not agree with our interpretation or determination, you may appeal to the Trust Fund after you have exhausted our appeal procedures. 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 Plan.

CHAPTER

2

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Eligible Charge

Definition

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

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

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

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

Copayment

Definition

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

Except as otherwise stated in this Guide:

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

Chapter 2: Payment Information

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

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

Amount

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

Annual Copayment Maximum

Definition

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

Amount

\$1,500 per person or

\$3,000 (maximum) per family

When You Pay More

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

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

Maximum Allowable Fee

Definition

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

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

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

Benefit Maximum

Definition

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

Chapter 2: Payment Information

Where to Look for Limitations

See *Chapter 4: Description of Benefits*.

Chapter 3: Summary of Benefits and Your Payment Obligations

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.

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

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

Chapter 3: Summary of Benefits and Your Payment Obligations

more info.
on page:

**Your Copayment Amount Is:
(Copayments are based on eligible charges)**

Routine and Preventive

Annual Preventive Health Evaluation (preventive visit)	24	None
Chlamydia (screening)	24	None
Diabetes Prevention Program	24	None when received from a provider that meets the requirements of the Diabetes Prevention Program as described in <i>Chapter 4: Description of Benefits</i> under <i>Special Benefits – Routine and Preventive</i>
Disease Management and Preventive Services Programs	24	None
Gonorrhea (screening)	24	None
Gynecological Exam	25	None
Immunizations	25	None
Mammography (screening)	25	None
Prostate Specific Antigen (PSA) Screening Test	25	None
Screening Services, Preventive Counseling, and Preventive Services	25	None
Vision Exam	26	\$15
Well-Being Services	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.
Well-Child Care	26	None

Online Care

Online Care	26	None
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Telehealth

Telehealth	26	Your copayment amounts vary depending on the type of services or supply you receive. See copayment amounts listed in this chart for the service or supply you receive.
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Physician Visits

Away from Home Care	27	\$15 for out of network urgent care in Hawaii \$15 for urgent care from a BlueCard provider outside Hawaii Host plan copayments apply for services from BlueCard providers outside Hawaii if you are enrolled in the Guest Membership Program Please see <i>Chapter 1: Important Information</i> under <i>Care While You are Away From Home</i> for more information
Emergency Room	27	None
Extended Care Facility	27	None
Home	28	\$15

Chapter 3: Summary of Benefits and Your Payment Obligations

more info.
on page:

**Your Copayment Amount Is:
(Copayments are based on eligible charges)**

Inpatient Hospital	28	None
Office	28	\$15
Outpatient Hospital	28	\$15
Surgical Center	28	\$15

Testing, Laboratory, and X-Ray

Allergy Testing	28	\$15 (office visit) \$15 (hospital outpatient) None (hospital inpatient)
Diagnostic Testing	28	None (office visit) None (hospital outpatient) None (hospital inpatient)
Evaluations for the Use of Hearing Aids	28	None (office visit)
Genetic Testing and Counseling	28	None (office visit) None (hospital outpatient) None (hospital inpatient)
Laboratory and Pathology	28	None (office visit) None (hospital outpatient) None (hospital inpatient)
X-rays and Other Radiology	28	\$15 per x-ray (office visit) \$15 per x-ray (hospital outpatient) None (hospital inpatient)

Surgery

Anesthesia	28	\$15 (outpatient professional charges) None (inpatient professional charges)
Assistant Surgeon Services	29	\$15 (outpatient professional charges) None (inpatient professional charges)
Bariatric Surgery	29	\$15 (outpatient professional charges) None (inpatient professional charges)
Oral Surgery	29	\$15 (outpatient professional charges) None (inpatient professional charges)
Surgical Procedures	29	None (outpatient surgical center) \$15 (outpatient professional charges) None (hospital operating room) None (inpatient professional charges)
Tubal Ligation	29	None (outpatient professional charges) None (inpatient professional charges)

Maternity

Artificial Insemination	29	\$15
In Vitro Fertilization	29	20% of eligible charge

Chapter 3: Summary of Benefits and Your Payment Obligations

more info.
on page:

**Your Copayment Amount Is:
(Copayments are based on eligible charges)**

Maternity Care – Delivery	30	None
Maternity Care – Routine Prenatal Visits and Postpartum Visits	30	None
Pregnancy Termination	30	\$15 (outpatient) None (inpatient)

Hospital and Facility Services

Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	30	None
Hospital Ancillary Services	31	None
Hospital Room and Board	31	None (You may owe amounts in addition to your copayment. Please see <i>Chapter 4: Description of Benefits</i> under <i>Hospital and Facility Services – Hospital Room and Board</i> for more information.)
Outpatient Facility	32	None
Private Duty Nursing	32	50% of eligible charge

Emergency Services

Emergency Room Facility Services	32	\$100
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Rehabilitation Therapy Services

Cardiac Rehabilitation	33	\$15 (outpatient)
Intensive Cardiac Rehabilitation	33	\$15 (outpatient)
Physical and Occupational Therapy	33	\$15 (office visit) \$15 (hospital outpatient) None (hospital inpatient)
Pulmonary Rehabilitation	34	\$15 (outpatient) None (inpatient)
Speech Therapy Services	34	\$15 (outpatient) None (inpatient)

Home Health Care and Hospice

Home Health Care	35	None
Hospice Services	35	None
Supportive Care	35	None

Chemotherapy and Radiation Therapy

Chemotherapy – Infusion/Injections	36	\$15 (office visit) \$15 (hospital outpatient) None (hospital inpatient)
Radiation Therapy	36	\$15 (outpatient) None (inpatient)

Chapter 3: Summary of Benefits and Your Payment Obligations

more info.
on page:

**Your Copayment Amount Is:
(Copayments are based on eligible charges)**

Miscellaneous Medical Treatments

Advance Care Planning	36	None
Ambulance (air)	36	20% of eligible charge
Ambulance (ground)	36	20% of eligible charge
Blood and Blood Products	37	20% of eligible charge
Breast Pump	37	None
Contraceptive IUD	37	None
Contraceptive Implants	37	None
Contraceptive Injectables	37	None
Dialysis and Supplies	37	\$15 (hospital outpatient) None (hospital inpatient)
Durable Medical Equipment and Supplies	37	20% of eligible charge
Gender Identity Services	38	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	38	\$15 (office visit) \$15 (hospital outpatient) None (hospital inpatient)
Implanted Internal Items/Implants – Outpatient	38	None
Inhalation Therapy	38	\$15 (office visit) \$15 (hospital outpatient) None (hospital inpatient)
Injections – Other than Self-Administered	38	\$15 (office visit) None (hospital outpatient) None (hospital inpatient)
Injections – Self Administered	39	None
Inter-island Transportation		None
Medical Foods	39	20% of eligible charge
Medical Nutrition Therapy	39	\$15
Orthodontic Services to Treat Orofacial Anomalies	39	None (You may owe amounts in addition to your copayment. Please see <i>Chapter 4: Description of Benefits</i> under <i>Miscellaneous Medical Treatments - Orthodontic Services to Treat Orofacial Anomalies</i> for more information.)
Orthotics and External Prosthetics	39	20% of eligible charge

Chapter 3: Summary of Benefits and Your Payment Obligations

more info.
on page:

**Your Copayment Amount Is:
(Copayments are based on eligible charges)**

Outpatient IV Therapy	40	None
Vision and Hearing Appliances	40	20% of eligible charge

Behavioral Health – Mental Health and Substance Abuse

Applied Behavior Analysis rendered by a Behavior Analyst Recognized by Us	41	None
Hospital/Facility Charges	40	None (hospital outpatient) None (hospital inpatient) (You may owe amounts in addition to your copayment. Please see Chapter 4: Description of Benefits under Behavioral Health – Mental Health and Substance Abuse for more information.)
Physician Visits	40	\$15 (office visit) \$15 (hospital outpatient) None (hospital inpatient)
Psychological Testing	40	None (office visit) None (hospital outpatient) None (hospital inpatient)

Organ and Tissue Transplants

Organ and Tissue Transplants	41	None (outpatient surgical center) \$15 (outpatient professional charges) None (hospital operating room) None (inpatient professional charges)
Organ Donations	43	None (outpatient surgical center) \$15 (outpatient professional charges) None (hospital operating room) None (inpatient professional charges)

Case Management Services

Case Management Services	43	Your copayment amounts vary depending on the type of service. See copayment amounts listed in this chart for the service you receive.
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Chapter 3: Summary of Benefits and Your Payment Obligations

Chiropractic Services

Copayments for **Chiropractic Services** are listed below. Coverage for chiropractic services are covered only when provided through your Complimentary Care Rider and approved by the American Specialty Health Group Inc. (“ASH”). See *Chapter 4: Description of Benefits* for more details.

more info.
on page:

Your Copayment Amount Is
(Copayments are based on the ASH Group eligible charges)

Chiropractic Services

Patient Exam (New or Established)	43	\$15
Office Visit (Follow-up)	43	\$15
X-rays/Radiological Consultations	43	None
Chiropractic – Supports and Supplies	43	Not Covered

CHAPTER

4

This Chapter Covers

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

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Be Sure to Also Read:

- Chapter 1: Important Information
- Chapter 3: Summary of Benefits and Your Payment Obligations

About this Chapter

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

Additional Coverage Mandated by Law

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

Chapter 4: Description of Benefits

Continuity of Care

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

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

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

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

Non-Assignment of Benefits

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

Routine and Preventive

Annual Preventive Health Evaluation (preventive visit)

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

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

Chlamydia (screening)

Covered.

