HMSA QUEST
Member Handbook

Effective June 2025

hmsa

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Welcome

HMSA QUEST

Welcome to HMSA QUEST. We're proud to be part of the Hawaii QUEST program. Your plan is a health maintenance organization (HMO) plan.

This is your member handbook. It has details about your medical plan. It tells you how to use its benefits. It also tells you what you need to know about preventive health services and programs. Please take some time to read your handbook. After you review it, be sure to keep it for your records. You can also find this handbook on our website at hmsa.com/quest.

Call us to request a printed copy of the handbook. We'll send it to you within five business days from when we receive your request. It will be sent to you at no cost.

Thank you for choosing HMSA.

Discrimination is against the law

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

Services HMSA provides

HMSA offers the following services to support people with disabilities and those whose primary language is not English. There is no cost to you.

- Qualified sign language interpreters are available for people who are deaf or hard of hearing.
- Large print, audio, braille, or other electronic formats of written information is available for people who are blind or have low vision.
- Language assistance services are available for those who have trouble with speaking or reading in English. This includes:
  - Qualified interpreters.
  - Information written in other languages.

If you need modifications, appropriate auxiliary aids and services, or language assistance services, please call 1 (800) 440-0640 toll-free or TTY 1 (877) 447-5990 toll-free.

How to file a grievance or complaint

If you believe HMSA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- Phone: 1 (800) 462-2085 toll-free
- TTY: 1 (877) 447-5990 toll-free
- Email: GA_Help@hmsa.com
- Fax: (808) 952-7546
- Mail: HMSA QUEST
  Attn: Grievance Coordinator
  P.O. Box 860
  Honolulu, HI 96808-0860

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.

This notice is available at HMSA's website: https://hmsa.com/non-discrimination-notice/.

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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
PAHIBALO: Kung dili English ang imong pinulongan, magamit nimo ang mga serbisyo sa tabang sa pinulongan nga walay bayad. Ang mga auxiliary nga tabang ug serbisyo anaa sab aron mohatag og impormasyon kanimo sa daling ma-access nga mga format nga walay bayad. Mga membro sa QUEST, tawag sa 1 (800) 440-0640 toll-free, TTY 1 (877) 447-5990, o pakig-istorya sa imong provider. Mga membro sa Medicare Advantage ug commercial plan, tawag sa 1 (800) 776-4672 o TDD/TTY 1 (877) 447-5990.

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 lengguahe. 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, wenno makisaritaka iti provider-yo. Dagiti miembro ti Medicare Advantage ken plano a pang-komersio, tawaganyo ti 1 (800) 776-4672 wenno 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**までお電話いただくか、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**までお電話いただくか、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
ຊຶ່ນຊາບ: ຖ້າທ່ານບໍ່ເວົ້າພາສາອັງກິດແມ່ນມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍພ້ອມໃຫ້ທ່ານ. ນອກຈາກນັ້ນກໍ່ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມເພື່ອໃຫ້ຂໍ້ມູນແກ່ທ່ານໃນຮູບແບບທີ່ ເຊົ້າເຖິງໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ສະມາຊິກ QUEST ແມ່ນໂທບໍ່ເສຍຄ່າໄດ້ທີ່ ເບີ 1 (800) 440-0640, TTY 1 (877) 447-5990 ຫຼື ປຶກສາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.ສະມາຊິກແຜນ ປະກັນ Medicare Advantage ແລະ ຊັ້ນທຸລະກິດ, ໂທ 1 (800) 776-4672 ຫຼື TDD/TTY 1 (877) 447-5990.

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Kajin Ṃajōḷ
KŌJELLA: Ñe 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 kōjrbal 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 kōjerbal injuran ko rej make wia, kall e 1 (800) 776-4672 ñe ejab TDD/TTY 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. Medicare Advantage me mwengei en kaiahn Pohnpei, kohdo mwengei 1 (800) 776-4672 me TDD/TTY 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/TTY 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/TTY 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/TTY 1 (877) 447-5990.

ไทย
โปรดให้ความสนใจ: หากท่านไม่พูดภาษาอังกฤษ เรามีบริการให้ความช่วยเหลือทางภาษาแก่ท่านโดยไม่มีค่าใช้จ่าย และยังมีความช่วยเหลือและบริการเสริมเพื่อให้ข้อมูลแก่ท่านในรูปแบบที่เข้าถึงได้โดยไม่มีค่าใช้จ่าย สำหรับสมาชิก QUEST โปรดโทรไปที่หมายเลขโทรฟรีที่หมายเลข 1 (800) 440-0640, TTY 1 (877) 447-5990 หรือพูดคุยกับผู้ให้บริการของคุณ สำหรับสมาชิก Medicare Advantage และแผนเชิงพาณิชย์ โปรดโทรไปที่หมายเลข 1 (800) 776-4672 หรือ TDD/TTY 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/TTY 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 aninis 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 aninis. Medicare Advantage ika chon apach non ekoch otot, kekeri 1 (800) 776-4672 ika TDD/TTY 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/TTY 1 (877) 447-5990.

Our Values

Our goal is to provide you with the best health plan we can. Here is how we work to meet that goal:

- Build and maintain mutually respectful relationships with our members and doctors. This helps promote effective, quality health care and services for our members.
- Focus on wellness and prevention. This helps keep our members healthy. It also lowers the risk of illness when it occurs. It can make managing a condition less complex.
- Offer services that help our members get well when they're sick.
- Hold network doctors to our standards.
- We aim to select doctors who:
  - Deliver quality health care.
  - Score high in patient care.
- Inform our members.
  - We do our best to explain how your health plan works.
  - We tell you how network doctors are paid.
- Explain how monitoring use supports good health care.
- Give our members and doctors rights to:
  - Voice grievances.
  - Appeal decisions.
  - Receive timely replies from us.
- Encourage health care decision making based on appropriate care and service and existence of coverage. Financial incentives are in place to encourage appropriate decisions on care.
- Do not reward doctors or others to deny care that you may need.
- Do not reward our employees with money for denying care our members need.

We Want to Hear from You

What you have to say is important to us. Please call or write to us if you have comments or suggestions about our programs, polices, or procedures.

How to Contact Us

General Questions for HMSA

You can reach us at the phone numbers and addresses listed in this chapter. Please feel free to call us with any questions. We're here to help you. Your questions may be about any of the following or another subject related to HMSA QUEST:

- Benefits.
- Claims.
- How to get care.
- Your handbook.
- A list of providers, including how to request a printed provider directory and access the directory online.
- How to get this handbook in a different format. For example, written in another language, shown in a larger text, or in audio format.
- How we do business, how we work, or how we are organized.

Behavioral Health Questions

If you have a behavioral health question, call us and ask to speak to a behavioral health care coordinator at:

- (808) 948-6997
- 1 (844) 223-9856 toll-free

Call Us

Our office hours are Monday through Friday, 7:45 a.m. to 4:30 p.m., but you can reach us by phone 24 hours a day. The phone numbers listed here also appear at the bottom of each page. Use these phone numbers to contact us except when we give you a unique number to call. When these general numbers apply, your handbook will say, "call us." When a unique number applies, the actual number will appear in the text that describes the situation.

- (808) 948-6486.
- 1 (800) 440-0640 toll-free.
- TTY users: 1 (877) 447-5990 toll-free

Visit Our Website

hmsa.com.

HMSA CENTERS

Visit one of our HMSA Centers with convenient locations and hours.

Honolulu, Oahu
818 Keeaumoku St.
Monday through Friday, 8 a.m.-5 p.m.
Saturday, 9 a.m.-2 p.m.

Pearl City, Oahu
Pearl City Gateway
1132 Kuala St., Suite 400
Monday through Friday, 9 a.m.-6 p.m.
Saturday, 9 a.m.-2 p.m.

Hilo, Hawaii Island
Waiakea Center
303A E. Makaala St.
Monday through Friday, 9 a.m.-6 p.m.
Saturday, 9 a.m.-2 p.m.

Kahului, Maui
Puunene Shopping Center
70 Hookele St., Suite 1220
Monday through Friday, 8 a.m.-5 p.m.
Saturday, 9 a.m.-1 p.m.

Lihue, Kauai
3-3295 Kuhio Highway, Suite 202
Monday through Friday, 8 a.m.-4 p.m.

Mail

HMSA QUEST
P.O. Box 3520
Honolulu, HI 96811-3520

Medication Assisted Treatment (MAT)

If you need help with getting treatment for substance use, contact HMSA's Behavioral Health Program. We can help you find a MAT provider and can also coordinate your services.

MAT uses a whole-person approach. The program combines medications, counseling, and behavior therapies for treating substance use disorders (SUD).

HMSA Behavioral Health
(808) 695-7700 or 1 (855) 856-0578 toll-free
Monday-Friday, 7:45 a.m.-4:45 p.m.

If You are Hearing or Speech Impaired

If you are a TTY user, call 1 (877) 447-5990 toll-free. Or let us know and we can provide sign language interpretation free of charge.

If You Speak a Different Language

If you need interpretation services or need your health plan information translated, please call us. This service is free of charge.

Questions for the Hawaii Department of Human Services (DHS)

If you have questions about your QUEST membership, please contact DHS.

Call DHS If:

- You need to report any changes to your eligibility for medical and dental coverage.
- You want to check on the status of your QUEST application.
- You have questions about your eligibility for QUEST because you got married or moved to another island.
- You just got a full-time job and want to know if you're still eligible for QUEST.
- You don't know if your QUEST membership was canceled.

Call Med-QUEST Customer Service

1 (800) 316-8005 toll-free
Hawaii Relay Service 711
For hearing impaired, deaf, and speech impaired
Fax: 1 (800) 576-5504
Mail: P.O. Box 3490
Honolulu, HI 96811-3490

Visit the Med-QUEST Service Center nearest you.

Hawaii
East Hawaii
1404 Kilauea Ave.
Hilo, HI 96720

West Hawaii
75-5591 Palani Road
Suite 3004
Kailua-Kona, HI 96740

Kauai
4473 Pahee St., Suite A
Lihue, HI 96766

Maui
210 Imi Kala St., Suite 101
Wailuku, HI 96793

Molokai
65 Makaena St., Room 110
Kaunakakai, HI 96748

Lanai
730 Lanai Ave.
Lanai City, HI 96763

Oahu
Honolulu
1350 S. King St., Suite 200
Honolulu, HI 96814

Kapolei
601 Kamokila Blvd., Suite 415
Kapolei, HI 96707

Waipahu
94-275 Mokuola St., Suite 301
Waipahu, HI 96797

How to Ask for an Authorized Representative

If you'd like your doctor or someone else to be able to talk to HMSA for you, you need to give us your consent.

Fill out and sign an Authorization to Request or Release Member Information form and send it to us. You can get a copy of the form on our website at hmsa.com. Or you can call us, and we'll send you a copy. Call us if you need help filling out the form.

Frequently Asked Questions

Here are some frequently asked questions about HMSA QUEST. Contact information appears earlier in this chapter.

WHO TO CALL		
Question	**DHS**	**HMSA**
What's going on with my QUEST application?	x	
I got a full-time job. Am I still eligible for QUEST?	x	
Do I have to pay a premium?	x	
Why was my QUEST membership canceled?	x	
I just got married or pregnant or I moved.	x	x
Does my HMSA QUEST plan cover my child?		x
What services does my HMSA QUEST plan pay for?		x
I want to change my primary care provider (PCP).		x
I need to see a doctor, but I don't know who my PCP is.		x
My claim wasn't paid.		x

Membership

Your Membership Card

When you join HMSA QUEST, we'll send you an HMSA QUEST membership card. If you lose your card, call us and we'll send you a new one. Or, you can order a new card online. Go to hmsa.com/my-account, register to create an account, and request a new card. You'll also get a new card if your plan changes in some way. If we send you a new card, throw away the old one. Replacement cards are sent within 10 days after you choose a PCP or if a PCP is auto-assigned to you.

When you get your card in the mail, check to see if it is correct. If you need to make changes, please call us.

Always carry your card with you.

The front of your card contains important information, such as:

- Your name.
- Your member number.
- The date your QUEST coverage began.
- Your benefit plan.
- Special information about your plan, including limits and benefits. For example, access to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.
- The name of your primary care provider (PCP), phone number, and the date you were assigned to your PCP, which is the "PCP Effective Date."
- Information about other health plans you may have. This appears in the TPL section of your card with a YES or NO indicator. TPL stands for third-party liability. If you have other health insurance, the other plan is primary. Your QUEST plan is secondary. You must use your primary plan first for payment before any QUEST claims will be paid. If you don't use your primary plan first, you may have to pay for the services you get.

The back of your card contains:

- 24-hour call center and nurse line telephone numbers.

Information You Must Report to HMSA and DHS

You must tell us and DHS about any changes that may affect your QUEST membership and require a change to the information on your membership card. Here are some examples of when you need to contact us:

- Change to your name.
- Change to mailing address or phone number.
- Change to your PCP.
- Move to a different island.
- Marriage or divorce.
- Pregnancy.
- Birth or adoption.
- Death of a family member.
- Admittance to a Hawaii state hospital or prison.
- The need for long-term care.
- A change in your health (such as a permanent disability).
- Not able to meet citizen documentation requirements.
- Care for injuries from a car accident or a workers' compensation claim.
- Enrollment in other health insurance or Medicare.
- Any other reason that results in a change to the information on your membership card or affects your continued eligibility for your next eligibility review.

Information We Must Report to You

If we make any major changes to your health plan, we'll tell you in writing. Here are examples of major changes:

- Your PCP leaves the network.
- Benefits change.
- Plan's operations change.

Events that End Your QUEST Coverage

DHS can remove you and your family from HMSA QUEST for these reasons:

- You move out of Hawaii.
- You don't qualify for QUEST anymore.
- You select a new health plan. (After being enrolled in their current plan for 12 months, QUEST members have a rolling plan change period to change health plans. DHS will send you information on how to make your rolling plan change selection when you are eligible.)
- You switch to a different Medicaid coverage category.
- You are admitted to the Hawaii state hospital or prison.
- You used false information to sign up for this QUEST plan.

If any of these happen to you, DHS will send you a letter that says why your plan is ending and give an end date. After the date on the letter, you may not use your HMSA QUEST card to get care.

If you don't agree with DHS, you may question their decision. The letter will tell you where to send your written inquiry within 10 days of the letter's date.

Changing to a Different Plan

You can change your plan at any time as long as you've been enrolled with your current health plan for at least 12 months. Once you become eligible, DHS will send you information on how to change your plan.

About Your Plan

What is a Managed Care Plan?

Being part of a managed care plan is like having your own health care team. The team is led by a primary care provider (PCP). Your PCP will coordinate your care with the team who'll help you with all your health care needs. In addition to your PCP, your team includes your health plan, other health care providers, and most of all, you. This team approach gives you timely access to your PCP and other services you need in a cost-effective way. HMSA QUEST is responsible for the overall coordination of your care.

When You're also Covered by Medicare

If you have Medicare and QUEST, Medicare pays your bills first. QUEST pays after Medicare and any other health insurance you have. We will also pay the copayment for your Medicare medical services. If you get your prescriptions through Medicare, we'll only pay for drugs that aren't a benefit of Medicare but are a benefit of QUEST.

How Your Doctors are Paid

When an HMSA doctor cares for you, the doctor bills HMSA. HMSA pays the doctor a fee for that service. Some doctors have a different set-up; HMSA pays them a set amount each month to care for a group of patients.

An HMSA doctor cannot charge you a no-show fee if you miss an appointment.

How to Get the Most from Your Plan

Being active in your health care means taking care of yourself. When you are sick or hurt, you should get care right away. But sometimes you might not know if you need to see a doctor. You can call your PCP to help you decide if you need care.

It's important for you to work closely with your doctor. Be sure to:

- Tell your doctor about changes in your health.
- Listen when your doctor tells you how to take care of yourself.
- Ask questions if you don't understand what your doctor is saying.
- Follow your doctor's instructions.

There are other ways to take an active role in your health care and get the most from your HMSA QUEST plan. Can you say "yes" to the following statements? If the answer to any of the items is "no," talk to your doctor or call us:

- I take good care of myself.
- I know what my HMSA QUEST plan covers.
- I always call my doctor to make an appointment first.
- My doctor answers all my questions.
- I follow my doctor's instructions.
- I make and keep all my appointments.
- I get regular physical exams.
- I take my medicine when I should.
- I ask my doctor and pharmacist for generic medicines.
- I know what a medical emergency is.
- When I need surgery, I ask my doctor if it can be done without staying in the hospital overnight.