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.

Services are covered in accordance with HMSA’s Diabetes Prevention Program policy and the following are true:

- Services are provided by practitioners who contract with HMSA to provide Diabetes Prevention Program, and
- Services are received in the State of Hawaii

For more details on the program criteria and how to find a provider, please visit our Diabetes Prevention Program page at 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 and Preventive Services Programs

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

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

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

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

Chapter 4: Description of Benefits

Gonorrhea (screening)	Covered.
Gynecological Exam	Covered, for an annual gynecological exam. You may receive an annual gynecological exam from a participating Health Plan Hawaii gynecologist or nurse midwife without a referral. Any services from a provider outside the Health Plan Hawaii network require an administrative review request by your PCP as described in <i>Chapter 1: Important Information</i> .
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 for screening mammography according to the following schedule: <ul style="list-style-type: none">• Age 35 - 39 years of age, one baseline mammogram.• Age 40 years of age or older, one mammogram per calendar year. Please note: Benefits for diagnostic mammography is described in other sections of this chapter under <i>X-rays and Other Radiology</i> .
Prostate Specific Antigen (PSA) Screening Test	Covered. For diagnostic PSA tests, see later in this chapter under <i>Testing, Laboratory, and X-Ray</i> .
Screening Services, Preventive Counseling, and Preventive Services	Covered for the following screenings: <ul style="list-style-type: none">• anemia and lead screening for children• colorectal cancer screening• fecal occult blood test• lipid evaluation• newborn metabolic screening• cervical cancer screening• osteoporosis screening• diabetes screening
	Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following: <ul style="list-style-type: none">• Preventive Counseling• Preventive Services• Screening Laboratory Services:<ul style="list-style-type: none">– 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:<ul style="list-style-type: none">– Screening for Abdominal Aortic Aneurysm– Screening for Osteoporosis in Postmenopausal Women
	Please note: Certain services must have precertification. See <i>Chapter 5: Precertification</i> .
	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 cover 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 <i>Testing, Laboratory, and X-Ray</i> .

Chapter 4: Description of Benefits

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 under *Gynecological Exam*, and in other sections of this chapter under *Surgery* and *Miscellaneous Medical Treatments*.

Vision Exam

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

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

Well-Being Services

HMSA offers a variety of well-being tools, programs and services to take care of you and your family. Visit hmsa.com/wellbeing to find the latest benefits available and to verify your eligibility. Members must meet HMSA's eligibility criteria and guidelines for certain programs.

Well-Child Care

Covered. Well-Child Care means routine and preventive care for children through age twenty-one. Well-Child Care includes:

- office visits for history,
- physical exams,
- sensory screenings,
- developmental/behavioral assessments,
- anticipatory guidance,
- laboratory tests, and
- immunizations as identified on the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care and in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP).

Please note: The AAP Bright Futures recommendations may change. If you need more details about the recommended schedule, please visit our website at www.hmsa.com or call us at one of the phone numbers listed on the back of this Guide.

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:

Chapter 4: Description of Benefits

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

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

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

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

Physician Visits

Away from Home Care

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

Emergency Room - Physician Visits

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

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

Examples of an emergency include:

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

Examples of non-emergencies are:

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

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

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

Extended Care Facility Physician Visits

Covered, when you are in an extended care facility, including physician consultations and visits by a specialty physician.

Chapter 4: Description of Benefits

Home Physician Visits	Covered, including physician consultations and visits by a specialty physician.
Inpatient Hospital Physician Visits	Covered, when you are inpatient at a hospital including physician consultations and visits by a specialty physician. Newborn care is covered in accord with the time periods specified later in the chapter under <i>Maternity and Newborn Length of Stay</i> .
Office Physician Visits	Covered, at a physician's office including physician consultations and visits by a specialty physician.
	<i>Please note:</i> A copayment will not be applied to outpatient miscarriage services.
Outpatient Hospital Physician Visits	Covered, when you are outpatient at a hospital including physician consultations and visits by a specialty physician.
Surgical Center Physician Visits	Covered, when you are in a surgical center, including physician consultations and visits by a specialty physician.

Testing, Laboratory, and X-Ray

Allergy Testing	Covered.
Diagnostic Testing	Covered, for tests to diagnose an illness or injury. Some examples of diagnostic testing include: <ul style="list-style-type: none">• Electroencephalograms (EEG).• Electrocardiograms (EKG or ECG).
Evaluations for the Use of Hearing Aids	Covered.
Genetic Testing and Counseling	Covered, but only if you meet HMSA's criteria. Call us for more details. Our phone number is listed on the back cover of this Guide.
	<i>Please note:</i> Certain services must have precertification. See <i>Chapter 5: Precertification</i> .
	Other services identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations are described under <i>Routine and Preventive, Screening Services, Preventive Counseling, and Preventive Services</i> .
Laboratory Tests	Covered. Some examples of lab tests include: <ul style="list-style-type: none">• Urinalysis• Blood tests• Throat cultures
X-rays and Other Radiology	Covered. Some examples of other radiology include: <ul style="list-style-type: none">• Computerized Tomography Scan (CT Scan).• Nuclear Medicine.• Ultrasound.• Diagnostic mammography.
	<i>Please note:</i> Some radiological procedures must have precertification. See <i>Chapter 5: Precertification</i> .

Surgery

Anesthesia	Certain surgical procedures must have precertification from HMSA. See <i>Chapter 5: Precertification</i> .
	Covered, as required by the attending provider and when appropriate for your condition. Services include: <ul style="list-style-type: none">• General anesthesia.• Regional anesthesia.• Monitored anesthesia when you meet HMSA's high-risk criteria.

Chapter 4: Description of Benefits

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

Assistant Surgeon Services

Covered, when:

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

Bariatric Surgery

Covered, but only if you meet HMSA's criteria and when:

- The facility is located in the state of Hawaii, has a contract with HMSA to perform bariatric surgery and has a comprehensive weight management program; or
- The facility is an approved Blue Distinction Center for bariatric surgery with an agreement for continuity of care in the state where the member primarily resides.

Oral Surgery

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

Reconstructive Surgery

Covered, but only for corrective surgery required to restore, reconstruct, or correct:

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

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

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

Surgical Procedures

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

Tubal Ligation

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

Maternity

Artificial Insemination

Covered.

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

In Vitro Fertilization

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

Chapter 4: Description of Benefits

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

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

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

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

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

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

Maternity Care – Delivery

Covered.

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

Maternity Care – Routine Prenatal Visits and Postpartum Visits

Covered, for:

- routine prenatal visits and,
- postpartum visits.

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

Maternity and Newborn Length of Stay

You have inpatient benefits for maternity as follows:

- 48 hours from time of delivery for a vaginal labor and delivery; or
- 96 hours from time of delivery for a cesarean labor and delivery.

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

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

Pregnancy Termination

Covered.

Hospital and Facility Services

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

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

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

- You are admitted by your PCP.
- Care is ordered and certified by your PCP.
- Care is for skilled nursing care, sub-acute care, or long-term acute care rendered in an extended care facility.

Chapter 4: Description of Benefits

- Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care.
- The confinement is not for custodial care.

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

Services and supplies are covered, including:

- routine surgical supplies,
- drugs,
- dressings,
- oxygen,
- antibiotics,
- blood transfusion services,
- diagnostic and therapy services,
- regular and special diets, and
- general nursing services.

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

Hospital Ancillary Services

Covered. Examples of ancillary services include:

- anesthesia,
- antibiotics and other drugs chemotherapy and radiation therapy,
- general nursing services,
- hemodialysis,
- lab tests,
- oxygen,
- regular and special diets,
- surgical supplies and
- X-rays.

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

Hospital Room and Board

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

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

Chapter 4: Description of Benefits

- Isolation units.
- Operating rooms.
- Newborn nursery care. Covered for the baby's nursery care after birth in accord with the time periods specified in this chapter under *Maternity and Newborn Length of Stay*.

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

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

Outpatient Facility

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

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

Private Duty Nursing

Covered, when:

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

Emergency Services

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

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

Examples of an emergency include:

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

Examples of non-emergencies are:

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

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

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

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You will not receive benefits if you use emergency services for any of these reasons:

- For your convenience.
- During normal office hours for medical conditions that are treatable in a physician's office.

Contacting Your PCP

If you are unable to contact your PCP before you get emergency services, you (or someone acting on your behalf) should contact your PCP to:

- Advise him or her of your condition; and
- Get instructions about follow-up care.

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

Emergencies Outside of Hawaii

For emergencies in another state or country, these guidelines apply:

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

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

How to Access Emergency Services

For emergencies you should do one of the following:

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

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

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

Rehabilitation Therapy Services

Cardiac Rehabilitation

Covered in accord with HMSCA's then current medical policy for cardiac rehabilitation which can be found at www.hmsa.com.

Intensive Cardiac Rehabilitation

Covered in accord with HMSCA's then current medical policy for cardiac rehabilitation which can be found at www.hmsa.com.

Intensive cardiac rehabilitation is a physician or nonphysician practitioner supervised program in the outpatient setting that furnishes cardiac rehabilitation. It has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements.

Please note: Coverage is limited to one cardiac rehabilitation or intensive cardiac rehabilitation program per qualifying event, as defined in HMSCA's then current medical policy.

Physical and Occupational Therapy

Covered in accord with HMSCA's then current 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 HMSCA's current medical policies, therapy services may be 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.

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- 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 HMSCA.
- 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, 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 and diagnosis are covered as described in HMSCA's medical policies for physical and occupational therapy. Information on our policies can be found at www.hmsa.com.

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

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

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 HMSCA's eligibility criteria and guidelines.

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

Speech Therapy Services

Covered in accord with HMSCA's then current 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 HMSCA's current medical policy, speech therapy may be 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 HMSCA's medical policies for speech therapy services. Information on our policies can be found at www.hmsa.com.
- The therapy does not duplicate service from another therapy or available through schools and/or government programs.

Speech therapy services include:

- speech/language therapy,

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

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

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

Home Health Care and Hospice Services

Home Health Care

Covered, when all of these statements are true:

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

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

Hospice Services

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

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

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

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

Supportive Care

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

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

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

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

Please note:

- We cover Supportive Care referral visits during which a patient is advised of Supportive Care options, regardless of whether the referred member is later admitted to Supportive Care.

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- Coverage is limited to 90 calendar days of services in a 12 month period that begins the first day Supportive Care services are provided.

Chemotherapy and Radiation Therapy

Chemotherapy – Infusion/Injections	Covered, including chemical agents and their administration to treat malignancy. Chemotherapy drugs must be FDA approved. Please note: Coverage includes at least one antineoplastic (monoclonal antibodies) drug.
Radiation Therapy	Covered. Please note: Benefits for high-dose chemotherapy, high-dose radiation therapy, or related services and supplies are covered when provided in conjunction with stem-cell transplants. See later in this chapter under <i>Stem-Cell Transplants (including Bone Marrow Transplants)</i> in the section <i>Organ and Tissue Transplants</i> .

Miscellaneous Medical Treatments

Advance Care Planning	Covered.
Ambulance (air)	Covered, for intra-island or inter-island air ambulance services to the nearest, adequate hospital to treat your illness or injury. We will cover your ambulance transportation if the following apply: <ul style="list-style-type: none">• Services to treat your illness or injury are not available in the hospital or nursing facility where you are an inpatient.• Transportation starts where an injury or illness took place or first needed emergency care.• Transportation ends at the nearest facility equipped to furnish emergency care.• Transportation is for the purpose of emergency treatment.• Transportation takes you to the nearest facility equipped to furnish emergency treatment. Please note: Air ambulance is limited to transportation within the state of Hawaii except as described in the next section labeled “ <i>Ambulance (air) – to the Continental United States</i> ”.
Ambulance (air) – to the Continental United States	Covered in certain situations when treatment for critical care is not available in Hawaii and air ambulance transportation to the continental US with life supporting equipment and/or a medical support team is needed. Services are covered in accord with HMSA’s medical policy on air ambulance services which can be found at www.hmsa.com . Please note: Air ambulance services to the continental US must be precertified. See <i>Chapter 5: Precertification</i> .
	Please note: Exclusions or limitations may apply. See <i>Chapter 6: Services Not Covered, Miscellaneous Exclusions</i> .
Ambulance (ground)	Covered, for ground ambulance services to the nearest, adequate hospital to treat your illness or injury. We will cover your ambulance transportation if the following apply: <ul style="list-style-type: none">• 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.

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Blood and Blood Products	<ul style="list-style-type: none">• 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.
Breast Pump	Covered, for blood, blood products, blood bank services, and blood processing including collection, processing and storage of autologous blood for a scheduled surgery when prescribed by a provider whether or not the units are used. You are not covered for any of the following: <ul style="list-style-type: none">• Blood bank processing for blood transfused as an outpatient.• Storage of or lab fees for blood or blood products.• Peripheral stem cell transplants except as described in this chapter under <i>Stem-Cell Transplants (including Bone Marrow Transplants)</i>.
Contraceptive IUD	Covered, for purchase of one device including attachments per pregnancy when purchased from a Health Plan Hawaii Network Provider or Participating Medical Pharmacy that provides medical equipment and supplies. You do not need a referral from your PCP. <i>Please note:</i> Hospital-grade rentals must be precertified. See <i>Chapter 5: Precertification</i> .
Contraceptive Implants	Covered. <i>Please note:</i> Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.
Contraceptive Injectables	Covered. <i>Please note:</i> Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.
Dialysis and Supplies	Covered.
Durable Medical Equipment and Supplies	Covered, but only when prescribed by your treating provider. The equipment must meet all of the following criteria: <ul style="list-style-type: none">• 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 HMSCA 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 HMSCA office listed on the back cover of this Guide for details. Examples of durable medical equipment include: <ul style="list-style-type: none">• oxygen equipment,• hospital beds,• mobility assistive equipment (wheelchairs, walkers, power mobility devices), and

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- insulin pumps.

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

Gender Identity Services

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

The services listed below are covered, but only when deemed medically necessary to treat gender dysphoria. Your copayment may vary depending on the type of service or supply you receive. Copayment amounts are listed in *Chapter 3: Summary of Benefits and Your Payment Obligations*. Benefit details about the service or supply you receive can be found in other sections of this chapter.

- Gender confirmation surgery
- Hospital room and board
- Hormone injection therapy
- Laboratory monitoring
- Other gender confirmation surgery related services and supplies which are medically necessary and not excluded. These include but are not limited to **sexual identification counseling**, pre-surgery consultations and post-surgery follow-up visits
- Otherwise covered services deemed medically necessary to treat gender dysphoria

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

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

Growth Hormone Therapy

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

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

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

Implanted Internal Items/Implants - Outpatient

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

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

Inhalation Therapy

Covered, for inpatient and outpatient inhalation therapy.

Injections – Other than Self-Administered

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

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

Injectable drugs must be FDA approved.

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

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Injections – Self-Administered	<p>Please note: Selected specialty drugs may not be a benefit of this plan. For questions regarding your EUTF specialty drug coverage, please contact the EUTF pharmacy benefit manager.</p> <p>Please note: Certain services must have precertification. See <i>Chapter 5: Precertification</i>.</p> <p>Covered, Injectable drugs must be FDA approved.</p> <p>If you have a drug plan with a similar benefit, there shall be no duplication or coordination of benefits between this Plan and your drug plan.</p> <p>Please note: Self-administered specialty drugs may not be a benefit of this plan. For questions regarding your specialty drug coverage, please contact the EUTF pharmacy benefit manager.</p> <p>Please note: Selected specialty drugs may not be a benefit of this plan. For questions regarding your EUTF specialty drug coverage, please contact the EUTF pharmacy benefit manager.</p> <p>Please note: Certain services must have precertification. See <i>Chapter 5: Precertification</i>.</p>
Inter-island Transportation	<p>Covered, as follows:</p> <ul style="list-style-type: none">• The transportation is for the covered person who requires treatment; and• The transportation is necessary because treatment is not available at your health center but is available on another island in the state of Hawaii. <p>Benefit Limitation: Benefits for inter-island transportation is limited to one round-trip inter-island transportation required for one complete episode of treatment. You are not covered for ground transportation or fees charged by the airlines for cancellation or changes to your reservations. Reimbursement shall be made for the lowest appropriate fare on an inter-island or commercial airline and/or ferry service. Payment will not be made for use of personally owned or privately chartered modes of transportation.</p>
Medical Foods	<p>Covered, to treat inborn errors of metabolism in accord with Hawaii law and HMSA guidelines.</p>
Medical Nutrition Therapy	<p>Covered to treat medical conditions, such as chronic kidney disease, in accord with Hawaii law and HMSA's medical policy on "Medical Nutrition Therapy" which can be found at www.hmsa.com.</p> <p>If you are diagnosed with an eating disorder by a qualified provider, medical nutrition therapy must be rendered by a recognized licensed dietitian.</p> <p>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 <i>Routine and Preventive, Screening Services, Preventive Counseling, and Preventive Services</i>.</p> <p>Please note: Certain services must have precertification. See <i>Chapter 5: Precertification</i>.</p>
Orthodontic Services to Treat Orofacial Anomalies	<p>Covered, to treat orofacial anomalies resulting from birth defects or birth defect syndromes, in accord with Hawaii law and HMSA's medical policy.</p> <p>Benefit Limitation: Benefits are limited to a maximum of \$6,930 per treatment phase.</p> <p>Please note: Services must be precertified. See <i>Chapter 5: Precertification</i>.</p>
Orthotics and External Prosthetics	<p>Orthotics are covered, when prescribed by your treating provider to provide therapeutic support or restore function.</p> <p>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.</p> <p>Examples of orthotics include:</p> <ul style="list-style-type: none">• braces,• orthopedic footwear, and

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- shoe inserts.