The Role of Our Partners

Under HMSA QUEST, HMSA may work with companies to provide you with some of your HMSA QUEST benefits. They may need to contact you.

- **Avalon Healthcare Solutions** may contact you about genetic testing services.
- **Magellan Hawai'i** may contact you about behavioral health services.
- **Our pharmacy benefit manager** may contact you about your prescription drugs.
- **Evolent** may contact you about radiology services (such as a CT scan or MRI), spine and joint surgery, and physical therapy or occupational therapy services.
- **EyeMed Vision Care** may contact you about routine vision services.
- **Modivcare** may contact you about coordinating non-emergency medical transportation as requested by your provider or about a travel-related reimbursement you've submitted.

The partners (i.e., vendors) mentioned in this handbook reflect our current contractual agreements and could change at any time. HMSA guarantees continued access to all covered services, regardless of vendor changes. For the most up-to-date information about our contracted partners and the services they provide, please contact Member Services or visit our website.

Call us if you have questions about our partners and how we work with them to keep you healthy.

Avalon Healthcare Solutions is an independent company providing laboratory benefits management on behalf of HMSA.

Magellan Healthcare, Inc., doing business as Magellan Hawaii, is an independent company providing designated behavioral health services on behalf of HMSA.

National Imaging Associates Inc. is a subsidiary of Evolent Health. Evolent Health and its affiliates and subsidiaries are collectively referred to as "Evolent." Evolent performs medical specialty management services for selected procedures on behalf of HMSA.

EyeMed Vision Care is an independent company making available routine vision benefits on behalf of HMSA.

Modivcare is an independent company that provides non-emergency medical transportation services on behalf of HMSA.

The Role of Your PCP

Your primary care provider (PCP) is your personal doctor. The term PCP is used in this handbook. Your PCP may be a doctor, clinic, or health center. Your PCP takes care of you unless you need more advanced care. In this case, your PCP will refer you to a specialist and/or hospital. For information about choosing a PCP, see the next chapter.

The relationship you have with your PCP is important. Your PCP will make sure you get the health care you need and make the most of your plan benefits. Contact your PCP when you need medical care. Here are examples of medical care:

- Preventive services
- Referral to specialists
- Hospitalization

If you have trouble finding the right care or if you don't have a PCP, contact us. With our large network of doctors, we can help find someone who is right for you and your family.

If your doctor can't treat you based on moral or religious grounds, please contact us. We'll find a doctor so you can get the care you need.

When You Have Medicare

If you're in a Medicare Advantage plan, you don't have to choose a PCP. If you have Original Medicare, you must choose a PCP, but the PCP you choose does not have to be in HMSA's QUEST provider network.

We'll work with you and your Medicare PCP to coordinate your QUEST care.

What You Should Do Before You Need Care

Your PCP is responsible for your care 24 hours a day, seven days a week. You should have this information about your PCP before you need medical care:

- Location of your PCP's office or offices.
- Your PCP's regular office hours (what days and times the PCP sees patients).
- How to reach your PCP after regular office hours, such as on weekends and holidays.
- Who will cover for your PCP when your PCP is not available.

What You Should Do When You Need Care

General Care

Call your PCP at the first sign that you may be sick or hurt. Also call if you need preventive health care. Depending on your medical needs, your PCP may tell you how to take care of yourself over the phone. Or you may be asked to make an appointment. Make sure you follow your PCP's instructions.

Specialty Care

Your plan pays for services that your PCP provides or arranges. If you need specialty care, your PCP should refer you to a specialist and document the referral in your medical records. This same rule applies if:

- You need follow-up care with a specialist.
- The specialist you are referred to sends you to another doctor.

Self-referrals

There are some cases when you can see a specialist without a referral from your PCP. These are called self-referrals. For details about self-referrals, see How to Access Care starting on page 14.

After-Hours Care

For after-hours services, call your PCP.

You may also call to talk to a nurse 24 hours a day. The nurse can answer your questions and tell you if you should see your doctor, go to the emergency room (ER), or care for yourself at home. The service is free for HMSA QUEST members.

If You Need Help Making an Appointment

If you are unable to or need help making an appointment, please call us.

Choosing a PCP

What is a PCP?

Your PCP is your primary care provider, someone who acts as your personal health care manager. Your PCP treats you and arranges for your care when you need to see specialists and other health care providers. When you sign up for HMSA QUEST, you must choose a PCP.

The PCP you choose may have other doctors who work in the office. The QUEST program covers services from these health care providers when you receive care for which they are licensed and/or certified to provide.

You must get all of your care from doctors who participate in the HMSA QUEST network, except for emergencies. This includes prescriptions for medicine. If you get drugs from a doctor or pharmacy that is not in the HMSA QUEST network, the plan won't pay for it. For more information about emergencies, see Emergency Care starting on page 17.

If you have a Medicare Part D drug plan, your drugs may be covered under Medicare Part D.

Who Can be a PCP?

- A licensed physician (M.D.) or a doctor of osteopathy (D.O.) who is a family practitioner, general practitioner, internist, pediatrician, obstetrician/gynecologist, or geriatrician.
- An advanced practice registered nurse who can write prescriptions and is licensed in the state of Hawaii.
- A physician's assistant licensed by the Hawaii Board of Medical Examiners.
- Others such as:
  - A clinic.
  - A specialist who treated you for your condition and is willing to be your PCP.

Contact us if you want to choose a specialist as your PCP.

Choosing Your PCP

Basic Rules

- Choose a PCP who works on the island you live on.
- Tell us who you chose within 10 days of joining HMSA. Write or call us. If you write to us, use the Primary Care Provider Selection form. We send this form to you in the mail when you sign up.
- The date you select your PCP is the soonest you can start to see your new PCP.
- If you have a Medicare Advantage plan, you don't have to choose a PCP for HMSA QUEST.
- If you have Original Medicare, you must choose a PCP. Your PCP doesn't have to participate with HMSA QUEST.

Tips for Choosing

- Do you already have a doctor you'd like to stay with? If so, go to hmsa.com and check for the doctor's name in the HMSA QUEST Participating Provider Directory. Or call us for a printed copy of the directory to be sent to you at no cost.
- What are your personal preferences? For example, would you rather see a male or female doctor? Do you have a cultural preference? Do you need the doctor to speak a certain language?
- There are two easy ways to find a doctor:
  - Use **Find a Doctor** at hmsa.com. Click Find a Doctor and choose QUEST as your plan. Click the box next to **Remember my plans** and click **Search**. Start your search based on location, languages spoken, specialty, or ailment.
  - View the printed HMSA QUEST Participating Provider Directory. Visit hmsa.com/quest. Scroll down to **Find a Doctor**. Click **Participating Provider Directory** to access a PDF of the directory. If you'd like a printed copy of the Participating Provider Directory, please call us. We'll send it to you at no cost.

Call Us for Help

- When you need more information about a doctor.
- When you can't decide on a PCP and need help choosing one.
- When you need to see a doctor before you choose a PCP.

Changing Your PCP

If you want to change your PCP, call HMSA. You may want to change your PCP when:

- You move.
- You have children who outgrow their pediatrician.
- You're pregnant and need an OB-GYN
- You wish to change doctors after your baby is born.
- You aren't happy with your PCP. You can change PCP when the request is possible and appropriate. It may be reviewed on a case-by-case basis.
- Your PCP moves, retires, or is no longer part of HMSA QUEST.
- You didn't choose your PCP when you signed up because we assigned one to you.

When We Must Assign Your PCP

We will assign a PCP on your behalf if:

- You do not select a PCP within 10 days of becoming an HMSA QUEST member. The PCP's name will be printed on your membership card.
- You do not choose a new PCP when the one you have no longer contracts with us. We'll let you know in writing that you need to choose a new PCP within the time given. If you do not reply within the given time, we will assign you to a new PCP.

Your access to care will not be interrupted during the transition period. Once you tell us who you want for your PCP, we will send you a new membership card with the name of your PCP.

When You Change Your PCP

If you change your PCP, you'll need to find out about the new PCP's office procedures. This may help prevent delays when you need care. Here are two things you should do before you need services:

- Authorize your old PCP to release your medical records to your new PCP. This will help your new PCP give you the best care.
- Contact your new PCP to see if there are any special procedures for new patients.

For example, your new PCP may schedule more time for new patients. Or your PCP may have set times when they take calls from patients.

How to Access Care

Appointments

Scheduling

When you need care, call your PCP's office to schedule an appointment. If you're unable to get an appointment or if you need help, call us.

You should be able to get an appointment within the following times.

Immediate care for emergency services (no prior approval needed for emergency medical situations)	Go to the nearest emergency room right away
Urgent care and PCP pediatric sick visits	Within 24 hours
PCP adult sick visits	Within 72 hours
PCP routine visits	Within 21 days
Behavioral health routine visits for adults and children	Within 21 days
Specialist care or non-emergency hospital care	Within four weeks

Attending

On the day of your visit:

- Check in at the desk.
- Show your HMSA QUEST card.
- Tell the office if you have any changes in your records. For instance, if you have a new name, address, or phone number.

Canceling

If you can't make it in time to see your PCP, call the PCP's office to cancel. You must cancel 24 hours in advance.

Calling Your PCP

There are times when you need to call your PCP to ask a question during regular office hours. When you call, explain your concern to the person who answers the phone. It is common for the person answering the phone to take a message and have your PCP or a nurse call you back later. This often happens because your PCP:

- Is busy with a patient.
- Needs to check your records.
- Has set times to take calls from patients. In this case, ask what time is best for calls.

When You Need Services from a Specialist

Your PCP will refer you to a specialist if you need one. If you get care from a specialist without a referral from your PCP, you may have to pay for the charges yourself. This rule does not apply to self-referral services. If you can't reach your PCP when you need to see a specialist, call us. We will help you get the care you need. You have the right to direct access to specialists (if you have a special health need), such as a woman's health specialist within the network for women's health care services.

Self-referrals

There are some services for which you may see a specialist without a referral. **However, you must see a doctor in the HMSA QUEST provider network.** If you see a doctor who is not in HMSA's QUEST provider network, the plan will not pay for it and you will have to pay for it yourself. For help finding an HMSA QUEST doctor, call us.

For family planning services, you may see any provider for family planning services. No referral is needed.

You do not need a referral to get the care listed in the following table.

TYPE OF CARE	EXAMPLES OF SERVICES	FOR MORE INFORMATION
WOMEN'S ROUTINE AND PREVENTIVE CARE (By a women's health care specialist)	• Breast exams. • Breast X-rays (mammograms). • Pap smears. • Pelvic exam. Follow-up care or care not related to routine services should be performed or arranged by your PCP.	See Preventive Services - Adults on page 37.
FAMILY PLANNING	Counseling to prevent pregnancy.	See Family Planning Services on page 25.
BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES	Behavioral health services provided by a licensed: • Psychiatrist. • Psychologist. • Advanced practice registered nurse. • Licensed clinical social worker. • Licensed marriage and family therapist. • Licensed mental health counselor.	If you need help finding a behavioral health specialist, please call (808) 695-7700 or 1 (855) 856-0578 toll-free.
VISION CARE	• Eye exams. • Eyeglasses to correct vision. Vision care doesn't include services for a medical problem such as eye pain. If you need an eye exam for a medical problem, you must call your PCP or HMSA before seeing a vision doctor. If you don't call first, you may have to pay for the charges yourself.	See Vision Services on page 35.

Services from a Nonparticipating Provider

Services you get from a nonparticipating provider (a provider who isn't in the HMSA QUEST provider network) aren't covered if we don't approve those services first. That means you'll have to pay for the services you get from that provider. If you aren't sure if the provider you want to see is in our network or if you need help finding a provider in your network, call us so we can help you.

If the services are related to an emergency, see Emergency Care on page 17.

However, if you have Medicare, you don't need our approval to get services covered by Medicare.

Switching from Your Current QUEST Plan to HMSA QUEST.

If you're switching to HMSA QUEST from another QUEST plan and you're getting medically necessary covered services from the other plan, we'll continue to cover the services even if they are from a nonparticipating provider for at least 90 days after you enroll or until our service coordinator meets with you to assess your needs.

During Pregnancy

If you're in your second or third trimester of pregnancy the day before you enroll in HMSA QUEST, we will cover any medical prenatal services that you were getting from your previous QUEST plan's prenatal care provider regardless of whether or not the provider is in our network. We will also cover any postpartum services from that provider.

Prior Approval

Some services your PCP suggests to you may need our approval. In these cases, your PCP will request approval from us on your behalf before you get the services. If you get such services before your PCP gets our approval, the care may not be covered, and you will have to pay for all charges.

You do not need prior approval for emergency services. If you have questions about emergency services, see Emergency Care starting on page 17.

Special Health Needs

Help Getting Care

If you have questions about or problems getting the health care you need, call us. Our staff is ready to help you:

- Get transportation to and from a doctor's appointment.
- Find a language interpreter (language interpretation is a free service).
- Help if you are hearing impaired TTY users, call 1 (877) 447-5990 toll-free.
- Choose the right doctor for you.
- Understand and follow your doctor's instructions.
- Organize your medications.
- Find other services your health plan pays for.
- Manage your overall care.
- Get care when you need help.

Special Services

HMSA has services for members who have trouble with:

- Hearing.
- Seeing.
- Reading.
- Writing.
- Speaking English.
- Making an appointment.
- Getting medications.
- Getting transportation to and from a doctor's appointment.

If you need help with any of the above, please call us.

Health Coordination Services

If you have Special Health Care Needs (SHCN) including chronic conditions or complex health needs, or if you need special help getting the care you need, we will assign a health coordinator to you. Your health coordinator will meet with you in person to learn more about your health history and develop health goals. After that visit, your health coordinator will stay in touch with you and visit at least once a year or when you request to reassess your needs. If there is a significant change in your condition, such

as an inpatient hospital stay or decline in your health, your health coordinator will visit you within 10 days.

Your health coordinator will:

- Coordinate your physical and behavioral health services and long-term services and supports.
- Make sure that your health action plan is carried out and is working the way that it needs to.
- Work with your providers to make sure they know what is happening with your health care and to coordinate your services.

If you are unhappy with your health coordinator or would like a different one, call us at (808) 948-6997 or 1 (844) 223-9856 toll-free. TTY users: 1 (877) 447-5990 toll-free. There may be times when we need to change your health coordinator. If this happens, we will let you know who your new health coordinator is and how to contact them.

Emergency Care

Emergency Care

A medical emergency is when you suddenly become very sick or are seriously injured, the symptoms are severe (such as being in pain, having psychiatric disturbances and/or symptoms, substance abuse) and someone who has an average knowledge of health and medicine could reasonably expect that without emergency care and not getting care right away could result in any of the following:

- Placing your life in danger.
- Putting your health, a body function, or body part in danger.
- Harming yourself or another person due to alcohol or drug abuse emergency.
- Placing your life or your unborn baby's life in danger while you are pregnant.
- With respect to a pregnant person who is having contractions:
  - There is not enough time to make a safe transfer to another hospital before delivery.
  - Transferring to another hospital may pose a threat to the health or safety of the person and their unborn child.

Examples of emergency medical conditions that require emergency services include, but are not limited to:

- Loss of consciousness.
- Chest pain or other heart attack signs.
- Severe bleeding.
- Sudden weakness or numbness on one side of the body.
- Sudden severe headache (if there's no history of migraines).
- Disorientation.
- Severe and persistent abdominal pain.
- Bad pain.
- Breathing problems.
- Poisoning.
- Drug overdose.
- Convulsions or seizures.
- Bad allergic reaction.
- Bad burns.
- Broken bones.

Guidelines

If you need emergency care, call 911 or go to the nearest hospital or clinic that provides emergency care.

Emergency services are covered if the problem is an emergency. You can go to any emergency room (ER) even if it is not in our network. You do not need prior approval for emergency care.

If you are not sure if the problem is an emergency, you may also call us to talk to a nurse 24 hours a day. The nurse can answer your questions and tell you if you should see your doctor, go to the ER, or care for yourself at home. The service is free for HMSA QUEST members. If you need routine care, call your PCP. Your PCP knows your medical history and will work with you and other doctors to get you the care you need.

Care After an Emergency

When you get emergency care, you are also covered for care that keeps your condition stable or improves or resolves it after an emergency. This treatment is called post-stabilization services. Post-stabilization services are available 24 hours a day, seven days a week. It includes follow-up outpatient specialist care. Prior approval may be required.

Post-stabilization services provided with or without prior approval, regardless of whether the provider is in the HMSA QUEST provider network, will be covered if one of the following occurs:

- HMSA QUEST doesn't respond to a provider's request for prior approval within one hour of the request.
- HMSA QUEST cannot be reached.
- HMSA QUEST and the provider can't reach an agreement on your care and HMSA QUEST's provider isn't available for consultation. In this situation, the treating provider will be given a chance to consult with an in-network provider and the treating provider may continue to care for you until HMSA QUEST can reach their provider or one of the following happens:
  - An in-network provider with privileges at the treating hospital assumes your care.
  - You are transferred to an in-network provider who assumes responsibility for your care.
  - HMSA QUEST and the treating provider reach an agreement on your care.
  - You are discharged.

A list of emergency and post-stabilization providers can be found on the Healthcare Association of Hawaii website at https://www.hah.org/membership-list.

Urgent Care

Urgent care is care for a medical condition that's serious or acute but is not life threatening and needs treatment within 24 hours.

Examples of conditions that might require urgent care include:

- Sprains.
- Strains.
- Earaches.
- Sore throat.

Guidelines

When you need urgent care, call your PCP even if it is after hours. If you do not know who your PCP is, call us.

If you are not sure if you need urgent care, you may also call us to talk to a nurse 24 hours a day. The nurse can answer your questions and tell you if you should see your doctor, go to the emergency room, or care for yourself at home. The service is free for HMSA QUEST members.

Online Care

If you have a question for a doctor or specialist, but you can't get to an office, try HMSA's Online Care®. It's free for HMSA QUEST members. You do not need an appointment, and you can see a doctor 24 hours a day, seven days a week, from the comfort and privacy of your home or anywhere in Hawaii. If you need medicine, prescriptions can be sent to your pharmacy. All you need is a computer, tablet, or smartphone and an internet connection.

Download the free app or visit hmsaonlinecare.com from your computer to get started.

Amwell is an independent company providing hosting and software services for HMSA's Online Care platform on behalf of HMSA.

Care Away from Home

If you need medically necessary services that you can't get on the island you live on, and these services can't be carried out by using telehealth, we can provide these services off-island or out of state.

Neighbor Islands

If you need to be away from your home island so you can get medically necessary services, your PCP may refer you to a specialist. If this happens, your PCP will work with us to arrange your care.

We can't reimburse for travel arrangements you make on your own. If travel is needed to receive medical care, your PCP must contact Modivcare. We must do the booking and pay for air, ground transportation, lodging, and meals while you are away from home. If it is medically necessary for you to have an attendant and we approve it, we will also pay travel expenses for one adult to travel with you and help you. You are also covered for emergency and post-stabilization services while off-island.

Away from Home in the U.S.
If you travel to other states within the U.S., you are covered for emergency care and post-stabilization services. Children are also covered for all medically necessary Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

If you need care that is not available in Hawaii, your PCP must ask HMSA for prior approval to see a specialist in the U.S. If approved, we will work with you and your PCP to arrange your care. We will also arrange and pay for air and ground transportation, lodging, and meals while you are away from home getting prior approved care. If there is a medical reason for you to have an attendant and we approve it, we will also pay travel expenses for one adult to travel with you and help you. We cannot reimburse you for travel expenses that are not arranged by HMSA.

Outside the U.S.
You are not covered for any services outside the U.S. This is for care for children and adults.

QUEST Benefits

The benefits and services described in this handbook provide a general overview and could change at any time. For the most current and detailed information about your benefits and services, contact our Customer Service team at (808) 948-6486 or 1 (800) 440-0640 toll-free. TTY users, call 1 (877) 447-5990 toll-free.

This chapter provides a list of your QUEST benefits.

If you get services that are not covered by your plan and you can't pay for them, you won't lose your QUEST benefits. If you have questions, please call us.

What Does Medically Necessary Mean?

Your plan covers care that is medically necessary when you are sick or hurt.

"Medical necessity" means those procedures and services, as determined by the Department of Health Services, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) must be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

Definitions of terms are in the Department of Human Services, Med-QUEST Division, Hawaii Administrative Rules §17-1700.1-2. If you would like a copy of this rule, please call us.

HMSA reviews new technology for possible coverage. A new drug, device, treatment, test, or a new use of current technology is reviewed to see if it meets payment determination criteria and is appropriate for coverage.

Your doctor may not bill or collect charges for services or supplies that do not meet HMSA's payment determination criteria unless the doctor has a written acknowledgement of financial responsibility. The form must be specific to the service and signed by you or your legal representative before you get the services. For more information, see What's Not Covered starting on page 55.

The care you get must be consistent with HMSA's medical policies. Our policies are written by HMSA medical directors who are doctors. Each policy provides detailed coverage criteria for a specific service, drug, or supply. If you have questions about the policies, please call us. If you would like a copy of a policy that relates to your care, please call us.

Primary Care Provider (PCP)

Remember, in most cases you should get care from or arranged by your PCP. If you do not, you may be required to pay for the services. For more information, see Choosing a PCP starting on page 12. This rule does not apply to some self-referrals or any emergencies.

- For information about self-referrals, see How to Access Care starting on page 14.
- For information about emergencies, see Emergency Care starting on page 17.

Prescription Drugs

When you go to a participating HMSA pharmacy to fill a prescription, the pharmacist will put your data into the computer. The computer will check for:

- If the drug can be filled.
- Supply limits.
- Unwanted side effects that may occur with other medications you take.

The computer system only contains information on prescription drugs that you take while you are an HMSA member. That's why it's important to tell the doctor about all the drugs you take, even those you bought at the pharmacy or in the store over the counter.

The computer can check for all these things in a short time while you wait. If an adverse side effect shows up, the pharmacist will check with your doctor. If they can't reach your doctor, you may have to wait until they can. You may have to pick up your prescription later.

You can arrange with your participating pharmacy to pick up a 90-day supply of your maintenance prescription drugs at one time. This will save you from having to pick them up on different days. The pharmacy will work with you to determine which day of the month is right for you. The pharmacy can partially fill a prescription or allow an early refill to get your drugs coordinated. Drugs that are Schedule II narcotics are excluded from this service.

What's Covered

Your HMSA QUEST benefits are here for you. Most benefits are provided at no cost to you, but some will involve cost sharing.

Cost Sharing

You may have to share in the cost of your health care services. This happens when certain financial eligibility requirements are not met. Your Hawaii Medicaid eligibility worker will figure out your cost-sharing portion and let you know. If you have a cost share, you must pay that amount every month to one of your providers (e.g., a nursing facility or a home- and community-based provider) or us.

If you have Medicare, your cost share for Medicare services will be covered by QUEST except for prescription drugs.

Amwell is an independent company providing hosting and software services for HMSA's Online Care platform on behalf of HMSA.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
MEDICAL SERVICES	
Advance Care Planning	Voluntary advance care planning between you and a provider should be done before you cannot make your own medical decisions (with or without completing relevant legal forms).
Ambulance Services	Ground and air ambulance services. Prior approval is needed for air ambulance to the mainland.
Cancer Care	Treatment for cancer. Services include: • Inpatient hospital care. • Provider services. • Outpatient hospital services. • Chemotherapy. • Radiation therapy. • Hospice.
Cognitive Rehabilitation	Assess and treat problems for members with a traumatic brain injury who have trouble with: • Communicating. • Thinking. • Memory. • Paying attention. • Doing everyday tasks. An assessment is done to determine the need and to come up with a treatment plan. Reassessments are done regularly to check on progress. Treatment may last up to one year. Services are covered when medical necessity is established.
Dental Services - Adults	Dental coverage is for members age 21 or older. Some limitations and prior authorizations may apply. Community Case Management Corporation (CCMC) will help members get dental care. They will answer your questions and help you find a dentist. Call: (808) 792-1070 or 1 (888) 792-1070 toll-free.
Preventive Services	• Comprehensive oral evaluation, one every five years. • Periodic screening examinations, two per year. • Prophylaxis, two per year. • Topical fluoride or fluoride varnish, two per year.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Diagnostic and Radiology	• Bitewing X-rays, two per year. • Full series X-rays, one every five years. • Periapical X-rays. • Biopsies of oral tissue.
Endodontic Therapy	• Root canal therapy on permanent molars.
Restorative	• Amalgams on primary and permanent posterior teeth. • Composites on anterior and posterior teeth. • Pin and/or post reinforcement. • Case cores. • Recement inlays and crowns. • Stainless steel crowns.
Periodontal Therapy	• Scaling and root planning, one every 24 months.
Prosthodontics	• Complete upper and lower dentures, one every five years. • Partial dentures, one every five years. • Denture relines, one every two years. • Repairs.
Emergency and Palliative (pain) Treatment	• Gingivectomy for gingival hyperplasia. • Other medically necessary emergency dental services.
Diagnostic Testing	Medically necessary diagnostic testing to include: • Screening and diagnostic radiology and imaging. • Diagnostic or therapeutic radiology or lab services. • Some services need prior approval. • Magnetic resonance imaging (MRI). • Magnetic resonance angiogram (MRA). • Positron emission tomography (PET). • Reference lab tests that can't be done in Hawaii and are not specifically billed by labs in Hawaii. • New lab tests for specific diseases. • Psychological testing. • Neuropsychological testing. • Cognitive testing. Services are covered when medical necessity is established.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Dialysis	A treatment that is needed when your kidneys can no longer take care of your body's needs. Dialysis can be done in the following settings: • Medicare-certified hospital, inpatient services. • Medicare-certified hospital, outpatient services. • Medicare-certified non-hospital dialysis facility. • Patient's home. Services include: • Doctor visits. • Lab work. Services are covered when medical necessity is established.
Doctor Services	Services provided by or under the direct supervision of a doctor: • Physical exams. • Screening exams. If you need the services of a specialist, your PCP must refer you. Specialty services without a referral are not covered. HMSA QUEST covers one visit per day per doctor. Services are covered when medical necessity is established.
Durable Medical Equipment and Medical Supplies	Durable medical equipment needed to: • Reduce a medical disability. • Restore or improve function. Medical supplies as prescribed by your doctor to diagnose and treat a medical condition. The items can be rented or purchased. You must get prior approval by the treating doctor before you purchase or rent items if: • The total cost to HMSA of the item is more than $500; or • The total cost to HMSA for renting the item for the entire time you need it is more than $500. Some items that cost less than $500 to HMSA also require prior approval. Services are covered when medical necessity is established. Limit one small volume nebulizer per lifetime. You must get prior approval to replace a nebulizer that is broken, lost, or stolen.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Medical and mental health services to help keep persons healthy until age 21. Examples of the services in this category are: • Appropriate medical and behavioral health screening exams. • Complete medical. • Screening exams. • Developmental assessments and autism screening. Includes diagnosis and treatment of any issues found. For autism spectrum disorder, services include all medically necessary intensive behavioral therapy and applied behavioral analysis. This includes: – Psychiatric care. – Psychological care. – Speech, occupational, and physical therapy. – Prescription medication. – Counseling. • Diagnosis and treatment of acute and chronic medical and behavioral health conditions. • Diagnosis and treatment of eye or ear problems. • Diagnostic tests. • Help scheduling appointments. • Immunizations. • Lab tests. • Preventive care. • Supplies and services to treat conditions found under EPSDT, such as: – Prescription drugs not on the health plan's formulary. – Durable medical equipment not typically covered for adults. – Personal care. – Private duty nursing services. – Transportation to and from appointments. – Tuberculosis screenings. • Lead screening. Your doctor may need to contact us before you get these services. Call us at (808) 948-6486 or 1 (800) 440-0640 toll-free. TTY users, call 1 (877) 447-5990 toll-free.
Emergency Room Services	Services received in an emergency room for an emergency or urgent condition. Your condition must be a medical emergency. See Emergency Care on page 17 for a definition. If the condition does not meet emergency criteria, you pay all charges related to the visit. If you have a serious and persistent mental illness (SPMI) and are enrolled in Community Care Services (CCS), this service won't be covered by HMSA if the visit is related to behavioral health. Services are covered when medical necessity is established.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Family Planning Services	Services are provided to members who are sexually active and of child-bearing age. All family planning services are voluntary. You may see any provider for family planning services. No referral is necessary. Services provided for family planning include: • Consultations. • Contraceptive pills, devices, and supplies. • Emergency contraception. • Counseling. • Infertility diagnosis, but not treatment. • Pregnancy testing. • Medical exams. • Sterilizations. • Diagnosis and treatment of sexually transmitted diseases. **Sterilization** Sterilizations need your written consent at least 30 days before the procedure is done. They are not covered if you are: • Less than age 21. • Judged mentally incompetent. • Institutionalized. **Implants** Reinsertion of contraceptive implants requires prior authorization if performed during the period of effectiveness (e.g., for Implanon, the period of effectiveness is three years). **Over-the-counter Supplies** Any over-the-counter supply must be prescribed by your doctor. Your doctor may need to contact us before you get these services. Call us at (808) 948-6486 or 1 (800) 440-0640 toll-free. TTY users, call 1 (877) 447-5990 toll-free.
Habilitation Services	Services and devices include: • Audiology services. • Occupational therapy. • Physical therapy. • Speech-language therapy. • Vision services. • Devices to help communicate, read, and see. Habilitative services and devices should develop, improve, or maintain skills for daily living that aren't at the appropriate level.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Habilitation Services (continued)	Services and devices are covered only when medically necessary and not already covered. Devices used only for activities at school aren't covered. Services and devices are covered when medical necessity is established.
Hearing Services	Hearing services include: • Hearing exams. • Unilateral and binaural hearing aids with standard features. • Ear molds. • Hearing-aid batteries. Prior approval is required for all hearing aids. Hearing services are subject to these limits: • One hearing-aid evaluation every 12 months. • Hearing aids once every 24 months. Prior approval is required to replace lost, stolen, or damaged hearing aids.
Home Health Services	Services provided at your home by qualified home health agencies when you are: • Homebound due to illness or injury; and • Require part-time skilled nursing care. Services include: • Home health aide. • Skilled nursing. • Physical therapy. • Occupational therapy. • Speech therapy. • Audiology. • Medical supplies. Services can also be provided at a location other than a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for intellectual disability. Custodial and homemaker services are not covered.
Hospice	Services to provide comfort and support in the last stages of a terminal illness. For patients who are expected to have six months or less to live. Services can be provided in the home, outpatient, or inpatient setting: • Appliances. • Counseling. • Drugs.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Hospice (cont'd)	• Home health aide. • Home health services. • Inpatient care for pain control and medical management. • Medical social services. • Medical supplies. • Nursing. • Doctor services. • Respite care. While under hospice care, services must be received: • From an agency certified by Medicare. • From hospice if the condition is related to the terminal condition. You may get care outside hospice if the medical condition is not related to the terminal condition. Children under the age of 21 can receive treatment to manage or cure their disease while in hospice.
Inpatient Psychiatric Hospitalizations	Inpatient behavioral health services provided by a licensed psychiatrist such as: • Psychiatric services. • Substance abuse treatment services. Inpatient psychiatric hospitalization includes: • Room and board. • Nursing care. • Medical supplies and equipment. • Medications and medication management. • Diagnostic services. • Ancillary services. • Other services. These services aren't covered by HMSA if you're a member with SPMI and are enrolled in CCS. Services are covered when medical necessity is established.
Inpatient Stay	Treatment in a hospital, rehabilitation hospital, or other inpatient medical facility when your condition requires an inpatient stay. • Inhalation therapy and physical therapy. • Lab work, pathology, and X-rays. • Medical and surgical intensive care and cardiac units. • Operating room and specialized treatment rooms. • Room and board for semi-private room. • Surgical and anesthetic supplies, drugs, and medicines.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Inpatient Stay (continued)	**Admissions** You must notify us in advance if an admission is for: • An elective procedure. It is expected that you will be admitted on the day the procedure is scheduled. • Services that usually are done in an outpatient setting. **Maternity** Women in good health who delivered without complications may stay in the hospital for up to: • 48 hours after a natural birth. • 96 hours after a cesarean section. If you have a serious and persistent mental illness (SPMI) and are enrolled in Community Care Services (CCS), this service will not be covered by HMSA if the visit is related to behavioral health.
Medical Services Related to Dental Needs	Covered dental services to treat medical conditions when medical necessity is met. Services are provided in a medical facility, such as a hospital and an ambulatory surgical center. Medical services provided to adults and children as part of the dental treatment, and are performed by both dentists, such as oral surgeons, and doctors, such as plastic surgeons, otolaryngologists (ears, nose, and throat doctors), and general surgeons. Services include referrals, follow up, coordination and provision of appropriate medical services related to dental needs when medical necessity is established. This includes: • Emergency room treatment. • Hospital stays. • Ancillary inpatient services. • Operating room services. • Excision of tumors. • Removal of cysts and cancer. • Removal of bone tissue. • Surgical incisions. • Treatment of fractures. • Oral surgery to repair traumatic wounds. • Surgical supplies. • Blood transfusions. • Ambulatory surgical center services. • X-rays. • Labs. • Drugs. • Physical examinations, consultations and second opinions. • Sedation services for dental treatment when performed in an acute care setting by a doctor anesthesiologist.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Medical Services Related to Dental Needs (continued)	Covered by HMSA QUEST: • Dental or medical services in a hospital or surgery center as a result of a dental or medical condition. • Emergency services by a dentist or oral surgeon and providers such as plastic surgeons, otolaryngologists (ear, nose, and throat), and general surgeons due to a traumatic injury such as a car accident are covered. • Sedation services from an oral surgeon or other qualified dental anesthetist in a private office or hospital-based outpatient clinic for services not medically related are not covered. • Services provided in private dental offices, government-sponsored or subsidized dental clinics, and hospital-based outpatient clinics are not covered. • Prior approval is required. The provider must contact HMSA QUEST for approval or referral.
Non-emergency Transportation Services	Transportation is provided when your medical condition requires treatment that is not available in your area. Travel services include: • Transportation • Air transportation • Taxi services • Lodging • Meals Transportation services require prior approval. You may be allowed one approved attendant to help with any special travel needs you may have if determined medically appropriate. The attendant must be age 18 or older and able to help during travel.
Nutrition Counseling	To help persons better manage their health through making better food choices. • Diabetes self-management training. • Nutrition counseling. To get these services: • Your PCP must refer you for these services. • Services must be provided by a licensed dietitian. • An order from your doctor is needed before services start. • The services must be part of an overall diabetes prevention treatment program to lessen the effects of having diabetes. • The services are available for other medical conditions, such as obesity. Services are covered when medical necessity is established.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Other Practitioner Services	Other practitioner services include: • Advanced practice registered nurses. • Nurse midwives. Services from these practitioners often require a referral from your doctor. If you are not sure, ask your doctor. Services are covered when medical necessity is established.
Outpatient Behavioral Health Services	Services for outpatient behavioral health include: • Individual or group psychiatric or psychological evaluation and treatment. • Alcohol and chemical dependency services. • Day treatment. • Ambulatory mental health services. • Medication-assisted treatment (MAT), including methadone maintenance for treatment of substance-use disorders (SUD). If you are experiencing a substance use condition, ask your PCP for a referral to a Medication Assisted Treatment (MAT) provider. Or contact HMSA's Behavioral Health Program. We can coordinate your services and connect you with an MAT provider. Call us at: (808) 695-7700 or 1 (855) 856-0578 toll-free, Monday-Friday, 7:45 a.m.-4:45 p.m. • Crisis management. • Medications and medication management. Behavioral health services must be provided by a licensed: • Psychiatrist. • Psychologist. • Behavioral health nurse practitioners. • Clinical social worker. • Marriage and family therapist. • Mental health counselor. Services are covered when medical necessity is established. These services aren't covered by HMSA if you have an SPMI and are enrolled in CCS.
Outpatient Hospital	Services to prevent, diagnose, or manage the pain of an illness or injury. Prior approval from HMSA is needed if the service is usually done in an office setting or related to gender identity services. • Audiology services. • Blood storage and processing. • Cardiology services. • Lab studies.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Outpatient Hospital (continued)	• Oncology services. • Outpatient surgery services. • Respiratory services. • Speech therapy. • X-rays. • Other services that may be allowed under federal Medicaid rules and regulations.
Palliative Care	Effective Jan. 1, 2025, members who qualify can now receive community palliative care anywhere outside of the hospital setting, such as the member's home or clinic. Palliative care services in hospital settings are currently a covered benefit. Palliative care is specialized medical care that focuses on relieving symptoms, managing pain, and addressing the holistic needs of members diagnosed with a serious illness. The goal is to improve the quality of life for the member and their family by addressing symptoms and providing support. Palliative care can be delivered at any age and any stage of illness, and it can be provided along with treatment aimed at healing. Talk to your provider to learn more about whether palliative care is right for you.
Podiatry Services	Services are provided to treat problems of the foot and ankle, including: • Professional services not involving surgery performed in the office or clinic. • Professional services not involving surgery for diabetic foot care. • Surgery. • Diagnostic radiology limited to the ankle and below. • Foot and ankle care for infection or injury. • Removing bunions with skin ulcers or neuroma.
Pregnancy and Maternity Care	Services provided for pregnancy and maternity care including pregnancy-related services for the health of the pregnant person and their fetus without limitation. Services are covered during the pregnancy and up to 60 days after delivery when medical necessity is established. Covered services are: • Prenatal care. • Radiology, lab, and other diagnostic tests. • Delivery of the infant and postpartum care. • Prenatal vitamins. • Screening, brief intervention and referral to treatment (SBIRT) for conditions related to the pregnancy. • Screening for depression, substance use, and other behavioral health conditions with access to treatment and support.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Pregnancy and Maternity Care (continued)	• Breastfeeding support for at least six months. • Breast pump, purchased or rented, for at least six months. Parents with premature infants may request an extension. • Educational classes on childbirth, breastfeeding, and infant care. • Counseling on health behaviors. • Inpatient hospital services, doctor services, other practitioner services. • Any other services that impact a pregnancy. • Perinatal care provided to mothers and infants after delivery. Transfer and care of a pregnant person, mothers, newborns, and infants to an inpatient facility when necessary. • Have available and be accessible after delivery, appropriate outpatient and inpatient facilities capable of assessing, monitoring, and treating complex perinatal conditions. • Obstetricians/gynecologists, including maternal fetal medicine specialists and neonatologists capable of treating complex perinatal conditions.
Prescription Drugs	Prescription drugs and certain over-the-counter drugs that are: • On the QUEST list of approved drugs. Most of these drugs are generic. • Prescribed by your doctor who is licensed to prescribe. If the drug you need is medically necessary and isn't on the QUEST list of approved drugs, your doctor must request approval for the drug. To determine if it is covered, we ask these questions: • Are there comparable drugs on the list that were used to treat your condition? • Have you tried and failed at least two comparable drugs? If you have, did you have a bad reaction or did they not work for you? • Are you unable to try comparable drugs because of your condition or other drugs you are taking? Drugs to treat behavioral health conditions are not covered by HMSA if you have a serious and persistent mental illness (SPMI) and are enrolled in Community Care Services (CCS) because CCS will cover these drugs.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Prescription Drugs (continued)	A drug formulary exception will not be approved for the following: • When there's an FDA-approved A-rated generic equivalent or an over-the-counter (OTC) drug that has a generic equivalent available. • Controlled substances (i.e., Schedule II, III, IV, V drugs) prescribed to treat pain or used as a sedative. Specialty drugs must be obtained from a plan provider. Prescription mail order is available for most drugs. See Mail-order Pharmacy Program on page 49.
Prostheses and Orthoses	Prostheses and orthoses that help restore function or replace the function of a body part. You must get prior approval by the treating doctor if: • The total cost to HMSA of the item is more than $500. • The total cost to HMSA of buying or renting the item is more than $500. Some items that cost HMSA less than $500 also require prior approval. Penile and testicular prostheses and related services aren't covered.
Rehabilitation • Occupational therapy. • Physical therapy. • Speech therapy.	Therapy that helps restore function lost or impaired due to illness or injury. These services require a referral from your doctor and are covered as described in HMSA's medical policy. Prior approval must be obtained by the treating provider.
Rehabilitation Services	Services provided at a rehabilitation hospital: • Corrective surgery. • Durable medical equipment. • Medical supplies. • Occupational therapy. • Physical therapy. • Prostheses and orthose. • Respiratory services. • Speech therapy. Services must be provided by any of the following licensed providers: • Physical therapist (PT) • Occupational therapist (OTR) • Audiologist • Speech pathologist