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

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

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

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

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

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

Outpatient IV Therapy

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

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

Routine Care Associated with Clinical Trials

Covered in accord with the Affordable Care Act. Coverage is limited to services and supplies provided when you are enrolled in a qualified clinical trial if such services would be paid for by HMAA 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 HMAA office listed on the back cover of this Guide for details.

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

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

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

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

Behavioral Health – Mental Health and Substance Abuse

Covered, if:

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

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

- Epilepsy,

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

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

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

Alcohol or Drug Dependence Treatment

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

Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us

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

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

Autism Spectrum Disorders – Diagnosis and Treatment

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

- Behavioral health treatment. Benefits for Applied Behavior Analysis rendered by a Recognized Behavior Analyst as described more fully in the section labeled "*Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us*".
- Psychiatric care.
- Psychological care.
- Therapeutic care.

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

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

How to Access Services

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

Organ and Tissue Transplants

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

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

- Receive our approval. Without approval for the specified transplants, benefits are not available. Your PCP will get approval for you.
- Be from a facility that:
 - Accepts you as a transplant candidate, and
 - Is located in the State of Hawaii and has a contract with us to perform the transplant, or

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– Is an approved Blue Distinction Center for Transplants. You may call HMSA for a current list of providers

Benefits are not available for:

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

Corneal Transplant Surgery

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

Heart and Lung Transplants

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

Heart Transplants

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

Kidney Transplant Surgery

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

Liver Transplants

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

Lung Transplants

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

Pancreas Transplants

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

Simultaneous Kidney/Pancreas Transplants

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

Small Bowel and Multivisceral Transplants

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

Stem-Cell Transplants (including Bone Marrow Transplants)

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

Transplant Evaluation

Covered, if we approve, for:

- heart,
- heart-lung,
- liver,
- lung,
- pancreas,
- simultaneous kidney/pancreas,
- small bowel and multivisceral, or
- stem-cell transplants.

See *Chapter 5: Precertification*. **Transplant Evaluation** means those procedures, including:

- lab and diagnostic tests,
- consultations, and
- psychological evaluations, that a facility uses in evaluating a potential transplant candidate.

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

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Organ Donations

Organ Donor Services

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

Please note: This coverage is secondary and the living donor's coverage is primary when:

- You are the recipient of an organ from a living donor; and
- The donor's health coverage provides benefits for organs donated by a living donor.

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

Case Management Services

Case Management Services

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

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

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

Chiropractic Services

Chiropractic Services

Covered, in accord with American Specialty Health Group, Inc. ("ASH") which has been contracted by HMSA to administer the benefit through a Complementary Care Rider for the following services. All Definitions, provisions, limitations, exclusions, and conditions of the Complementary Care Rider shall apply to the chiropractic services benefits described in this Guide to Benefits.

- Office Visit - New/Established patient exam
- Follow-up office visits (include manipulation of the spine, joints, and /or musculoskeletal soft tissue, a reevaluation, and/or other services in various combinations).
- Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies covered only when provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- X-rays/radiological consultations when provided by or referred by an in-state or out-of-state ASH In-Network provider to another in-state or out-of-state ASH In-Network provider.

Chapter 4: Description of Benefits

Please note: Chiropractic benefits are available when provided by a participating in-state or out-of-state ASH In-Network provider. The BlueCard Program does not apply to the benefits described in this section and the Complementary Care Rider. For eligibility, benefit, or claim questions, call ASH Group's Customer Service at 1 (888) 981-2746 toll-free Monday through Friday between the hours of 3 a.m. and 6 p.m., and Saturday, between 10 a.m. to 6 p.m. Hawaii Standard Time. Hours adjusted during Daylight Savings Time: Monday through Friday 2 a.m. to 5 p.m. and Saturday 9 a.m. to 5 p.m. Hawaii Standard Time or visit www.ashlink.com/ash/hmsa.

Benefit Limitation and Maximums

- Office visits, no more than 20 visits per calendar year.
- Adjunctive modalities and procedures, when approved by ASH services are available for adjunctive therapy at each office visit.
- If adjunctive therapy is provided without an adjustment, the adjunctive therapy will count as an office visit toward the Benefit Maximum.

Please note: All chiropractic services except for the initial evaluation must be approved by ASH as medically necessary for treatment.

The amounts you pay towards Complementary Care Rider for chiropractic services do not apply toward meeting the medical copayment maximum. You are responsible for these amounts even after you have met the medical copayment maximum.

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Definition

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

Services and Supplies Which Require Precertification

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

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

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

Chapter 5: Precertification

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 Customer Service, and we will help you. We list our phone numbers on the back cover of this Guide.

Counseling Services

Bereavement Counseling

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

Genetic Counseling

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

Chapter 6: Services Not Covered

Marriage or Family Counseling	You are not covered for marriage and family counseling or other training services, except as described in <i>Chapter 4: Description of Benefits</i> . See <i>Behavioral Health – Mental Health and Substance Abuse</i> .
Sexual Orientation Counseling	You are not covered for <i>sexual orientation counseling</i> .

Coverage Under Other Programs or Laws

Military	You are not covered for treatment of an illness or injury related to military service when you get care in a hospital operated by an agency of the U.S. government. You are not covered for services or supplies that are needed to treat an illness or injury received while you are on active status in the military service.
Payment Responsibility	You are not covered when someone else has the legal obligation to pay for your care, and when, in the absence of this coverage, you would not be charged.
Third Party Reimbursement	You are not covered for services or supplies for an injury or illness caused or alleged to be caused by a third party and/or you have or may have a right to get payment or recover damages in connection with the illness or injury. You are not covered for services or supplies for an illness or injury for which you may recover damages or get payment without regard to fault. For more details about third party reimbursement, see <i>Chapter 9: Coordination of Benefits and Third Party Liability</i> .

Dental, Drug, and Vision

Dental Care	You are not covered for dental care under this health coverage except those services listed in <i>Chapter 4: Description of Benefits</i> . Included in this exclusion are dental services that are generally provided only by dentists and not by physicians. The following exclusions apply regardless of the symptoms or illnesses being treated: <ul style="list-style-type: none">Orthodontics except as described in <i>Chapter 4: Description of Benefits</i> under <i>Orthodontic Services to Treat Orofacial Anomalies</i>.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 prescription drugs and supplies.
Eyeglasses and Contacts	Except as described in <i>Chapter 4: Description of Benefits</i> under <i>Miscellaneous Medical Treatments, Vision and Hearing Appliances</i> , you are not covered for: <ul style="list-style-type: none">Exams for a fitting or prescription (including vision exercises).Frames including repair and replacement of frame parts and accessories.Lenses including:<ul style="list-style-type: none">Nonstandard items for lenses including tinting and blending.Oversized lenses, and invisible bifocals or trifocals.Telescopic lenses.Low vision lenses.Corrective low vision lenses.Nonprescription industrial safety goggles.Prescription inserts for diving masks or other protective eyewear.Sunglasses.

Chapter 6: Services Not Covered

Vision Services

You are not covered for:

- Refractive eye surgery to correct visual acuity problems.
- Replacement of lost, stolen or broken lenses, contact lenses or frames.
- Vision training.
- Aniseikonic studies and prescriptions.
- Reading problem studies or other procedures determined to be special or unusual.

Fertility and Infertility

Contraceptives

You are not covered for contraceptive services or contraceptives including diaphragms, cervical caps, oral contraceptives, and other contraceptive methods except as described in *Chapter 3: Summary of Benefits and Your Payment Obligations* and *Chapter 4: Description of Benefits under Miscellaneous Medical Treatments*.