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Rehabilitation Services (continued	Prior approval is required for all services except for the initial evaluation. Services are limited to persons who expect to improve in a reasonable period of time. Conditions found during an EPSDT screening that need rehabilitation will be subject to EPSDT requirements.
Routine Costs for Qualifying Clinical Trials	Medically necessary items and services: • Usually covered if the services weren't part of a clinical trial. • Required solely to be able to provide the investigational item or service. • Medically necessary items and services to diagnose and treat complications due to a provision of an investigational item or service.
Skilled Nursing Facility	Skilled nursing care provided in an acute care hospital or skilled nursing hospital. When acute care is no longer needed, you may still need more treatment at another facility and must wait to be moved. Your stay at the skilled nursing facility is still covered even though your level of care has changed.
Sleep Lab Test	Diagnoses sleep-related disorders. Prior approval needed.
Smoking Cessation Counseling	Services are provided by licensed providers: • Doctor. • Dentist. • Psychologist. • Clinical social worker in behavioral health. • Advanced practice registered nurse (APRNs). • Mental health counselor. • Certified tobacco treatment specialists under the supervision of a licensed provider. Services are accessible statewide and combine counseling and tobacco cessation drugs. Limited to four in-person counseling sessions per quit attempt. Counseling could happen one-on-one, in a group, or by phone. Medications are those recommended in the current public health service guidelines. Includes tobacco cessation drugs approved by the U.S. Food and Drug Administration (FDA). This includes nicotine and non-nicotine agents and effective drug combinations. No prior authorization is required.

QUEST BENEFITS PACKAGE	
Service	**Description and Limitations**
Speech Therapy	Treatment of communication impairment or swallowing function that has been lost or impaired by injury, illness, or surgery. These services require a referral from your doctor and are covered as described in HMSA's medical policy. Prior approval must be obtained by the treating provider.
Vision Services	Vision services include: • Eye exams to test for refraction. • Eyeglasses to improve vision. • Visits to your eye doctor if you have an eye condition or if you notice a change in your vision. Vision services are limited as listed here: • One routine eye exam every 24 months for adults and every 12 months for children under age 21. • Your plan covers either one pair of glasses or one pair of contact lenses (not both) every 24 months. • You must select frames from your vision provider's designated assortment. • Contact lenses are covered if you have a condition that can't be corrected with glasses. • Your doctor may need to provide an attestation for you to get contact lenses unless you have a specific medical condition that doesn't require provider attestation. • Persons under age 40 who need bifocal lenses require a medical reason. If there is a change in an adult's vision within 24 months of receiving glasses or contact lenses, contact your doctor. This may make you eligible for a new pair of glasses or contact lenses. Provider attestation is required. The following require provider attestations: • Contact lenses, except for certain medical conditions. • Polycarbonate glasses for adults. • Replacement for glasses or contacts that are lost, stolen, or damaged before the glasses or contacts are 24 months old. Eye surgery to improve vision so glasses are no longer needed, and tinted lenses used for cosmetic reasons aren't covered.

Routine Care – Adults

Preventive care is your key to good health. A wellness visit usually includes immunizations, screenings, tests, and health information and education. You should get this care from your PCP.

We have many programs to help you and your family stay well. The programs help prevent or detect illnesses and diseases in earlier, more-treatable stages. Catching health conditions early greatly reduces the risk of illness, disability, early death, and medical costs. They also help find illness early and can make treatment easier. If you have an illness, see your PCP.

We follow screening and preventive services from clinical practice guidelines, such as those published by the:

- United States Preventive Services Task Force (USPSTF).
- Centers for Disease Control and Prevention (CDC).
- Women's Preventive Services Guidelines from the Health Resources & Services Administration (HRSA).
- Hawaii Department of Health's guidelines on screening for tuberculosis.

Adult preventive services include:

- Immunizations.
- Screening for common chronic and infectious diseases and cancers.
- Clinical, nonclinical, and behavioral interventions to manage chronic disease and reduce the risks and complications.
- Support for self-management of chronic disease.
- Support for self-management for individuals at risk of developing a chronic disease.
- Screening for pregnancy intention.
- Counseling to support healthy living.
- Support for lifestyle change when needed.
- Screening for behavioral health conditions.
- Diabetes Self-Management Education (DSME) for those who have diabetes or become diabetic during pregnancy (gestational diabetes).

PREVENTIVE SERVICES-ADULTS		
Service	**Description**	**Recommendations and Limitations**
Blood Pressure	Blood pressure measurement	• Once per office visit, or • Every two years or more frequently for members with high blood pressure.
Breast Cancer	Mammogram with or without clinical breast exam	• For women ages 40 and older, breast exams and mammograms every one to two years or as often as your doctor suggests.
Cervical Cancer	Pap test and pelvic exam	• For women who are sexually active, ages 18-65, every one to three years or earlier as your doctor suggests, or earlier if sexually active.
Cholesterol	Total cholesterol level blood	Once every five years for: • Men age 35 to 65. • Women age 45 to 65.
Colorectal Cancer	Sigmoidoscopy or fecal occult blood test	Starting at age 45: • Fecal occult blood or stool blood test yearly; or • Sigmoidoscopy at age 45, then every five years or every 10 years if combined with a fecal immunochemical test (FIT) every year.
Weight	Weight measurement	Once every two years.

Immunizations

Immunizations help protect you against serious diseases. They're also called vaccinations. You may be most familiar with childhood immunizations, but adults need them, too. Getting the recommended immunizations helps keep you healthy.

Our adult immunization program informs members about flu vaccinations. We follow the advice of the Advisory Committee on Immunization Practices (ACIP) on immunizations and vaccines. Each fall, we send reminders and information to members based on their risk factors. Examples of risk factors are age, asthma, coronary artery disease, diabetes, and chronic obstructive pulmonary disease.

Routine Care – Keiki

Help Keep Your Child Healthy

Regular checkups and medical care are important to keep your child healthy. This chapter tells you about preventive services, many of which are free when your child is enrolled in this plan. If your child is ill or injured, take your child to their PCP.

We follow screening and preventive services from clinical practice guidelines, such as those published by the:

- United States Preventive Services Task Force (USPSTF).
- Centers for Disease Control and Prevention (CDC).
- American Academy of Pediatrics.
- Hawaii Department of Health's guidelines on screening for tuberculosis.

Child and adolescent preventive services and maternal/parental depression screening include:

- Immunizations.
- Screening for common chronic and infectious diseases and cancers.
- Clinical, non-clinical, and behavioral interventions to manage chronic disease and reduce the risks and complications.
- Support for self-management of chronic disease.
- Support for self-management for individuals at risk of developing a chronic disease.
- Screening for pregnancy intention.
- Counseling to support healthy living.
- Support for lifestyle change when needed.
- Screening for behavioral health conditions.
- Diabetes self-management education (DSME) for those who have diabetes or become diabetic during pregnancy (gestational diabetes).

Regular Checkups

Your child's regular checkups, shots, and many other health care services are free. This program is called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The EPSDT program covers QUEST members from birth through age 20. Here's a list of what to expect at your child's EPSDT checkups:

- Height, weight, and blood pressure checks.
- Eye exams.
- Hearing tests.
- Dental checkups. Community Case Management Corporation (CCMC) will help your child get dental care. They will answer your questions and help you find a dentist. Call: (808) 792-1070 or 1 (888) 792-1070 toll-free.
- Lab tests.
- Immunizations.
- Lead and TB (tuberculosis) assessments and screening.
- Mental and physical assessment.
- Screening for behavioral health or substance abuse.
- Screening for autism spectrum disorder.
- Medicines, including fluoride and multivitamins.
- Referrals to specialists for problems found during the exam.
- Referrals for the treatment of autism spectrum disorder include medically necessary intensive behavioral therapy and applied behavioral analysis. Services include psychiatric care, psychological care, speech, occupational and physical therapy, and prescription medication.
- Health education and guidance about your child's health care, growth, and development.

Well-baby and Well-child Care

Children should have regular checkups, or EPSDT visits. Checkups are needed more often during a child's first year and less often as they get older. We'll send reminders to you about getting the scheduled care for your child.

Preventive care is very important for children. Well-child visits with the doctor can help spot problems before they become serious. Your child doesn't have to be sick to get these checkups. You have other benefits under this plan if your child is sick and needs a doctor.

Call us for more information about:

- Your child's QUEST benefits.
- Finding a PCP for your child to get these checkups.
- Other services not covered by this plan. We can send you to other resources in the community.

Remember, all checkups listed here are free.

Immunizations

Immunizations should start at birth. Here are some guidelines:

- Most should be given before a child turns 2.
- A few more are needed between age 4 and 6.
- Children get remaining immunizations between the age of 11 and 12. This is also the age they should "catch up" on any immunizations they didn't get on time.

Please talk to your child's doctor if you have any questions.

Keep a record of your child's shots. Your child's doctor can give you a copy. Be sure to bring this record card, the "Official Lifetime Hawaii Immunization Record" (or your own record), whenever you take your child to the doctor, hospital, or clinic. Make sure the doctor or nurse signs and dates the card every time your child gets an immunization.

Note about Children Age 14-17

If you have children age 17 and younger, you must give your consent before they can get medical care. However, according to state law, children age 14 through 17 can get certain services without your approval. These services include:

- Care for a venereal disease.
- Care for a pregnancy.
- Family planning services.
- Outpatient mental health services.
- Substance abuse services.

Long-Term Services & Supports (LTSS)

Based on your enrollment category, you may be eligible for long-term services and supports (LTSS) if you meet a nursing-facility level of care.

You may also qualify if you're at risk of having to move into an institution to receive care and support. At-risk services are certain home and community-based services (HCBS) provided to you if your assessment indicates that you're at risk for worsening and going into a nursing home or other type of care outside of your home. You don't need to meet the criteria to receive all HCBS services. At-risk services include:

- Adult day care.
- Adult day health.
- Home-delivered meals.
- Personal assistance level I and II.
- Personal Emergency Response System (PERS).
- Private duty nursing.

To find out if you're eligible for these services, call us at (808) 948-6997 or 1 (844) 223-9856 toll-free to speak to a health coordinator. TTY users, call 1 (877) 447-5990 toll-free.

Health Coordination Services

When you become eligible for long-term services and supports, we will assign a health coordinator to you. Your health coordinator will:

- Coordinate your physical and behavioral health and long-term services and supports (LTSS).
- Make sure your care plan is carried out and is working the way that it needs to.
- Work with your providers to make sure they know what's happening with your health care and to coordinate your services.

Within 15 days of being approved for LTSS, your health coordinator will arrange to meet you in person to learn more about your health history. They will also work with you to develop a health action plan to ensure you receive the services

you need. After that visit, your health coordinator will stay in touch with you and reassess your needs annually or upon your request. If there is a significant change in your health condition your health coordinator will meet with you within 10 days for a reassessment. A significant change could be a change in living arrangements, being placed in an institution, or a change in health status.

If you are unhappy with your health coordinator or would like a different one, call us at (808) 948-6997 or 1 (844) 223-9856 toll-free. TTY users, call 1 (877) 447-5990 toll-free. There may be times when we need to change your health coordinator. If this happens, we will let you know who your new health coordinator is and how to contact them.

All LTSS services require prior approval and must be included as part of the health action plan. Working with your health coordinator will ensure that the services you receive are approved.

LONG-TERM SERVICES AND SUPPORTS BENEFITS	
Service	**Description and Limitations**
Adult Day Care	Adult day care is regular supportive care provided to four or more disabled adult participants. Services include: • Observation and supervision by center staff. • Coordination of behavioral, medical, and social plans and implementation of the instructions as listed in the participant's health action plan. • Therapeutic, social, educational, recreational, and other activities. Prior approval is required.
Adult Day Health	Adult day health refers to an organized day program of therapeutic, social, and health services. These services are provided to adults with physical and/or mental impairments who require nursing oversight or care. These services can include: • Emergency care. • Dietetic services. • Occupational therapy. • Physical therapy. • Doctor services. • Pharmaceutical services. • Psychiatric or psychological services. • Recreational and social activities. • Social services. • Speech-language pathology. • Transportation services. Prior approval is required.
Assisted Living Services	Assisted living services include: • Personal care. • Supportive care (homemaker, chore, personal care services, and/or meal preparation). Room and board are not covered. Prior approval is required.

LONG-TERM SERVICES AND SUPPORTS BENEFITS	
Service	**Description and Limitations**
Attendant Care	Also called personal assistance services. Attendant care is for children without family living with them to help with their Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADLs). The services are to prevent a decline in health status and to support keeping them in their homes and communities safely. Personal assistance services Level I (PAI): • May be self-directed. Member must be a social services recipient. • If institutional level of care is not met, services are limited to 10 hours per week. Personal assistance services Level II (PAII) • For help with ADLs and health maintenance that require moderate/substantial to total assistance. • To be provided by a: – Home health aide (HHA). – Personal care aide (PCA). – Certified nurse aide (CNA), or – Nurse aide (NA). • May be self-directed. Member must be a social services recipient.
Community Care Foster Family Home (CCFFH) Services	Services include: • Personal care. • Nursing. • Homemaker services. • Chores. • Companion services. • Medication oversight (to the extent permitted under state law). All services must be provided in a certified private home by a care provider who lives in the home. To get CCFFH services, you must already receive ongoing community care management agency (CCMA) services. Prior approval is required.
Community Care Management Agency (CCMA)	Care coordination services you will receive when you live in a CCFFH or other community setting. Prior approval is required.

LONG-TERM SERVICES AND SUPPORTS BENEFITS	
Service	**Description and Limitations**
Counseling and Training	Counseling and training activities include: • Member care training for member's family and caregivers regarding the nature of the disease and the disease process. • Methods of transmission and infection control measures. • Biological, psychological care, and special treatment needs/ regimens. • Employer training for consumer-directed services; instruction about the treatment regimens. • Use of equipment specified in the health action plan. • Employer skills updates as necessary to safely maintain the individual at home. • Crisis intervention. • Supportive counseling; family therapy. • Suicide risk assessments and intervention. • Death and dying counseling; anticipatory grief counseling. • Substance abuse counseling and/or nutritional assessment and counseling on coping skills to deal with the stress caused by the member's deteriorating functional, medical, or mental status. Counseling and training are a service provided to: • Members. • Families/caregivers on behalf of the member. Prior approval is required.
Environmental Accessibility Adaptations	These adaptations are necessary changes made to your home to ensure your health, welfare, and safety or to enable you to function with greater independence at home. Examples include: • Installation of ramps and grab-bars. • Widening of doorways. • Modification of bathroom facilities. • Installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. • Window air conditioners may be installed when necessary for your health and safety. Prior approval is required.

LONG-TERM SERVICES AND SUPPORTS BENEFITS	
Service	**Description and Limitations**
Home-delivered Meals	Nutritious meals delivered to where you live (excluding residential and institutional settings). The meals will not replace or substitute for a full day's nutrition. No more than two meals per day. Prior approval is required.
Home Maintenance	Home maintenance services are not included as a part of personal assistance and include: • Heavy duty cleaning to bring a home up to acceptable standards of cleanliness at the start of the service to you. • Minor repairs to essential appliances limited to stoves, refrigerators, and water heaters. • Fumigation or extermination services. Prior approval is required.
Licensed Residential Care	Residential care is a service provided in a licensed private home by a principal care provider who lives in the home. Residential care services include: • Personal care services. • Nursing, homemaker, chore, attendant care, and companion services. • Medication oversight (to the extent allowed by law). Prior approval is required.
Moving Assistance	This service is provided when a health coordinator assesses that you need to move to a new home to remain healthy. Circumstances are: • Unsafe home due to deterioration. • You use a wheelchair and live in a building with no elevator, multi-story building with no elevator. • Your home unable to support your equipment needs. • You are evicted. • You are unable to afford your home due to a rent increase. When possible, family members, neighbors, or others who can provide this service without cost must be used. Prior approval is required.
Non-medical Transportation	This service helps you travel as required by your care plan to get to community services, activities, and resources. When possible, family members, neighbors, or others who can provide this service without cost must be used. If you live in a residential care facility or a community care foster family home, this is not a covered service. Prior approval is required.

LONG-TERM SERVICES AND SUPPORTS BENEFITS	
Service	**Description and Limitations**
Nursing Facility Services	This service is covered when you need 24-hour-a-day care from a licensed nurse for help with activities of daily living and instrumental activities of daily living (IADLs). Nursing facility services include: • Independent and group activities. • Meals and snacks. • Housekeeping and laundry services. • Nursing and social work services. • Nutritional monitoring and counseling. • Pharmaceutical services and rehabilitative services. Prior approval is required.
Personal Assistance Services – Level 1	Assistance services Level 1 provides services to members who are unable to perform daily activities such as preparing meals; running errands to pay bills; picking up medications, groceries, or personal needs; or doing light or heavy housework without assistance. Level 1 services include: **Companion services** Nonmedical care that includes supervising and socializing with you. A companion may assist or supervise with making meals and doing laundry, shopping, and errands. A companion may do light housekeeping when it is incidental to your care and supervision. **Homemaker/chore services** Covers for the person who's responsible for routinely providing these services for you but is unable to care for themself and others right now or is absent for a short time. The services are routine and do not require special training or need the professional skills of a nurse or home health aide. Services are only for you, not for other members of the household. Services may include: • Do routine housecleaning (sweep; mop; dust; make beds; clean toilet, shower, or bathtub; take out the trash). • Wash, dry, iron, or mend clothing. • Shop for your household and personal needs. • Light yard work (e.g., mowing the lawn). • Make home repairs (e.g., changing light bulbs). • Make meals. • Run errands to pay bills or pick up medication. • Go with you to medical visits.

LONG-TERM SERVICES AND SUPPORTS BENEFITS	
Service	**Description and Limitations**
Personal Assistance Services – Level 1 (continued)	• Help with or supervise your bathing, dressing, grooming, eating, and moving around. • Check and document when you do treatments and take medication. • Report changes in your need for more or less services. Prior approval is required.
Personal Assistance Services – Level 2	Personal assistance services level 2 is provided to members who need help with their activities of daily living and health maintenance. Personal assistance services are provided by a home health aide, personal care aide, certified nurse aide, or nurse aide with applicable skills. Activities may include: • Personal hygiene and grooming including bathing, skin care, oral hygiene, hair care, and dressing. • Help with bowel and bladder care. • Help with movement and mobility. • Help with transfers. • Help with medications. • Help with routine or maintenance health care services by a personal care provider. • Help with feeding, nutrition, meal preparation, and other dietary activities. • Help with exercise, positioning, and range of motion. • Taking and recording vital signs including blood pressure. • Measuring and recording intake and output when ordered. • Collecting and testing specimens as directed. • Delegated nursing care. Prior approval is required.
Personal Emergency Response System (PERS)	PERS is a 24-hour emergency assistance service that enables you to get immediate help in an emergency. PERS items include a variety of electronic devices/services designed for emergency assistance. PERS services are limited for those individuals who: • Live alone. • Are alone for significant parts of the day. • Have no regular caregiver for extended periods. • Would otherwise need extensive routine supervision. PERS is not covered if you are living in a nursing home or hospital. Prior approval is required.
Respite Care	Respite care is provided on a short-term basis to provide relief to caregivers. It may be provided hourly, daily, and overnight. Respite care may be provided in the following locations: • Your home or place of residence. • Foster home or expanded-care adult residential care home. • Medicaid certified nursing facility.

LONG-TERM SERVICES AND SUPPORTS BENEFITS	
Service	**Description and Limitations**
Respite Care (continued)	• Licensed respite day care facility. • Other community care residential facility approved by HMSA. Prior approval is required.
Skilled (Private Duty) Nursing	Private duty nursing is provided when you need ongoing skilled nursing care. The service is provided by a licensed nurse and is included in your care plan. Prior approval is required.
Specialized Medical Equipment Warranty and Supplies	Specialized medical equipment and supplies refer to the purchase, rental, lease, warranty costs, assessment costs, installation, repairs, and removal of devices, controls, or appliances specified in the health action plan. This also includes: • Items necessary for life support. • Supplies and equipment needed to support the proper functioning of such items. Examples may include: • Specialized infant car seats. • Modification of a parent-owned motor vehicle to accommodate the child, e.g., wheelchair lifts. • Shower seat. • Portable humidifiers. • Medical supplies. • Heavy-duty items. Prior approval is required.
Subacute Facility Services	These services are provided in either a licensed nursing facility or a licensed and certified hospital in accordance with Hawaii Administrative Rules. The purpose of subacute facility services is to provide you with the support you need if you require more intensive skilled nursing care, but not acute care services. Prior approval is required.

Self-directed Care

If you receive personal assistance, respite care, or attendant care, self-directed care offers you more choices and control over who provides these services to you in your home. This also means you hire, train, and fire your providers. In some cases, you can choose a friend or loved one to do this for you.

Community Integration Services (CIS)

CIS assists members with behavioral health and/or complex physical health needs and are at risk of or do not have an adequate place to stay overnight or have a history of frequent and/or lengthy stays in a facility.

CIS will work with you to have a person-centered plan that will help you get housing and support while seeking or continuing treatment that will improve, stabilize, or prevent further worsening of your condition.

CIS provides the following services:

Pre-tenancy support

- Have a housing assessment that states your preferences, the support CIS provides that you need to integrate in the community, and a budget for housing and living expenses.
- Have a housing support plan based on the assessment with short- and long-term goals and how they will be met.
- Assist with:
  - Securing social services to help with getting the documents needed.
  - Completing applications for assistance.
  - Setting up training on pre-tenancy supports.
- Take part in person-centered plan meetings.

Tenancy sustaining services

- Support you in:
  - Service planning.
  - Attending person-centered plan meetings.
- Coordinate and link you to services and service providers:
  - Primary care and health homes.
  - Substance use disorder (SUD) treatment.
  - Mental health providers.
  - Providers for medical, vision, nutritional, and dental services.
  - Vocational, education, employment, and volunteer support.
  - Hospital and emergency room services.
  - Probation and parole.
  - Crisis services.
  - End of life planning.
  - Other support groups and natural supports.
- Assist in accessing support to preserve the most independent living. Services include:
  - Individual and family counseling.
  - Support groups.
  - Natural supports.
- Provide support to help you inform the landlord/property manager:
  - About your disability (if authorized and appropriate.)
  - Detailing accommodations needed.
  - Addressing emergency procedures.
- Coordinate with you to review, update, and modify the housing support and crisis plan on a regular basis. The plan should have the current needs and address existing or recurring housing retention barriers.
- Connect you to training and resources to assist in being a good tenant and to comply with their lease.
- Provide ongoing support with activities related to household management

These services are for members age 18 or older. Prior approval is required.

Additional Benefits – Managing Your Health and Well-being

Maternity Programs

HMSA wants to support you in your pregnancy and having a healthy baby.

If you are pregnant, connect with your OB-GYN or primary care provider. Your provider will work with you on your pregnancy and give you personalized information and guidance. They can also help you get the right care and link you to helpful community resources.

HMSA Pregnancy and Postpartum Support Program

To help you have a healthy pregnancy, this program pairs you with a maternity nurse who will call you to provide personalized education and counseling. Nurse support, which complements the care you receive from your OB-GYN, lasts through your pregnancy and up to six months after your baby is born. This program is available to HMSA members at no cost. As soon as your pregnancy is confirmed, call 1 (855) 329-5461 toll-free to enroll.

Positively Pregnant

HMSA works with Kapiolani Medical Center for Women and Children to offer a free two-hour class. Positively Pregnant is a community program open to people who are pregnant or thinking of starting a family. Partners are urged to come, too.

Call Hawaii Pacific Health at (808) 527-2588 if you have any questions or to sign up.

Diabetes During Pregnancy

For those who develop diabetes while pregnant (this is called gestational diabetes), their doctor may refer them to community resources to help manage and monitor their health. These services give those who are pregnant the information and skills to help them have a healthier pregnancy. Talk to your doctor if you have questions about your condition.