Infertility Treatment

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

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

Sterilization Reversal

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

Provider Type

Complementary and Alternative Medicine Provider

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

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

Dietitian

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

Provider is an Immediate Family Member

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

Provider Nondiscrimination

To the extent an item or service is a Covered Service under this Plan and consistent with reasonable medical management techniques specified under this Plan with respect to the frequency, method, treatment or setting for an item or service, HMAA 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. HMAA is not required to accept all types of providers into its network. And HMAA has discretion governing provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

Chapter 6: Services Not Covered

Social Worker

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

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

Transplants

Living Donor Transport

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

Living Organ Donor Services

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

Mechanical or Non-Human Organs

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

Organ Purchase

You are not covered for the purchase of any organ.

Transplant Services or Supplies

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

Transportation Related to Organ and Tissue Transplants

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

Miscellaneous Exclusions

Act of War

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

Acupuncture

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

Airline Oxygen

You are not covered for airline oxygen.

Ambulance (air)

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

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

Biofeedback

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

Blood

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

Carcinoembryonic Antigen (CEA)

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

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,

Chapter 6: Services Not Covered

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

Complications of a Non-Covered Procedure

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

Convenience Treatments, Services or Supplies

You are not covered for treatments, services or supplies that are prescribed, ordered or recommended primarily for your comfort or convenience, or the comfort or convenience of your provider or caregiver. Such items may include:

- ramps,
- home remodeling,
- hot tubs,
- swimming pools,
- deluxe/upgraded items, or
- personal supplies such as surgical stockings.

Cosmetic Services, Surgery or Supplies

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

Custodial Care

You are not covered for custodial care, sanatorium care, or rest cures. *Custodial Care* consists of training in personal hygiene, routine nursing services, and other forms of personal care, such as:

- help in walking,
- getting in and out of bed,
- bathing,
- dressing,
- eating, and
- taking medicine.

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

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.

Chapter 6: Services Not Covered

Erectile Dysfunction	Refer to Sexual Dysfunction.
Extracorporeal Shock Wave Therapy	You are not covered for extracorporeal shock wave therapy except to treat kidney stones.
False Statements	You are not covered for services and supplies if you are eligible for care only by reason of a fraudulent statement or other intentional misrepresentation that you or the Trust Fund made 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 the Trust Fund are responsible for reimbursing us.
Foot Orthotics	You are not covered for foot orthotics except, under the following conditions: <ul style="list-style-type: none">• Foot orthotics for persons with specific diabetic conditions per Medicare guidelines;• Foot orthotics for persons with partial foot amputations;• Foot orthotics that are an integral part of a leg brace and are necessary for the proper functioning of the brace, and;• Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.
Genetic Testing	You are not covered for genetic tests except as stated in <i>Chapter 4: Description of Benefits</i> under <i>Testing, Laboratory, and X-Ray and Routine and Preventive</i> .
Growth Hormone Therapy	You are not covered for growth hormone therapy except as stated in <i>Chapter 4: Description of Benefits</i> .
Hair Loss	You are not covered for services or supplies related to the prevention and/or treatment of baldness or hair loss regardless of condition. This includes hair transplants and topical medications.
Hypnotherapy	You are not covered for hypnotherapy.
Incontinence Supplies	You are not covered for incontinence supplies including but not limited to pads, diapers, protective underwear, underpads, gloves and wipes.
Intradiscal Electro Thermal Therapy (IDET)	You are not covered for intradiscal electro thermal therapy.
Massage Therapy	Massage therapy is not covered unless rendered as part of an approved rehabilitative therapy treatment plan.
Microprocessor (Upper/Lower Prostheses and Orthoses)	You are not covered for microprocessor or computer controlled, or myoelectric parts of upper and lower limb prosthetic and orthotic devices.
Motor Vehicles	This Plan does not cover the cost to buy or rent motor vehicles such as cars and vans. You are also not covered for equipment and costs related to converting a motor vehicle to accommodate a disability.
Non-Medical Items	You are not covered for durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances, and devices that are not primarily medical in nature. Some examples of non-medical items that are not primarily medical in nature are: <ul style="list-style-type: none">• environmental control equipment or supplies (such as air conditioners, humidifiers, dehumidifiers, air purifiers or sterilizers, water purifiers, vacuum cleaners, or supplies such as filters, vacuum cleaner bags and dust mite covers);• hygienic equipment;• exercise equipment;• items primarily for participation in sports or leisure activities, and• educational equipment.
Non-Related Items Exclusion	You are not covered for any service, procedure, or supply that is directly or indirectly related to a non-covered service, procedure, or supply.
Physical Exams	Physical exams and any associated screening procedures in connection with third party requests or requirements, such as those for: <ul style="list-style-type: none">• employment,• participation in employee programs,• sports,

Chapter 6: Services Not Covered

- camp,
- insurance,
- disability licensing, or
- on court order or for parole or probation are not covered.

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

Private Duty Nursing

You are not covered for outpatient private duty nursing services.

Prohibited by Law

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

Radiation (High-dose)

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

Radiation (Nonionizing)

You are not covered for treatment with nonionizing radiation.

Recreational Therapy

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

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

Repair/Replacement

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

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

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

Reversal of Gender Confirmation Surgery

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

Self-Help or Self-Cure

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

Services Related to Employment

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

Sexual Dysfunction

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

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

Supplies

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

Thoracic Electric Bioimpedance (Outpatient/Office)

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

Chapter 6: Services Not Covered

Topical Hyperbaric Oxygen Therapy	You are not covered for topical hyperbaric oxygen therapy.
Travel or Lodging Cost	You are not covered for the cost of travel or lodging, except as described in <i>Chapter 4: Description of Benefits</i> under <i>Miscellaneous Medical Treatments, Inter-island Transportation</i> .
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: <ul style="list-style-type: none">• vitamins,• minerals,• medical foods or• food supplements except as described in <i>Chapter 4: Description of Benefits</i> under <i>Miscellaneous Medical Treatments</i>.
Weight Reduction Programs	You are not covered for weight reduction programs and supplies, whether or not weight reduction is medically appropriate. This includes: <ul style="list-style-type: none">• 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

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

How to File Claims

One Claim Per Person and Per Provider

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

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

What Information You Must File

Subscriber Number

The subscriber number that appears on your member card.

Provider Statement

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

The provider statement must include:

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

Phone Number

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

Signature

Make sure you sign the claim.

Chapter 7: Filing Claims

Proof of Payment

Make sure you enclose proof of payment.

Other Claim Filing Information

Where to Send Claim

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

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

Keep a Copy

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

Information given to us will not be returned to you.

Report to Member

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

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

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

Cash or Deposit any Benefit Payment in a Timely Manner

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

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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.

Chapter 8: Dispute Resolution

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

If you would like to appeal HMSCA's decision, you must do one of the following:

- If you are appealing an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness; or a determination by HMSCA that the service or treatment is experimental or investigational, you must request review by an Independent Review Organization (IRO) selected by the Insurance Commissioner.
- For all other issues, you must:
 - Request arbitration before a mutually selected arbitrator; or
 - File a lawsuit against HMSCA 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 HMSCA'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 HMSCA's internal appeals process or show that HMSCA 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 HMSCA'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.

Chapter 8: Dispute Resolution

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

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- 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.

Chapter 9: Coordination of Benefits and Third Party Liability

CHAPTER

9

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What Coordination of Benefits Means

Coverage that Provides Same or Similar Coverage

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

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

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

What You Should Do

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

Other coverage includes:

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

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

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

To help us coordinate your benefits, you should:

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

Chapter 9: Coordination of Benefits and Third Party Liability

What We Will Do

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

General Coordination Rules

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

No Coordination Rules

The coverage without coordination of benefits rules pays first.

Member Coverage

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

Active Employee Coverage

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

Earliest Effective Date

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

Dependent Children Coordination Rules

Birthday Rule

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

Court Decree Stipulates

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

Court Decree Does Not Stipulate

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

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

Earliest Effective Date

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

If You Are Hospitalized When Coverage Begins

If You are Hospitalized on the Effective Date of Coverage

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

Motor Vehicle Insurance Rules

Automobile Coverage

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

Chapter 9: Coordination of Benefits and Third Party Liability

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. For more information, contact your employer or the Centers for Medicare & Medicaid Services.

If You are Age 65 or Older

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

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

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

Dual Medicare Eligibility

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

This Plan Secondary Payer to Medicare

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

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

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

Chapter 9: Coordination of Benefits and Third Party Liability

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.
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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.

Chapter 9: Coordination of Benefits and Third Party Liability

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

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

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

Payment of Benefits Subject to Our Right to Recover Our Payments

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

- Settlement, judgment, or award;
- Motor vehicle insurance (other than personal injury protection benefits) including liability insurance or your underinsured or uninsured motorist coverage;
- Workplace liability insurance;
- Property and casualty insurance;
- Medical malpractice coverage; or
- Other insurance.

We shall have a first lien on such recovery proceeds, up to the amount of total benefits we pay or have paid related to the injury or illness. You must reimburse us for any benefits paid out of the corresponding amount of special damages recovered by you, or on your behalf by your legal representative, heirs, or attorney, even if the recovery proceeds obtained by insurance or settlement:

- Do not expressly 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.