Postpartum Depression Program

Postpartum care is a critical component to healthy parents. The new parents and their doctor will work together on their postpartum needs, including help if they develop serious depression after giving birth.

These people are at risk for depression:

- Those who gave birth within the last year.
- Those who had a miscarriage.
- Those who recently weaned a child from breastfeeding.

Signs of depression may not go away without help from a doctor. You may not be able to take care of yourself and your baby if you do not get help. The good news is that there are safe and effective ways to treat postpartum depression.

HMSA encourages you to check on your current level of health with your doctor. If you have any questions or would like information, call 1 (855) 329-5461 toll-free. TTY users, call 1 (877) 447-5990 toll-free.

Smoking Cessation Program

Quitting tobacco is one of the hardest things to do. That's why HMSA partnered with the Hawai'i Tobacco Quitline to give you the support you need to quit for good. Hawaii based Quit Coaches® will be in touch with you over the phone or online to teach you strategies for dealing with cravings and nicotine withdrawal. Check with your PCP to see if this program is a good option for you, then call 1 (800) QUIT-NOW (784-8669) toll-free.

HMSA Well-being Resources

HMSA's approach to well-being provides you with additional support to help you work closely with your provider to improve and maintain good health.

- Tools to help you learn more about your condition and keep track of your medications, exercise, and action plans.
- Potential phone calls from health care professionals who may conduct a health and well-being assessment, answer questions, help you create a self-care goal plan, provide information about a disease, and offer psychological support.
- Reminders about important screenings and exams.
- Other educational materials on request.

Members with the following conditions are automatically enrolled in the program:

- Asthma.
- Chronic obstructive pulmonary disease.
- Cardiovascular disease.
- Diabetes.
- Hypertension

There's no cost for this program. You may opt out at any time.

Mail-order Pharmacy Program

Do you take daily medications for ongoing health conditions such as high blood pressure, high cholesterol, or diabetes? You could get a 90-day supply of those medications mailed to you at no cost.

It's a convenient, safe option for HMSA QUEST members. Controlled substances, however, cannot be mailed.

Ask your doctor if your medication is available through mail order. Your doctor can call your prescription in to our mail-order pharmacy.

Health Education Workshops

A healthy lifestyle can help you live life to the fullest. We use fun, interactive methods to teach you about fitness, nutrition, how to manage stress, and overall well-being. HMSA members, you can come to our workshops at no charge.

Our workshops are currently offered only online. For information, visit hmsa.com/well-being/workshops/ or call 1 (855) 329-5461 toll-free.

HMSA365

If you're trying to live healthy at prices you can afford, HMSA can help. HMSA365 helps you save money on all kinds of health and wellness products and services such as:

- Acupuncture.
- Chiropractic care and massage therapy.
- Gym memberships, yoga, and exercise classes.
- Hearing aids.
- Hypnotherapy.
- LASIK, eye exams, frames, and lenses.
- Medical transportation.
- Vitamins and supplements.

And much more!

With HMSA365, you can reach your health goals and save money. All you need is your HMSA membership card.

For more information, call HMSA's Health and Well-being Support at 1 (855) 329-5461 toll-free. TTY users, call 711. Or visit hmsa.com/hmsa365.

HMSA Identity Protection Program

HMSA works hard to protect and secure your personal information. For an extra layer of protection, HMSA offers eligible HMSA members identity restoration and credit monitoring services at no cost.

For more information or to sign up, visit hmsa.com/help-center/identity-protection/.

Other Programs

You may be eligible for free services offered through the state and community. If you or your children qualify, we can help you get in touch with these programs.

PROGRAM NAME	DESCRIPTION
Early Intervention	The Hawaii Department of Health's early intervention programs are for children from birth through age 3 who: • Have delays in development. • May be at risk to develop a delay and need special medical care and services. The following services are provided in the locations where your child lives, learns, and grows: • Assistive technology (special equipment). • Audiology services. • State of Hawaii, care coordination services. • State of Hawaii, family training, counseling, and home visits. • State of Hawaii, health services related to early intervention. • Medical services for diagnosis or evaluation. • Nursing services. • Nutrition services. • Occupational therapy (self-help, small muscles). • Physical therapy. • Psychological services. • Social work services (counseling) • Special instruction. • Speech-language pathology. • Transportation for early intervention services. • Vision services. Call (808) 594-0066 or 1 (800) 235-5477 toll-free.
Head Start	The Executive Office of Early Learning's Head Start and Early Head Start programs help meet the health needs of eligible kids and get them ready for school. Free services are available. Call (808) 586-0796 or visit earlylearning.hawaii.gov. Early Head Start (EHS) and Head Start (HS) programs. • Parents & Children Together – Hawaii Island (HS) (808) 961-0570 – Oahu (EHS/HS) (808) 842-5996 • Family Support Hawaii (Kona) (EHS) (808) 376-2368 or (808) 466-2029 • Maui Economic Opportunity, Inc (HS) (808) 249-2988 • Maui Family Support Services (EHS) (808) 242-0900 • Honolulu Community Action Program (HS) (808) 847-2400 • Child and Family Service (Kauai) (HS) (808) 245-5914

PROGRAM NAME	DESCRIPTION
Supplemental Nutrition Program for Women, Infants, and Children (WIC)	The Hawaii Department of Health's Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a national program that helps those who are pregnant, new parents, and young children eat well and stay healthy. If you qualify for this program, you get credit on an eWIC card to buy healthy foods such as milk, juice, eggs, cereal, cheese, and peanut butter. You can also see a nutritionist. Examples of how the nutritionist will help you include: • Choosing the right foods to eat while you are pregnant. • Teaching you about breastfeeding. • How to take care of yourself to grow a healthy baby. • Teaching you about infant feeding.
Intentional Termination Of Pregnancies (ITOPs)	Intentional terminations of pregnancy (ITOPs) aren't covered by HMSA. They are covered by the Med-QUEST Division (MQD). Your provider must contact MQD's Clinical Standards Office (CSO), an ITOP request for authorization. MQD can also arrange transportation.
Services for Individuals with Developmental Disabilities/Intellectual Disabilities(DD/ID)	The Hawaii Department of Health Developmental Disability Division (DOH/DDD) provides services for people who need developmental or intellectual disability services to help them remain in the community. The DDD case manager is the primary case manager who coordinates services and conducts regular assessments of the member to develop a health action plan to carry out needed services. The DDD case manager ensures there is good coordination with the health plan health coordinators. Services may include: • Adult day health. • Assistive technology. • Chore services. • DD/MR emergency services. • Environmental accessibility adaptations. • Modifications to vehicles. • Monitoring and supervision of Member. • Personal assistance/habilitation (PAB). • Personal emergency response system (PERS). • Residential habilitation (RESHAB). • Respite care. • Skilled and/or private nursing. • Specialized medical equipment and supplies. • Speech, physical, and occupational therapy. • Supported employment. • Training and consultation. • Transportation. Call (808) 586-5840 or fax (808) 586-5844 for more information.

PROGRAM NAME	DESCRIPTION
Behavioral Health Services for Children/Support for Emotional and Behavioral Development (SEBD) Program	Children age 3 through 20 years who have significant problems with different areas of life such as home and school, have a qualifying mental health diagnosis, and qualify for QUEST are eligible for the SEBD program. SEBD is part of the Hawaii Department of Health's Child and Adolescent Mental Health Division (CAMHD). Call the nearest family guidance center and speak with an SEBD intake coordinator to make an appointment. SEBD provides services that are appropriate to the child's needs and may include: • 24-hour crisis mobile outreach. • Community-based residential programs. • Functional family therapy. • Hospital-based residential services. • Intensive case management. • Intensive home and community-based intervention. • Multidimensional treatment foster care. • Multisystemic therapy. • Psychosexual assessment. • Respite home. • Therapeutic group home. **Family Guidance Centers** **OAHU** Central Oahu – Pearl City 860 Fourth St., 2nd Floor Pearl City, HI 96782 Phone: (808) 453-5900 Fax: (808) 453-5940 Windward Oahu – Kaneohe 45-691 Keaahala Road Kaneohe, HI 96744 Phone: (808) 233-3770 Fax: (808) 233-5659 Leeward Oahu 601 Kamokila Blvd., Suite 355 Kapolei, HI 96707 Phone: (808) 692-7700 Fax: (808) 692-7712 Honolulu 3627 Kilauea Ave., Room 401 Honolulu, HI 96816 Phone: (808) 733-9393 Fax: (808) 733-9377 Family Court Liaison Branch 42-470 Kalanianaole Highway Building 3 Kailua, HI 96734 Phone: (808) 266-9922 Fax: (808) 266-9933 **MAUI** Wailuku 270 Waiehu Beach Road, Suite 213 Wailuku, HI 96793 Phone: (808) 243-1252 Fax: (808) 243-1254 Lahaina 1830 Honoapiilani Highway Lahaina, HI 96761 Phone: (808) 243-1252 Fax: (808) 243-1254

PROGRAM NAME	DESCRIPTION
Behavioral Health Services for Children/Support for Emotional and Behavioral Development (SEBD) Program (continued)	**MOLOKAI** 65 Makaena Place Kaunakakai, HI 96748 Phone: (808) 553-7878 Fax: (808) 553-7874 **LANAI** c/o Lahaina Office 1830 Honoapiilani Highway Lanai City, HI 96763 Phone: (808) 662-4045 Fax: (808) 661-5450 **HAWAII** Hilo 88 Kanoelehua St., Suite A-204 Hilo, HI 96720 Phone: (808) 933-0610 Fax: (808) 933-0558 Kona 81-980 Halekii St., Room 101 Kealakekua, HI 96750 Phone: (808) 322-1541 Fax: (808) 322-1543 Waimea 65-1230 Mamalahoa Highway, Kamuela, HI 96743 Phone: (808) 887-8100 Fax: (808) 887-8113 **KAUAI** 3-3204 Kuhio Highway, Room 104 Lihue, HI 96766 Phone: (808) 274-3883 Fax: (808) 274-3889
Community Care Services	Adults diagnosed with a serious and persistent mental illness can get more behavioral health services. These services include: • Coordinating your services through a case manager. • Psychosocial rehabilitation. • Therapeutic living support. • Partial hospitalization or intensive outpatient hospitalization. • Psychiatric or psychological evaluation and treatment. To find out if you are eligible for these services, call ‘Ohana Community Care Services at 1 (888) 846-4262 toll-free. If you’re enrolled in this program, all your care related to behavioral health will be covered by CCS.

PROGRAM NAME	DESCRIPTION
State of Hawaii Organ and Tissue Transplant (SHOTT) Program	Medically necessary transplants are covered through the SHOTT program. The type of transplants may include the following: For adults: • Liver. • Heart-lung. • Kidney. • Bone marrow. • Heart. • Lung. • Kidney-pancreas. For children from birth until the month of their 21st birthday, transplants may include the transplants listed above for adults and: • Small bowel with liver. • Small bowel without liver. The Department of Human Services and the SHOTT program determine member eligibility for a transplant. The SHOTT program coordinates air and ground transportation, meals, and lodging. If you have any questions, call the MQD provider hotline at (808) 692-8099.
Cleft And Craniofacial Services	Kapiolani Cleft and Craniofacial Clinic serves children with cleft and craniofacial disorders who live in Hawaii. The Children with Special Health Needs (CSHN) branch of the Hawaii Department of Health's Family Health Services Division can assist with coordinating care, outreach and support, and obtaining health plan approval for services.

What's Not Covered

Certain medical care is never covered by this plan. If a treatment, service, supply, or drug isn't specifically listed here, it doesn't always mean it's covered by your plan. Even if your doctor recommends a service or supply, it may not be covered. Excluded services will be reviewed for medical necessity on request. If you have questions about your plan, please call us.

HMSA QUEST will not pay for inpatient hospital services related to a medical condition that was not present when admitted to the hospital. Members are also not required to pay for these services.

The following treatments, services, supplies, and drugs are not covered:

- All medical and surgical procedures, therapies, supplies, drugs, and equipment for the treatment of sexual dysfunction or inadequacies.
- Ambulance wait time, doctor wait time, stand-by services, telephone consultations, telephone calls, writing of prescriptions, and stat charges.
- Biofeedback, acupuncture, naturopathic services, faith healing, Christian Science services, hypnosis, massage treatment (by masseurs), and any other form of self-care or self-help training and any related diagnostic testing. Self-help classes such as diabetes education, nutrition classes, and prenatal care classes are not QUEST medical benefits, but are available as a community education service to HMSA QUEST members.
- Care and treatment for sex and marriage problems, bereavement counseling, weight control, employment counseling, primal therapy, long-term character analysis, marathon group therapy, and consortium.
- Chiropractic services unless covered by Medicare or prescribed to treat conditions detected under EPSDT.
- Contact lenses for cosmetic purposes and bifocal contact lenses for adults.
- Experimental and/or investigational services, procedures, drugs, devices, and treatments, and drugs not approved by the FDA. Routine costs related to a qualifying clinical trial are covered. Prior authorization is required. Refer to the QUEST Benefits Package table. Go to Routine Costs for Qualifying Clinical Trials for more information.
- Immunizations for travel or work-related indications.
- Lounge beds, bead beds, water beds, day beds, over-bed tables, bed lifters, bed boards, and bed side rails if not an integral part of a hospital bed.
- Nonmedical items such as books, telephones, beepers, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, fans, household items, motor vehicles, and furnishings.
- Organ transplants that don't meet the guidelines established by Medicaid and organ transplants that aren't specifically identified as a Medicaid benefit.
- Orthoptic training.
- Oversized lenses blended or progressive bifocal lenses (except when prescribed for children), tinted or absorptive lenses (except for aphakia, albinism, glaucoma, or medical photophobia), trifocal lenses (except as a specific job requirement), and spare glasses.
- Penile and testicular prostheses and related services, sterilization reversal, in vitro fertilization, artificial insemination, sperm banking procedure, fertilization by artificial means, and all procedures and drugs to treat infertility or enhance fertilization.
- Personal care items such as shampoo, toothpaste, toothbrushes, mouthwash, denture cleanser, shoes, slippers, clothing, laundry services, baby oil and powder, sanitary napkins, soap, lip balm, and bandages.
- Physical exams for travel – domestic or foreign.

- Physical exams for employment when the member is self-employed or as a requirement for continuing employment (e.g., truck and taxi drivers' licensing, other physical exams as a requirement for continued employment by the state or federal government or by private business).
- Physical exams or psychological evaluations as a requirement for Hawaii or other states drivers' licenses or to secure life and other insurance policies or plans.
- Refractive eye surgery.
- Routine foot care and treatment of flat feet.
- Services provided by a medical professional to a member of the professional's immediate family or household. Immediate family is defined as husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.
- Surgery or treatment that only improves physical appearance and does not restore or materially improve a bodily function (e.g., hair transplants, piercing of ears or other body areas, electrolysis).
- Swimming lessons, summer camp, gym membership, and weight control classes.
- Topical application of oxygen.
- Treatment of baldness, including hair transplants, topical medications, wigs, and hairpieces.
- Treatment of complications resulting from previous cosmetic, experimental, or investigative services, and other services that are not covered.
- Treatment of persons confined to public institutions.
- Treatment for obesity, weight loss programs, food, and food supplements, including prepared-formula health foods. HMSA QUEST covers surgical treatment of morbid obesity. Other services performed for weight loss or weight control are not a benefit. If you're being treated for heart disease, thyroid disease, or other medical conditions, be sure your doctor indicates the appropriate medical diagnosis on the claim.
- Treatment of Hansen's disease after a definite diagnosis has been made except for surgical or rehabilitative procedures to restore useful function.
- Treatment of pulmonary tuberculosis when treatment is available at no charge to the general public.

Rights & Responsibilities

HMSA complies with applicable federal and state laws on member enrollment rights and ensures that HMSA's staff and participating providers take these rights into account when providing services to enrolled members.

Your Rights

You have a right to receive information about your health plan that is easily understood; in larger print; in audio format; translated into Chinese, Korean, Ilocano, or Vietnamese; or orally translated at no charge to you. Once you tell us that you want us to send you information in one of the alternate languages, we will send it to you within seven days of the request or the next business day.

You have a right to oral interpretation at no cost. You have a right to sign language services and TTY/TDD services at no cost.