If a settlement or insurance recovery is stated to be for general damages only, we must prove that it duplicates our medical expenses paid in order to exercise our right to reimbursement. Our lien will be reduced by a reasonable sum for the attorney's fees and costs incurred by you in bringing a civil action or claim for your injuries.

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 a court or arbitrator determines that we are entitled to reimbursement of payments made on your behalf under HRS § 663-10 and these rules, and we do not promptly receive full reimbursement, we shall have a right to set-off from any future payments payable on your behalf under this Guide to Benefits.

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.

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10

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When Coverage Ends

Notifying Us When Your Child's Eligibility Ends

You must inform the Trust Fund, in writing, if a child no longer meets the eligibility requirements. You must notify the Trust Fund 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 the Trust Fund by July 1.

If you fail to inform the Trust Fund 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.

Notifying Us When Other Events Cause Coverage To End

You must inform the Trust Fund, in writing, if other events occur that end coverage, such as divorce or the dissolution of a domestic partnership.

Termination for Fraud

Your eligibility for coverage will end if you or the Trust Fund use this coverage fraudulently or intentionally misrepresent or conceal material facts in any claim for benefits.

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

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

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

Continuity of Care

Continuing Care Patient

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

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

Chapter 10: General Provisions

- you are under a group health plan and the contract between such group health plan and HMSA is terminated.

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

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

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

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

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

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

No Surprises Act Emergency Services and Surprise Bills

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

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

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

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

Continued Coverage

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 Subscriber Dies

Upon the death of a subscriber, the subscriber’s spouse or domestic partner enrolled in the plan as an eligible dependent, if not eligible for group coverage, may become a subscriber under an individual payment plan. In the event a subscriber’s spouse or domestic partner becomes a subscriber under an individual payment plan, all dependent children of the deceased may continue to be enrolled as members under such individual payment plan.

Chapter 10: General Provisions

Continued Coverage if You have Medicare

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

Confidential Information

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

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

Terms of Coverage

Terms of Coverage

By enrolling in this Plan, you accept and agree to the provisions of the Plan which includes Chapter 87A, Hawaii Revised Statutes and the Trust Fund's administrative rules now in force and as amended in the future. You also appoint the Trust Fund as your administrator for sending and receiving all notices to and from HMSA concerning the Plan.

Authority to Terminate, Amend, or Modify Coverage

The Trust Fund has the authority to modify, amend, or end the coverage provided by this Plan at any time. If the Trust Fund ends this coverage, you are not eligible to receive benefits under this coverage after the termination date.

Governing Law

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

Payment in Error

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

Notice Address

You may send any notice required by this chapter to:

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

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

CHAPTER

11

Actual Charge	The amount a provider bills for a covered service or supply.
Acute Care	Inpatient 24-hour hospital care that needs physician and nursing care on a minute-to-minute, hour-to-hour basis.
Administrative Review	Administrative review is an approval process that is required for services to be rendered by a provider who is located out of state or who does not participate with HMSA.
Admission	The formal acceptance of a patient into a facility for medical, surgical, or obstetric care.
Advance Care Planning	Advance care planning (ACP) prepares members in the event they become very sick. Members discuss with their doctor what matters most to them and document the desired care. ACP becomes important when a member cannot communicate decisions.
Alcohol Dependence	Any use of alcohol that produces a pattern of pathological use that causes impairment in social or occupational functions or produces physiological dependence evidenced by physical tolerance or withdrawal.
Allogeneic Transplant	Transplant in which the tissue or organ for a transplant is obtained from someone other than the person receiving the transplant.
Ambulance Service	Air or ground emergency transport to a hospital.
Ambulatory Surgical Center	A facility that provides surgical services on an outpatient basis for patients who do not need an inpatient, acute care hospital bed.
Ancillary Services	Facility charges other than room or board. For example, charges for inpatient drugs and biologicals, dressings, or medical supplies.
Anesthesia	The use of anesthetics to produce loss of feeling or consciousness, usually with medical treatment such as surgery.
Annual Copayment Maximum	The maximum copayment amounts you pay in a calendar year. Once you meet the copayment maximum you are no longer responsible for copayment amounts unless otherwise noted.
Applied Behavior Analysis	The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of: <ul style="list-style-type: none">• 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.

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Assisting Surgeon	A physician who actively assists the physician in charge during a surgical procedure.
Autologous Transplant	Transplant in which the tissue or organ for a transplant is obtained from the person receiving the transplant.
Away from Home Care	A program sponsored by the Blue Cross and Blue Shield Association. The program offers medical benefits when you need medical care while you are away from your service area (but within the U.S.).
Benefit Maximum	A limit that applies to a specified covered service or supply. A service or supply may be limited by duration or the number of visits. The maximum may apply per service or calendar year.
Benefits	Services and supplies that are medically necessary and qualify for payment under this coverage.
Bereavement Services	Services that focus on healing from emotional loss.
Biofeedback	A technique in which a person uses information about a normally unconscious bodily function, such as blood pressure, to gain conscious control over that function. The condition to be treated must be a normally unconscious physiological function. A device or feedback monitoring equipment (i.e., external feedback loop) must be used to treat the condition. The purpose of treatment is to exert control over that physiological function.
Biological Therapeutics and Biopharmaceuticals	Any biology-based therapeutics that structurally mimic compounds found in the body. This includes: <ul style="list-style-type: none">• recombinant proteins,• monoclonal and polyclonal antibodies,• peptides,• antisense oligonucleotides,• therapeutic genes, and• certain therapeutic vaccines.
Birthing Center	A facility that provides services for normal childbirth. This facility may be in a hospital or it may be a separate, independent facility.
Blood Transfusion	Transferring blood products such as blood, blood plasma, and saline solutions into a blood vessel, usually a vein.
BlueCard Provider	A provider that participates with the Blue Cross and Blue Shield Association. BlueCard participating providers file claims for you and accept the eligible charge as payment in full.
Breast Prostheses (External)	Artificial breast forms intended to simulate breasts for women who have uneven- or unequal-sized breasts who decide not to, or are waiting to, undergo surgical breast reconstruction after a covered mastectomy or lumpectomy. They include: <ul style="list-style-type: none">• mastectomy bras (surgical bras),• forms,• garments and• sleeves.
Calendar Year	The period starting January 1 and ending December 31 of any year. The first calendar year for anyone covered by this Plan begins on that person's effective date and ends on December 31 of that same year.
Cardiac Rehabilitation	A comprehensive medically supervised program in the outpatient setting that aims to improve the function of patients with heart disease and prevent future cardiac events.

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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.
Child	Means any of the following: your son, daughter, stepson or stepdaughter, your legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian, or your eligible foster child (defined as an individual who is placed with you by an authorized placement agency or by judgment, decree or other court order).
Chiropractor	A health care professional who practices the system of healing through spinal manipulation and specific adjustment of body structures.
Claim	A written request for payment of benefits for services covered by this coverage.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 that offers you and your eligible dependents continuation of this coverage if you lose coverage due to a qualifying event.
Consultation Services	A formal discussion between physicians on a case or its treatment.
Contact Lenses	Ophthalmic corrective lenses ground as prescribed by a physician or optometrist who fit the lenses directly to your eyes.
Contraceptive Services	Services that facilitate the use of contraceptives to prevent pregnancy.
Contraceptives	Any prescription contraceptive supplies or devices, including: <ul style="list-style-type: none">• oral medicine,• implants,• injectables,• IUDs or• other appropriate methods intended 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. It is either a fixed percentage of the eligible charge or a fixed dollar amount. Exception: For services provided at a participating facility, your copayment is based on the lower of the facility's actual charge or the maximum allowable fee. You owe a copayment even if the facility's actual charge is less than the maximum allowable fee.
Cosmetic Services	Services that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function, or are prescribed for psychological or psychiatric reasons.
Covered Services	Services or supplies that meet payment determination criteria and are: <ul style="list-style-type: none">• Listed in this Guide in <i>Chapter 4: Description of Benefits</i>, and• Not listed in this Guide in <i>Chapter 6: Services Not Covered</i>.
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: <ul style="list-style-type: none">• plastic,• metal,• leather, or• cloth in the form of sheets, bars, etc.

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It	<p>It involves substantial work such as:</p> <ul style="list-style-type: none">• vacuum forming,• cutting,• bending,• molding,• sewing, etc.
It	<p>It may involve the incorporation of some prefabricated components but it involves more than:</p> <ul style="list-style-type: none">• trimming,• bending, or• making other modifications to a substantially prefabricated item.
Deluxe/Upgraded Items	Items that have certain convenience or luxury features that enhance standard or basic equipment. Standard equipment is equipment that meets the medical needs of a patient to perform activities of daily living primarily in the home and is not designed or customized for a specific individual's use.
Dependent	The subscriber's spouse or domestic partner and/or eligible child(ren) who are eligible to enroll in the Plan under Chapter 87A, Hawaii Revised Statutes, and the Trust Fund's administrative rules, which may be amended from time to time.
Detoxification Services	A process of detoxifying a person who is dependent on alcohol and/or drugs. The process involves helping a person through the period of time needed to get rid of, by metabolic or other means, the intoxicating alcohol or drug dependency factors.
Diagnosis	The medical description of the disease or condition.
Diagnostic Testing	A measure used to help identify the disease process and signs and symptoms.
Directory of Health Centers and Providers	A complete listing of HPH health centers and network providers.
Drug	Any chemical compound that may be used on or given to help diagnose, treat or prevent disease or other abnormal condition, to relieve pain or suffering, or to control or improve any physiologic or pathogenic condition.
Drug Dependence	Any pattern of pathological use of drugs that cause impairment in social or occupational function and produces psychological or physiological dependence or both, as evidenced by physical tolerance or withdrawal.
Dues	The monthly premium amount for HPH membership.
Durable Medical Equipment	An item that meets these criteria: <ul style="list-style-type: none">• 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: <ul style="list-style-type: none">• oxygen equipment,• hospital beds,• mobility assistive equipment (wheelchairs, walkers, power mobility devices), and• insulin pumps.
Effective Date	The date on which you are first eligible for benefits under this coverage.

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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. HMSCA's payment, and your copayment, are based on the eligible charge. <u>Exception:</u> For services from participating facilities, HMSCA'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: <ul style="list-style-type: none">• 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.
Employee	An Active employee who is eligible to enroll in this Plan under Chapter 87A, Hawaii Revised Statutes, and the Trust Fund's administrative rules, which may be amended from time to time.
Extended Care Facility	A facility that provides ongoing skilled nursing care, sub-acute care, or long-term acute care as ordered and certified by your attending Provider.
Facility	Examples include hospitals, extended care facilities, birthing centers, and ambulatory surgical facilities
False Statement	Any fraudulent or intentional misrepresentation you or the Trust Fund made for membership or in any claims for benefits.
Family Coverage	Means coverage is for you the subscriber, and two or more eligible, dependent children.
Family Member	The subscriber's spouse or domestic partner and/or children who are eligible and enrolled in the Plan.
Foot Orthotics	Devices that are placed into shoes to assist in restoring or maintaining normal alignment of the foot, relieve stress from strained or injured soft tissues, bony prominences, deformed bones and joints and inflamed or chronic bursae.
Frame	An eyeglass frame or similar frame into which two lenses are fitted.
Gender Dysphoria	The distress experienced when a person's gender assigned at birth does not match their gender identity.
Gender Identity	A person's internal sense of being male, female, a gender different from the gender assigned at birth, a transgender person, or neither male nor female.
Gender Transition	The process of a person changing the person's outward appearance, including sex characteristics, to accord with the person's gender identity.
Group	Those members who share a common relationship such as employment or membership.
Guest Membership	Pearranged membership from an HMO Host Plan offered by the Blue Cross and/or Blue Shield plan in the service area where you require services.
Guide to Benefits	This document, along with any riders or amendments that provide a written description of your health care coverage.

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HMSA	Hawai‘i Medical Service Association, an independent licensee of the Blue Cross and Blue Shield Association.
High-Dose Chemotherapy	A form of chemotherapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a stem-cell transplant is needed.
High-Dose Radiotherapy	A form of radiation therapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a stem-cell transplant is needed.
Home Health Agency (HHA)	An approved agency that provides skilled nursing care in your home.
Home Infusion Therapy	Treatment in the home that involves giving nutrients, antibiotics and other drugs and fluids intravenously or through a feeding tube. Drugs must be FDA approved.
Homebound	Due to an illness or injury, you are unable to leave home, or leaving your home requires a large and taxing effort.
Hospice Program	A program that provides care in a comfortable setting for patients who are terminally ill and have a life expectancy of six months or less. Care is normally provided in the patient's home.
Hospital	An institution that provides diagnostic and therapeutic services for surgical and medical diagnosis, treatment and care of injured or sick persons.
Illness or Injury	Any bodily disorder, injury, disease or condition, including pregnancy and its complications.
Immediate Family Member	Your child, spouse, domestic partner, parent, or yourself.
Immunization	An injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.
Implanted Internal Items/Implants (Surgical/Orthopedic)	Internal prosthetic devices used during surgery that are necessary for anatomical repair or reconstructive purposes. These devices remain in the body and replace a missing biological structure or support or enhance a damaged biological structure. Examples include, but are not limited to: <ul style="list-style-type: none">• cardiac pacemakers,• defibrillators,• heart valves and stents,• breast implants for post-mastectomy reconstruction,• hip and knee replacements,• hardware necessary to anchor fractured bones,• implanted cataract lenses,• cochlear implants,• adjustable gastric bands for bariatric surgery, and• human tissue. The device must be FDA-approved for the purpose it is being used.
In Vitro Fertilization	A method used to treat infertility in women.
Incidental Procedure	A procedure that is an integral part of another procedure. Such procedures are not reimbursed separately.
Inhalation Therapy	Therapy to treat conditions of the cardiopulmonary system.

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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.
Intensive Cardiac Rehabilitation	A physician or nonphysician practitioner supervised program in the outpatient setting that furnishes cardiac rehabilitation. It has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements.
Intravenous Injection	An injection made into the vein.
Laboratory Services	Services used to help diagnose, prevent, or treat disease.
Lenses	Ophthalmic corrective lenses ground as prescribed by a physician or optometrist for fitting into a frame.
Limited Services	Those covered services that are limited per service, per episode, per calendar year or per lifetime.
Long-Term Acute Care	A level of care for patients who: <ul style="list-style-type: none">• no longer require care in an acute hospital,• are chronically and severely ill,• are felt to have the potential for improvement, and• require an intensity and specialization of care that is beyond that provided in any other level of post-acute care. Examples include: <ul style="list-style-type: none">• skilled nursing facility,• home healthcare,• inpatient rehabilitation facility, and• for a limited period until the condition is stabilized or a predetermined treatment course is completed.
Mammogram	An x-ray exam of the breast using equipment dedicated specifically for mammography.
Mammography (screening)	An x-ray film that screens for breast abnormalities.
Maternity Care	Routine prenatal visits, delivery, and postpartum visits.
Maximum Allowable Fee	The maximum dollar amount HMSA will pay for a covered service, supply, or treatment.
Medicaid	A form of public assistance sponsored jointly by the federal and state governments providing medical assistance for eligible persons whose income falls below a certain level. The Hawaii Department of Human Services pursuant to Title XIX of the federal Social Security Act administers this program.
Medication	The treatment of disease without surgery.
Medicine	To diagnose and treat disease and to maintain health.
Member	The subscriber and the subscriber's eligible dependents enrolled in the plan.
Member Card	Your member card issued to you by us. You must present this card to your provider at the time you get services.

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Mental Health Outpatient Facility	A mental health clinic, institution, center, or community mental health center that provides for the diagnosis, treatment, care or rehabilitation of people who are mentally ill.
Mental Health Illness/Disorder	A syndrome of clinically significant psychological, biological, or behavioral abnormalities that result in personal distress or suffering, impairment of capacity to function, or both. Mental health illness and disorder are used interchangeably in this Guide and as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or in the International Classification of Disease.
Microprocessor-Controlled Prosthetic Device	Prosthetic devices that use feedback from sensors to adjust joint movement on a real-time as-needed basis.
Myoelectric Prosthetic Device	Prosthetic devices powered by electric motors with an external power source. For example, the movement of an upper limb prosthesis (e.g., hand, wrist, and/or elbow) is driven by micro-chip-processed electrical activity in the muscles of the remaining limb stump.
Network Provider	All providers represented in all health centers that have contracted with Health Plan Hawaii to care for its members.
Newborn	A recently born infant.
Newborn Care	All routine non-surgical physician services and nursery care provided to a newborn during the mother's initial hospital stay.
Non-Assignment	When benefits for covered services and supplies cannot be transferred or assigned to anyone for use.
Non-Network Provider	A provider that is not under contract with HMSA to treat Health Plan Hawaii members.
Nurse Midwife	A health care professional who provides services such as pre and post natal care, normal delivery services, routine gynecological services, and any other services within the scope of his or her certification.
Occupational Therapy	A form of therapy involving the treatment of neurological and musculoskeletal dysfunction through the use of specific tasks or goal-directed activities designed to improve the functional performance of an individual.
Online Care	Care provided by video conferencing, phone or web if obtained from HMSA Online.
Ophthalmologist	A physician specializing in the diagnosis and treatment of diseases and defects of the eye.
Optometrist	One who specializes in the examination, diagnosis, treatment and management of diseases and disorders of the visual system, the eye and related structures.
Oral Surgeon	A dentist licensed as a doctor of dentistry (D.M.D.) or dental surgery (D.D.S.) to diagnose and treat oral conditions that need surgery.
Organ Donor Services	Services related to the donation of an organ.
Orofacial Anomalies	Cleft lip or cleft palate and other birth defects of the mouth and face affecting functions such as eating, chewing, speech, and respiration.