You have a right to direct access to a specialist who is able to take care of your special health care needs identified through an assessment and outlined in a course of treatment.

You have rights under state law, as stated in the Hawaii Revised Statutes 432E, Patient's Bill of Rights and Responsibilities.

You have the right to be furnished with health care services in accordance with 42 CFR sections 438.206 through 438.210.

You have rights under this plan. You may make suggestions to us about your rights and responsibilities. If you have a grievance, follow the process described in Grievances & Appeals starting on page 60.

Exercising your rights will not negatively affect how we or network providers treat you. This is true regardless of race, ancestry, sex, physical or mental disability, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or the source of the payment for your care.

You have rights to receive services in a culturally competent manner.

You have rights to receive services in a coordinated manner.

Respect

You have the right to be treated with dignity and respect This includes the right to treatment that:

- Is fair, without prejudice, and given with regard to your culture.
- Does not restrain or keep you away from others unless it's medically necessary or for safety.
- Will not be used to control, punish, or retaliate. Nor will it be for convenience only.

Privacy and Information

You have the right to have your privacy protected. You have a right to information and the privacy of that information. This includes the right to:

- Information about HMSA and its services.
- Information about member rights and responsibilities.
- Information about HMSA providers.
- Keep your medical records and talks with your doctors private.
- Request and get copies of your medical records. Only you, your authorized representative, or your doctor may get copies of your records without your written approval. This is true unless otherwise allowed by law.
- Request that your medical records be amended or corrected.
- Know what medical services you can get and how to get them.
- Know the names and skills of the doctors involved in your treatment.

Your PCP

You have the right to choose or change your PCP. This includes knowing how to do so. PCP means primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate or arrange your care.

Your Plan
You have the right to:

- Know how we make treatment decisions. This includes payment structure.
- Review any bills for services that aren't covered. This right is without regard to the payment source.
- Know the reason a service isn't covered.
- Voice grievances or appeals about HMSA or the care we provide.
- Not have services arbitrarily denied or reduced in amount, duration, or scope solely because of diagnosis, type of illness, or condition.
- Covered services provided by HMSA QUEST for which DHS doesn't pay us for.
- Receive services out-of-network if the providers in the HMSA QUEST network are unable to provide the services. The services provided out-of-network would be paid not more than what would be paid if the services were provided in the HMSA QUEST provider network.

Your Medical Condition
You have a right to information about:

- Your medical condition It should be given to you in a way that you can understand. Except for emergency services, the information should include:
  - A description of the procedure or treatment.
  - Significant risks involved with a procedure or treatment.
  - Any alternate course of treatment or non-treatment.
  - Any risks involved with an alternate course of treatment or non-treatment.
  - The name of the person who will carry out the services.
- Any medications you take or may need to take. For example, the name of the drug and how you need to take it.
- Any care you need after you check out of a hospital.

Right to Consent or Refuse Care
You have the right to consent to or refuse treatment. You have the right to take part in treatment decisions. This includes the right to:

- Work as part of a team with a provider in deciding what health care is best for you.
- Say yes or no to the treatment your doctor recommends.

You have the right to:

- Advance notice, including:
  - The time and location of an appointment.
  - The name of the doctor providing care.
- Access to care that's timely, including:
  - Medical care within 24 hours for immediate care and without prior approval for emergency medical services.
  - Medical care within 24 hours for urgent care and for PCP pediatric sick visits.
  - Medical care within 72 hours for PCP adult sick visits.
  - Medical care within 21 days for PCP routine visits.
  - Behavioral health care within 21 days for adult and child routine visits.
  - Medical care within four weeks for visits with a specialist or for non-emergency hospital admissions.
- Provider office hours of operation for HMSA QUEST members to be the same as the provider office hours for all other patients.
- Access to care that's without barriers in accordance with the Americans with Disabilities Act, including:
  - Being able to get in and out of a doctor's office if you have a disability or other condition that limits mobility.
  - The right to an interpreter who can:
    - Speak your native language.
    - Help with a disability.
    - Help you understand information.

Providers
You have the right to:

- Go to a specialist with a referral from your PCP.
- Go to a doctor who is not in the network if:
  - A network doctor is not available.
  - A network doctor does not have the skills to treat your condition.
  - You have a medical emergency and cannot reach a network provider.
  - In these cases, you will not pay more than if you had received the services from a provider in the network.
- A second opinion at no cost to you.
- Go to an emergency room if you have:
  - A medical emergency.
  - Unusual or extenuating circumstances that prevent you from getting care from your PCP.

Consistency
You have the right to coverage that is consistent. This right is without regard to diagnosis, type of illness, or condition. Services won't be arbitrarily denied or reduced in amount, duration, or scope.

Treatment Decisions
You have the right to:

- Discuss treatment options with your doctor. It should be given to you in a way that you can understand your condition. This right is without regard to cost or coverage.
- You have the right to participate in the development of a treatment or service plan if you need one.
- Refuse treatment or leave a hospital. Any negative outcome of such decision is your responsibility if it's against the advice of your doctor.
- Know if a doctor wants to engage in an experiment that could impact your care or treatment. You have the right to refuse to take part in such research projects.
- Complete an advance directive, living will, or other directive to give to your doctors. See Advance Directives on page 67.
- Transfer your rights to a person who has legal authority to make medical decisions on your behalf.

Right to Financial Protection
You are not responsible for:

- HMSA's debts in the event we go out of business.
- Services that we choose to cover even though DHS does not pay HMSA.
- Covered services you get that DHS or HMSA does not pay the provider for.
- Charges for covered services that are more costly than covered services provided by a network provider because the provider:
  - Is under a contract.
  - Was referred to you.
  - Other arrangement.

Your Responsibilities

You have the responsibility to learn and understand each right you have under the QUEST program. You should:

- Ask questions if you don't understand your rights.
- Learn what health plan choices are available in your area.
- Read your member handbook.
- Comply with all terms of your membership.
- Give your health care providers the information they need to care for you to the extent possible.
- Report changes that may affect your membership.

Self-management
To the degree possible, you must:

- Participate in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. Be included in service and care plan development, if applicable.
- Understand your health problems.
- Work as a team with your provider in deciding what health care is best for you.
- Follow care plans and instructions for care that you and your provider have agreed on.
- Understand how the things you do can affect your health.
- Do the best you can to stay healthy.
- Treat providers and staff with respect.
- Report any wrongdoing or fraud.

- Be aware that should the state make changes to QUEST that requires you to share in the costs of your medical coverage, you will be responsible for your cost share as described in 42 CFR 447.50.

Cost Sharing
You may be responsible to share in the cost of your health care services. This happens when certain financial eligibility requirements aren't met. Your Hawaii Medicaid eligibility worker will figure out your cost-sharing portion and let you know. If you have a cost share, you must pay that amount every month to one of your providers (e.g., a nursing facility or a home- and community-based provider) or us.

You would only be responsible for cost sharing in accordance with 42 CFR sections 447.50 through 447.57.

Inquiries

We welcome any questions you may have about the activities or behaviors of:

- Your health plan,
- Our operations,
- Our partners,
- Our providers,
- Requests for disenrollment, and
- Your relationship with us.

Please call us with your questions or if you want to let us know how we're doing.

Grievances & Appeals

Sometimes, you may tell us that you are not happy with our responses to your questions. We will tell you, your authorized representative, or a provider who's acting on your behalf with your consent of your grievance and appeal rights. Call us and we can guide you through the process. Our staff can even help you file a grievance or an appeal by working with you to write a summary.

There are times when you may want your doctor or someone else to represent you. You can call and tell us who it is, but to make sure that we have the right person, be prepared to give your consent in writing.

If your first language is not English, we will give you every reasonable assistance in completing the forms and taking the needed steps to file your request. This includes providing auxiliary aids and services to you on request. These services include providing written translation or oral interpretation services. If you are hearing impaired and use TTY, call 1 (877) 447-5990 toll-free for help.

Your grievance or appeal will be reviewed by someone who has not been involved in deciding anything about your case earlier and who isn't subordinate to the reviewer(s) who previously reviewed your case.

For an appeal that deals with medical, behavioral health, and long-term services, or an administrative denial for children under age 21, a health plan medical director will be the reviewer. This is especially true for any of the following:

- A grievance or appeal that deals with medical, behavioral health, and long-term services.
- An appeal that approves a service that's less than the service requested.
- A grievance that deals with a review of an expedited appeal.
- An appeal of a denial due to lack of medical necessity.

All administrative denials for those under age 21 will be reviewed and approved by the medical director.

Failure to meet notice and time frame deadlines
If we fail to meet the notice and time frame deadlines for a grievance or an appeal, you or your authorized representative may file a request for a state administrative hearing.

We will review all documents, records, and information you give us. You may also send us information that wasn't part of the record we used to make the initial decision.

Grievances

When to File
You or your authorized representative may file a grievance if you're not happy with:

- The quality of the care or service provided.
- The way our staff treated you.
- Your doctor and how you were treated by the doctor or the staff.
- The way your rights weren't respected.
- You don't agree with us extending the time we need to make a prior authorization decision.

Who Can File
You, a person you choose, or your doctor can file a grievance, either verbally or in writing, at any time. We will accept any grievance filed on your behalf from a representative even without verbal or written consent from you. However, we will send a written copy of our decision to you. We need your verbal consent before we can interact with your authorized representative or your doctor. You or your authorized representative must give us written consent before a doctor can file a grievance on your behalf.

We Can Help You Write Your Grievance
Our grievance coordinator can write a summary of your grievance and get your consent when you want someone else to represent you. We can also get interpreter services if you do not speak English. If you are hearing impaired, call TTY at 1 (877) 447-5990 toll-free.

The grievance must include:

- Your name, address, phone number, and HMSA membership number.
- The date of the grievance.
- The facts to support the grievance.
- Copies of any related records or papers. Keep a copy of what you send to us for your records. We will not return the packet to you.

Timeframe for Our Response
You can submit your grievance at any time. There is no time limit.

We have five business days from the date we receive your grievance to let you know by an acknowledgement letter that we received it.

We have 30 calendar days from the date we received your grievance to give you our decision. We'll tell you the results and date of our decision in a resolution letter.

If we need more time to make our decision and this delay is in your interest, we'll let you know why in writing and what additional information is required. We will make every reasonable effort to call you to let you know as soon as possible. We will give you written notice of the delay within two days of our decision. This notice will have the reason for our decision to extend the timeframe. You will also be informed of your right to file a grievance if you disagree with the extension.

If this happens, we'll add up to 14 more calendar days to our response time. You can also request an extension.

Grievance Decision
Once we decide, we'll tell you in a resolution letter. It will include our decision and the date of the decision. We'll also explain the reason for our decision, and we'll tell you about your right to file a grievance review with DHS. Our decision is final unless you choose to file a grievance review.

When You Disagree – Asking for a Grievance Review

When to File

If you're not happy with the resolution of your grievance or you feel your grievance is unresolved, you can ask for a grievance review from DHS, Med-QUEST Division.

How to File

- To file your grievance review by phone, call DHS, Med-QUEST Division, at (808) 692-8094.
- To submit a written grievance review, write to the DHS, Med-QUEST Division, at:

  Med-QUEST Division

  Health Care Services Branch
  P.O. Box 700190
  Kapolei, HI 96709-0190

  Phone: (808) 692-8094

Timeframe

You have 30 calendar days from the date you receive our final grievance decision to ask for a grievance review.

Grievance Review Decision

The DHS, Med-QUEST Division, will respond within 90 calendar days after receiving your request for a grievance review. The grievance review decision made by DHS, Med-QUEST Division, is final.

Appeals

When to File

You may file an appeal with us when one of the following adverse decisions (previously called "actions") has occurred and you've received notice of our adverse benefit decision:

- The service you asked for was denied or restricted.
- The authorization for a service was terminated, suspended, or reduced.
- You aren't happy with your health care services because they weren't timely, there were unreasonable delays, or the grievance or appeal decision wasn't carried out in a timely way.
- You don't agree with a payment that was denied or reduced.

Who Can File

You, your authorized representative, or your doctor can file an appeal either verbally or in writing. We need your verbal consent before we can interact with your doctor or authorized representative. Your doctor may request for an appeal on your behalf but must provide your written consent to do so. When someone requests an appeal for you, they're called an "authorized representative." To have an authorized representative, you must file a form with us with the person's name. Call us to request the form and/or if you need help writing the appeal.

The appeal request must include:

- Your name, address, phone number, and HMSA membership number.
- The date of the appeal.
- The facts to support the appeal and why you don't agree with our decision.
- Copies of any related records or papers. Keep a copy of what you send to us for your records. We won't return the packet to you.

You or your authorized representative have the right to ask to review your case file, including medical records and any other documents that are part of your appeal. When you ask to review your case file we have for the appeal, you or your authorized representative have the right to ask for a copy. It will be provided free of charge. The request must be made sufficiently in advance of when we need to make our appeal decision.

We Can Help You Write Your Appeal

Our grievance coordinator can write a summary of your appeal and get your verbal consent when you want someone else to represent you. We can also get interpreter services if you don't speak English. If you're hearing impaired and use TTY, call 1 (877) 447-5990 toll-free.

Timeframe for Our Response

You have 60 calendar days from the date of the denial letter to file an appeal.

We have five business days from the date we receive your appeal request to send you an acknowledgement letter.

We have 30 calendar days from the date we receive your appeal to give you our decision in a final resolution letter. We may give you a response sooner if your health condition requires a quick response.

If we need more time to make our decision, we'll let you know why in writing within two calendar days and what additional information is required. We'll make every reasonable effort to give you verbal notice of the delay. We'll also send you written notice within two calendar days and the reason for the decision to extend the timeframe, and what additional information is required. If we fail to keep to the notice and timing requirements of your appeal, our failure would be seen as having exhausted your appeal process and you may choose to file for a state fair hearing.

If this happens, we'll add up to 14 more calendar days to our response time. You can also request an extension.

We may give you a response sooner if your health condition requires a quick response. We'll tell you in writing the results of the decision and the date of the decision.

Appeal Decision
Once we decide, we'll tell you in writing. It will include our decision and the date of the decision. We'll also explain the reason for our decision, and we'll tell you about your right to request a state administrative hearing and what steps you need to take.

Mail or Fax Written Grievances or Appeals
For written grievances or appeals, mail, email, or fax us the information.

Mail HMSA P.O. Box 1958
Honolulu, HI 96805-1958
Attn: Grievance Coordinator

Email ga_help@hmsa.com

Fax (808) 948-8224

Phone Numbers
For grievances or appeals over the phone, call the grievance coordinator. The phone numbers are:

- (808) 952-7843
- 1 (800) 462-2085 toll-free

Expedited Appeals

When to File
You may file an expedited appeal if the standard appeal timeline:

- Could seriously jeopardize your life, physical or mental health,
- Could seriously jeopardize your ability to attain, maintain, or regain maximum function, or
- Could subject you to severe pain that can't be managed without the care or treatment that's being requested.

We'll let DHS know within 24 hours after we receive your request that you've filed an expedited appeal.

Who Can File
You, your authorized representative, or your doctor can file an expedited appeal either verbally or in writing. We need your verbal consent before we can interact with your doctor or authorized representative. You must give us written consent before your authorized representative or doctor can file an expedited appeal on your behalf. When someone requests an expedited appeal for you, they're called an "authorized representative." To have an authorized representative, you must file a form with us with the person's name. Call us to request the form and/or if you need help writing the expedited appeal.

No punitive action will be taken against a provider who requests an expedited appeal or who supports a member who files an expedited appeal.

The expedited appeal request must include all of the following:

- Your name, address, phone number, and HMSA member number.
- The date of the expedited appeal. For requests received over the phone, the date of the call will be the date of the inquiry.
- The facts to support the expedited appeal.
- Copies of any related records or papers. Keep a copy of what you send to us for your records. We won't return the packet to you.
- Please use the mail, fax, or phone information noted earlier in this chapter to file your expedited appeal request.

We Can Help You Write Your Expedited Appeal
If you need help writing an expedited appeal, we can help. Our grievance coordinator can write a summary of your expedited appeal and get your consent when you want someone else to represent you. We can also get interpreter services if you don't speak English. If you're hearing impaired and use TTY, call 1 (877) 447-5990 toll-free. A written appeal request isn't required when an oral request has been made.

Timeframe for Our Response
We have no more than 72 hours from the date we receive your expedited appeal request to give you our decision.

If we need more time to make our decision, we'll let you know why in writing within two calendar days and make reasonable efforts to inform you orally. We'll let you know what additional information we need and how much time you have to get it to us. We'll report our request for an extension to DHS and show how this delay will be in your best interest. If this happens, we'll add up to 14 more calendar days to our response time. We may give you a response sooner if your health condition requires a quick response but no later than the date the extension expires. You may also send us a request for an extension.

Denial of Expedited Appeal Request
If you asked for an expedited appeal but we decide that one isn't needed, we'll call and inform you in writing within 72 hours. It will include the reason for our decision. You should receive our written notice within two calendar days from the date of the decision. The information we share will include that your appeal is being reviewed as a standard appeal and we'll tell you how to file a grievance if you're not happy with our decision.

Expedited Appeal Decision
Within 72 hours from the time we receive your request, we'll tell you in writing the results of the decision and the date of the decision. We'll make every reasonable effort to tell you our decision by phone followed by a written notice within two days from the date of the decision.

For decisions that aren't all in your favor, the notice will explain your rights to request:

- A state administrative hearing and instructions on how to file an appeal.
- An expedited state administrative hearing and instructions on how to file an appeal.
- To continue benefits while the hearing is pending and how to make this request. You will also be told that you may be held liable for the cost of benefits paid during the hearing if the state's decision isn't in your favor.

DHS State Administrative Hearing

You can ask for a state administrative hearing if you're not happy with our final appeal decision. The appeal must be in writing. You must submit the appeal request to the DHS Administrative Appeals Office within 120 calendar days from the time you received our final appeal decision.

Mail the appeal to:

Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0039

DHS will make its decision within 90 calendar days from the date the appeal request was filed. The DHS administrative hearing decision is final. If DHS overturns our decision, we'll provide the services we denied as soon as your health condition requires, but no later than 72 hours from the date you received the state's decision.

Expedited DHS Administrative Hearing

You may file for an expedited hearing with DHS only when we deny your expedited appeal. You must send a letter to DHS within 120 calendar days from the date you received our decision.

Send the letter to:

Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

DHS will decide on your request within three business days after you filed your request. DHS won't extend this deadline. We'll send DHS the information that was used to make our decision within 24 hours from the time of the denial.

Continuation of Benefits

You, your authorized representative, or a provider you authorized to act on your behalf, have the right to request that we continue to pay for covered services when the following conditions are met:

- You asked for a continuation of benefits during the state administrative hearing.
- You filed for an administrative hearing within 10 calendar days from the mail date of the change(s) or before the effective date of the proposed final resolution letter.
- The appeal or request for state administrative hearing is about ending, suspending, or reducing treatment that had been approved before.
- The services were ordered by the authorized provider and the original authorization period hasn't ended.

If we continue or reinstate your benefit coverage, while the appeal or state administrative hearing is pending, we'll do so until one of the following occurs:

- You withdraw your appeal or request for a state administrative hearing.
- You didn't request a state administrative hearing and continuation of benefits within the 10 calendar days from when the notice of adverse benefit determination was mailed.
- The state administrative hearing decision was unfavorable to you (i.e., the hearing decision upholds our final resolution).
- If the final resolution of the appeal or state administrative hearing is upheld, you may have to pay us back for the services you received during the time the appeal was pending.
- If the state administrative hearing decision reverses our decision to deny, limit, or delay services, we will authorize or provide these services promptly and as soon as your health condition requires. But no later than 72 hours from the date you receive notice that reverses our decision.

Medicaid Ombudsman Program

The Hawaii Department of Human Services has the Medicaid ombudsman program to help you with any problems with HMSA QUEST.

- Oahu: (808) 746-3324
- Maui and Lanai: 1 (888) 488-7988 toll-free
- Kauai: 1 (888) 488-7988 toll-free
- Hawaii: 1 (888) 488-7988 toll-free
- Molokai: 1 (888) 488-7988 toll-free

TTY: 711

Oahu fax: (808) 356-1645

Medicaid Ombudsman website:
himedicaidombudsman.com

Email: hiombudsman@koanrisksolutions.com

General Provisions

Keeping Information Private

We keep your medical records and information about your care confidential. We don't use or disclose your medical information except as permitted or required by law. You may be required to provide us with information about your medical treatment or condition. In accordance with law, we may use or disclose your medical information (including providing this information to third parties) for the purposes of payment activities and health care operations, such as:

- Quality assurance.
- Disease management.
- Provider credentialing.
- Administering the plan.
- Complying with government requirements.
- Research or education.

Release of Information to a Third Party

Federal privacy laws limit what we can discuss with a third party without your consent. If you are calling for an adult family member or friend, we need them to say it's OK for us to talk with you. You may give your consent in a written statement or verbally. If you handle matters for a family member or friend on a regular basis, you may want to arrange a standing authorization. Our Membership Services staff can help you set this up.

When you call our Membership Services staff, they'll confirm who you are before they discuss personal information. This helps protect your privacy. We can also take additional steps. For more information, call us.

Reporting Fraud, Waste, and Abuse

HMSA doesn't tolerate fraud, waste, or abuse. Fraud, waste, or abuse can be carried out by anyone, including a provider or an HMSA member. If you think anyone has committed fraud, waste, or abuse related to HMSA's plans or benefits, you have a responsibility to report it to HMSA's Special Investigations Unit. HMSA's Special Investigations Unit will report fraud, waste, and abuse allegations to regulatory agencies and may pursue criminal penalties and/or financial recoveries.

Examples of those who may commit fraud, waste, or abuse:

- HMSA members
- Physicians
- Pharmacies
- Hospitals
- Medical laboratories
- Medical equipment suppliers
- Caregivers
- Behavioral health counselors
- Therapists

Examples of fraud, waste, and abuse:

- A provider ordering services that aren't medically necessary.
- Giving or selling drugs or medical supplies that were ordered for you to another person.
- A provider billing HMSA for services that were not performed.
- A provider billing HMSA for unwanted medical supplies or equipment.
- If someone else uses your HMSA membership card to get medical services, drugs, or supplies.
- Using transportation services intended for medical appointments (air and/or ground) for your personal use.
- Falsifying or misrepresenting information (such as income) to qualify for Medicaid coverage.

How to Report Fraud, Waste, and Abuse
If you think anyone is committing fraud, waste, or abuse related to HMSA or your HMSA QUEST plan, report it to us using any of the following methods:

- Phone: (808) 948-5166 or 1 (888) 398-6445 toll-free
- Mail:
  HMSA
  Special Investigations Unit
  P.O. Box 860
  Honolulu, HI 96808
- Email: fraud&abuse@hmsa.com

Advance Directives

Advance directives are written instructions that you want followed if you're too sick to make your own decisions. This way, everyone will know and act on what you want done.

Advance directives are usually prepared as a living will or durable power of attorney. Once you decide to make an advance directive, you may want to talk to a lawyer or a friend for help before you fill it out.

Make Your Wishes Known
Your right to decide is made possible by Hawaii state law, the Uniformed Health Care Decisions Act (Modified), Hawaii Revised Statutes (HRS), Chapter 327E. This law gives you the right to choose someone to act for you and gives you the right to leave instructions to follow when you are unable to make health care decisions. Your instructions can include when to accept or refuse medical or surgical care. If the state makes changes to this law, we'll let you know within 90 days what the changes are.

To ensure that your wishes are honored, complete an advance directive or execute a power of attorney for health care.

Send a copy of your advance directive to:

- Your health care agent (the person you have chosen to carry out your wishes).
- Your PCP and doctors.
- Your family and friends who might be involved in caring for you.

If you'd like a copy of an advance directive form created under HRS Chapter 327E or if you'd like to talk to someone who can provide more education on advance directives, please call us. As a matter of conscience, HMSA doesn't limit your right to implement an advance directive.

When Your Wishes Aren't Followed
If your doctor doesn't follow your wishes, you can send a grievance to the Office of Health Care Assurance at:

Department of Health
Office of Health Care
Assurance Medicare Section
601 Kamokila Blvd., Suite 395
Kapolei, HI 96707

If your doctor tells us that they have a conscientious objection or other limitation to following your advance directive or if we're aware of such an objection, we'll tell you and your agent and, if necessary, we'll transfer you to another doctor or facility where your wishes can be carried out.

HMSA QUEST doesn't discriminate against its members by requiring or not requiring an advanced directive as a condition for providing covered services.

Other HMSA Plans You May be Eligible to Join

If you're no longer eligible for the Hawaii QUEST program or other state programs, we offer other health plans you can buy. For information, call us. You must call within 30 days of losing your QUEST plan. Our phone number is (808) 948-5555, option 1, or 1 (800) 620-4672, option 1, toll-free.

Terms

Administrative denial: A decision that involves cost sharing, copayments, premiums, the amount we paid, the timeliness of our decision, or because the service is excluded from coverage.

Adult: A QUEST member age 21 and older for benefit purposes only.

Appeal: A review by the health plan and/or State Administrative Appeal of an adverse benefit determination.

Authorized representative: An individual or organization designated by an applicant or a member in writing with the designee's signature or by legal documentation of authority to act on behalf of an applicant or member, in compliance with federal and state law and regulations. Designation of an authorized representative may be requested at the time of application or at other times as required and will be accepted through the same modalities as applications for medical assistance.

Benefits: Those health services that the member is entitled to under the QUEST program and that the health plan arranges to provide to its members.

Child: A QUEST member age 20 and younger for benefit purposes only.

Copayment: The amount that a Member shall pay, usually a fixed amount of the cost of a service.

Crisis management: Short term help for someone who has an event happen to them and is unable to cope with the emotional, mental, physical, and behavioral distress.

Department of Human Services (DHS): The Hawaii Department of Human Services, which also serves as the single state agency responsible for administering the medical assistance program.

Doctor: A physician – M.D. or D.O. – who provides care. Doctors' services are covered by HMSA only when they:

- Provide care for a condition that they have the appropriate license and/or accreditation for, and
- Are recognized by HMSA.

Durable medical equipment (DME): Durable medical equipment can withstand repeated use and is primarily and customarily used for a medical purpose. It's generally not useful to a person in the absence of an illness or injury and is appropriate for home use. Examples of DME are wheelchairs, walkers, and hospital beds.

Emergency: Emergency services consisting of covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

Emergency medical condition: The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms, substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of emergency service or immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman, or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily function.
- Serious harm to self or others due to an alcohol or drug abuse emergency.
- Injury to self or bodily harm to others,
- With respect to a pregnant woman who is having contractions:
  - There is inadequate time to safely transfer them to another hospital before delivery.
  - The transfer may pose a threat to the health or safety of the woman or her unborn child.

Emergency medical transportation: Ambulance transport for individuals experiencing a medical emergency. It includes both ground and air transportation options to ensure timely access to medical care.

Emergency room care: Care that is available in an emergency room 24 hours a day, seven days a week, and without prior authorization to treat a life-threatening or very severe illness.

Emergency services: Covered inpatient and outpatient services needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

Enrollment: The process to join HMSA. To enroll, you must meet certain Hawaii QUEST guidelines.

EPSDT: EPSDT stands for Early and Periodic Screening, Diagnostic, and Treatment. It's a federal program that provides preventive health care for children. EPSDT services aim to identify physical or mental defects in individuals and provide health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered in accordance with Section 1905(r) of the Social Security Act. EPSDT includes services to:

- Seek out individuals and their families and inform them of the benefits of prevention and the health services available.
- Help the individual or family use health resources, including their own talents, effectively, and efficiently.
- Ensure the problems identified are diagnosed and treated early, before they become more complex and their treatment more costly.

Excluded services: Health care services that the health plan does not pay for or cover.

Family planning: Services to prevent an unplanned pregnancy.

Grievance: An expression of dissatisfaction from a member, member's representative, or provider on behalf of a member about any matter other than an adverse benefit determination.

Habilitation services and devices: Services and devices to develop, improve, or maintain skills and functioning for daily living that were never learned or acquired to an appropriate level.

Health insurance: Any health insurance program for which a person pays for insurance benefits directly to the carrier, participation through an employer or union-sponsored program, or participation through a federal or state program (such as Medicaid).

Home health care: Services provided in the home setting, including medical equipment and supplies, therapy or rehabilitative services, skilled nursing care, and home health aide services.

Hospice services: Services to provide comfort and support for members and their families in the last stages of a terminal illness.

Hospital outpatient care: Care in a hospital that usually does not require an overnight stay.

Hospitalization: Care in a hospital that requires admission as an inpatient for an overnight stay. An overnight stay for observation could be outpatient care.

Medical necessity: Procedures and services, as determined by DHS, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) shall be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

Medical supplies: Disposable health care materials ordered or prescribed by a doctor. They can't be used by a person in the absence of illness or injury or repeatedly by different people. Examples of medical supplies include ostomy supplies, catheters, diabetic supplies, and bandages.

Medication Assisted Treatment (MAT): This whole person approach combines drugs, counseling and behavior therapies for treating substance use disorder (SUD). The drugs used must have been approved by the Food and Drug Administration (FDA) for use in treating the specific SUD. It must be tailored to meet the needs of the person being treated.

Network: A group of doctors, hospitals, pharmacies, and other health care experts contracted by a health plan to care for its members.

Nonparticipating provider: A provider such as a doctor, nurse, physician assistant, or other health care provider that does not have a contract with HMSA to provide health care services to its members.

Orthotic: A rigid or semi-rigid device used to support, align, prevent, or correct deformities or to improve function of the moving parts of the body.

Participating provider or facility: A doctor or facility that contracts with HMSA to care for QUEST members. HMSA will only pay for covered services from these contracted providers.

Physician services: Health care services that a doctor provides.

Plan: A benefit employers, unions, or other group sponsors or state or federal programs (such as Medicaid) provide to pay for healthcare services.

Premium: An amount to be paid for an insurance policy or plan.

Prescription drugs: Medicine that is ordered or prescribed by your doctor and includes medication management and patient education.

Prescription drug coverage: Part of health insurance that helps pay for prescription drugs and medications.

Primary care provider (PCP): A practitioner selected by the member to manage the member's utilization of health care services who is licensed in Hawaii and is:

- A doctor, either an M.D. or a D.O., and shall generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician gynecologist (for women, especially pregnant women) or geriatrician;
- An APRN-Rx. PCPs have the responsibility for supervising, coordinating, and providing initial and primary care to enrolled individuals and for initiating referrals and maintaining the continuity of their care; or
- A physician's assistant recognized by the State Board of Medical Examiners as a licensed physician assistant.

Prior approval: Special approval from HMSA before you can get certain services. Your doctor will request approval from HMSA on your behalf. This approval is sometimes called preauthorization, prior authorization, preauthorization, or precertification.

Prosthesis: An artificial device used to replace a missing body part such as a limb or heart valve.

Provider: Any licensed or certified person or public or private institution, agency, or business concern authorized by DHS to provide health care, services, or supplies to individuals.

Rehabilitation services and devices: Services provided at a rehabilitation hospital, including physical and occupational therapy and speech-language pathology, to help restore function lost or impaired due to illness or injury. Licensed healthcare therapists provide services.

Rolling plan change: A rolling period during which QUEST (Medicaid) members can change health plans after being enrolled in their current plan for at least 12 months. Once you become eligible, DHS will send you information on how to make your rolling plan change selection.

Skilled nursing care: A level of care (LOC) that includes services that can only be performed safely and correctly by a licensed nurse (an RN, an LPN, or an APRN).

Specialist: A doctor specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-doctor specialist is a provider who has more training in a specific area of healthcare.

Urgent care: The diagnosis and treatment of medical conditions that are serious or acute but pose no immediate threat to life or health but require medical attention within 24 hours.

HMSA CENTERS

HMSA Center in Honolulu
818 Keeaumoku St.
Monday through 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 through 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 through Friday, 9 a.m.-6 p.m. | Saturday, 9 a.m.-2 p.m.

HMSA Center in Kahului
Puunene Shopping Center | 70 Hookele St., Suite 1220
Monday through Friday, 8 a.m.-5 p.m. | Saturday, 9 a.m.-1 p.m.

HMSA Center in Lihue
3-3295 Kuhio Highway, Suite 202
Monday through Friday, 8 a.m.-4 p.m.

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