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Orthodontic Services to Treat Orofacial Anomalies	Direct or consultative services from a licensed dentist with a certification in orthodontics by the American Board of Orthodontics.
Orthotics/Orthotic Devices/Orthoses	Rigid or semi-rigid devices that are used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a diseased or injured part of the body. They must provide support and counterforce (i.e., a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace. An orthotic can be either prefabricated or custom-fabricated.
Osteopathy	Medicine that specializes in diseases of the bone.
Other Providers	Health care providers other than facilities and practitioners. Examples include hospice agencies, ambulance services, retail pharmacies, home medical equipment suppliers, and independent labs.
Our	Reference to HMSA (Hawai‘i Medical Service Association).
Outpatient	Care received in a practitioner's office, the home, an ambulatory infusion suite, the outpatient department of a hospital or ambulatory surgery center.
Participating Medical Pharmacy	A participating retail pharmacy that also contracts with us to provide items that are covered under this plan such as medical equipment and supplies.
Physical Therapy	A form of therapy involving treatment of disease, injury, congenital anomaly or prior therapeutic intervention through the use of therapeutic modalities and other interventions that focus on a person's ability to go through the functional activities of daily living and on alleviating pain.
Physician	A medical doctor (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.).
Physician Assistant	A practitioner who provides care under the supervision of a physician.
Physician Services	Professional services necessarily and directly performed by a doctor to treat an injury or illness.
Plan	This health benefits plan, including hospital and medical coverage, as defined in this Guide to Benefits. The Plan is subject to Chapter 87A, Hawaii Revised Statutes, and the Trust Fund's administrative rules, which may be amended from time to time. The Trust Fund may modify or amend the terms and conditions of the Plan from time to time.
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.

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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.
Preoperative Care	Care that occurs, is performed, or is administered before, and usually close to, a surgical operation.
Prescription	The instructions written by a provider with statutory authority to prescribe directing a pharmacist to dispense a particular drug in a specific dose.
Primary Care Provider (PCP)	The provider you choose within your health center to act as your personal health care manager, and who renders general medical care focusing on preventive care and treatment of routine injuries and illnesses.
Private Duty Nursing	24-hour nursing services by an approved nurse who is dedicated to one patient.
Prosthetic Appliances	Devices used as artificial substitutes to replace a missing natural part of the body and other devices to improve, aid, or increase the performance of a natural function.
Provider	A physician or other practitioner, facility, or other health care provider, such as an agency or program, recognized by us.
Psychological Testing	A standard task used to assess some aspect of a person's cognitive, emotional, or adaptive function.
Psychologist	An approved provider who specializes in the treatment of mental health conditions.
Radiology	The use of radiant energy to diagnose and treat disease.
Referral	When your PCP determines that your condition requires the services of a specialist, he or she will arrange for you to get treatment from the appropriate provider.
Registered Bed Patient	A person who is registered by a hospital or extended care facility as an inpatient for an illness or injury covered by this Guide.
Report to Member	The report you get from us that notes how we applied benefits to a claim. You may get copies of your report online through My Account on hmsa.com or by mail upon request.
Service Area	The island or islands of Hawaii where the health center operates its facilities (excluding Hana, Maui) and where you reside.
Sexual Identification Counseling	Psychotherapy for a person with gender dysphoria.
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 subscriber only.
Skilled Nursing Care	A level of care for patients who require skilled nursing and/or rehabilitation care, i.e., services that must be performed by or under the supervision of professional or technical personnel, on a daily basis.

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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	The subscriber's husband or wife as the result of a marriage who is legally recognized in the State of Hawaii. For purposes of this Guide to Benefits, "spouse" also includes an Employee's domestic partner who is eligible to enroll in the Plan under the Trust Fund's administrative rules.
Sub-Acute Care	A level of care for patients who no longer require care in an acute hospital and require more intensive skilled care that is beyond that traditionally provided in a skilled nursing facility, e.g., require frequent and recurrent patient assessment and review of clinical course and treatment plan.
Subscriber	The person who meets eligibility requirements and who executes the enrollment form that is accepted in writing by the Trust Fund. It does not include anyone enrolled in the plan as an eligible dependent.
Subscriber Number	The number that appears on your HPH member card.
Substance Abuse Services	Providing medical, psychological, nursing, counseling, or therapeutic services as treatment for alcohol or drug dependence or both. Services may include aftercare and individual, group and family counseling services.
Supportive Care	A comprehensive approach to care for members with a serious or advanced illness including Stage 3 or 4 cancer, advanced Congestive Heart Failure (CHF), advanced Chronic Obstructive Pulmonary Disease (COPD), or any advanced illness that meets the requirements of the Supportive Care policy. Members get comfort-directed care, along with curative treatment from an interdisciplinary team of practitioners.
Surgical Services	Cutting, suturing, diagnostic, and therapeutic endoscopic procedures; debridement of wounds, including burns; surgical management or reduction of fractures and dislocations; orthopedic casting manipulation of joints under general anesthesia or destruction of localized surface lesions by chemotherapy cryotherapy, or electrosurgery.
Third Party Liability	Our rights to reimbursement when you or your family members get benefits under this coverage for an illness or injury and you have a lawful claim against another party or parties for compensation, damages, or other payment.
Transgender Person	A person who has gender identity disorder or gender dysphoria, received health care services related to gender transition, adopts the appearance or behavior of the opposite sex, or otherwise identifies as a gender different from the gender assigned to that person at birth.
Transplant	The transfer of an organ or tissue for grafting into another area of the same body or into another person.
Treatment	Management and care of the patient to combat a disease or disorder.
Trust Fund	Hawaii Employer-Union Health Benefits Trust Fund (EUTF). The trust fund has executed an Agreement with us to administer a health benefits plan covering eligible members.

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Tubal Ligation	A sterilization procedure for women.
Urgent Care	When you require medical care for an unexpected illness or injury that is not life threatening but cannot be reasonably postponed until your return to your service area.
Us	HMSA (Hawai‘i Medical Service Association).
Vasectomy	A sterilization procedure for men.
Vision Services	Services that test eyes for visual acuity and identify and correct visual acuity problems with lenses and other equipment.
We	HMSA (Hawai‘i Medical Service Association).
Well-Being Services	A variety of well-being tools, programs and services to take care of you and your family. Visit hmsa.com/wellbeing to find the latest benefits available to our members.
You and Your Family	You and your family members enrolled in this plan and eligible for this coverage.

Serving you

Meet with knowledgeable, experienced health plan advisers. We'll answer questions about your health plan, give you general health and well-being information, and more. Hours of operation may change. Please go to hmsa.com/contact before your visit.

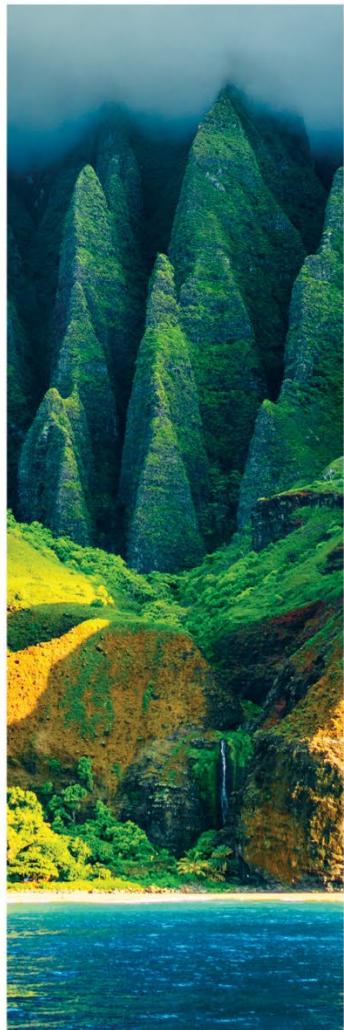
HMSA Center in Honolulu

818 Keeaumoku St.
Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m.



HMSA Center in Pearl City

Pearl City Gateway | 1132 Kuala St., Suite 400
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.



HMSA Center in Hilo

Waiakea Center | 303A E. Makaala St.
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center in Kahului

Puunene Shopping Center | 70 Hookele St.
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center in Lihue

Kuhio Medical Center | 3-3295 Kuhio Highway, Suite 202
Monday–Friday, 8 a.m.–4 p.m.

Contact HMSA. We're here with you.

Call (808) 948-6499 or 1 (800) 776-4672.

hmsa.com/EUTF



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

