# Table of Contents

**Welcome.**
- HMSA QUEST Integration ........................................... 1
- Our Values ...................................................................... 2
- We Want to Hear From You ........................................ 2

**How to Contact Us.**
- General Questions for HMSA ....................................... 3
- Call Us. .......................................................................... 3
- Visit Our Website .......................................................... 3
- Mail Us ............................................................................ 3
- Behavioral Health Questions .......................................... 4
- If You are Hearing or Speech Impaired ............................ 4
- If You Speak a Different Language .................................. 4
- Questions for State Department of Human Services (DHS) .. 4
- How to Ask for an Authorized Representative .................. 6
- Commonly Asked Questions .......................................... 6

**Membership**
- Your Membership Card ................................................. 7
- Information You Must Report to HMSA and DHS ............... 7
- Information We Must Report to You ................................. 8
- Events That End Your QUEST Integration Coverage .......... 8
- Changing to a Different Plan ........................................... 8

**About Your Plan**
- What is a Managed Care Plan? ....................................... 9
- When You are Also Covered by Medicare ......................... 9
- How Your Doctors Are Paid .......................................... 9
- How to Get the Most from Your Plan ............................... 9
- The Role of Our Partners .............................................. 10
- The Role of Your Primary Care Provider (PCP) ................. 10
- What You Should Do Before You Need Care ..................... 11
- What You Should Do When You Need Care ...................... 11

**Choosing a PCP**
- What is a PCP? ........................................................... 12
- Who Can Be a PCP? ...................................................... 12
- Choosing your PCP ...................................................... 12
- Call Us for Help .......................................................... 13
- Changing Your PCP ..................................................... 13
- When We Must Assign Your PCP .................................... 13
- When You Change Your PCP ......................................... 14

**How to Access Care**
- Appointments ............................................................. 14
- When You Need Services from a Specialist ....................... 15
- Self-Referrals .............................................................. 15
- Services from a Non-Participating Provider ...................... 17
- Prior Approval ............................................................. 17

**Special Health Needs**
- Help Getting Care ....................................................... 18
- Special Services ........................................................... 18
- Service Coordination .................................................... 18

**Emergency Care**
- Emergency Care .......................................................... 19
- Care after an Emergency .............................................. 19

**Urgent Care** .............................................................. 20
Care Away from Home .............................................. 20
  Neighbor Islands ............................................. 20
  U.S. Mainland ................................................ 20
  Outside the United States ................................ 20

**QUEST Integration Benefits** .................................. 21
  What Does Medically Necessary Mean? .................. 21
  Primary Care Provider (PCP) ............................... 21
  Prescription Drugs .......................................... 22
  What's Covered ............................................... 22
  Cost-Sharing .................................................. 22

**QUEST Integration Benefits Package** ..................... 23

**Routine Care – Adults** .................................... 37
  Immunizations .................................................. 38

**Routine Care – Keiki** .................................... 38
  Help Keep Your Child Healthy ................................ 38
  Regular Checkups ............................................ 38
  Well Baby and Well Child Care .......................... 39
  Immunizations ............................................... 39
  Note about Children Ages 14-17 ......................... 39

**Long-Term Services & Supports (LTSS)** ................. 40
  Service Coordination ....................................... 40
  Long-Term Services and Supports Benefits ............ 41
  Self-Directed Care .......................................... 48

**Additional Benefits – Managing Your Health and Well-Being** .............................................. 48
  Maternity Programs ......................................... 48
  Smoking Cessation Program ............................... 49
  Disease Management Program ............................ 49
  Mail-Order Pharmacy Program ........................... 50
  Health Education Workshops ............................. 50
  HMSA365 ...................................................... 51
  ExtraCare® Health Card .................................... 51
  Other Programs .............................................. 52

**What's Not Covered** .......................................... 56

**Rights & Responsibilities** ................................ 57
  Your Rights ................................................... 57
  Your Responsibilities ...................................... 61
  Inquiries ......................................................... 61

**Grievances & Appeals** ..................................... 62
  Grievances ...................................................... 62
  When You Disagree – Asking for a Grievance Review ........................................ 63
  Appeals .......................................................... 64
  Expedited Appeals .......................................... 65
  DHS State Administrative Hearing ....................... 67
  Expedited DHS Administrative Hearing ............... 67
  Continuation of Benefits .................................. 67
  Medicaid Ombudsman Program ........................... 68

**General Provisions** ......................................... 68
  Keeping Information Private ............................... 68
  Release of Information to a Third Party ............... 68
  Reporting Fraud and Abuse ................................ 68
  Advance Directives .......................................... 69
  Other HMSA Plans You May be Eligible to Join ...... 70

**Terms** .......................................................... 71
Welcome

HMSA QUEST Integration
Welcome to HMSA QUEST Integration. We are proud to be part of the Hawaii QUEST Integration 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 benefits. Plus, it 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.

This document has important information from HMSA QUEST Integration. You can ask for this written document to be given to you only in Ilocano, Vietnamese, Chinese (traditional), and Korean. If you need it in another language, you can ask to have it read to you in any language. There is no charge. We also offer large print, Braille, sign language, and audio. Call us at 948-6486 or 1 (800) 440-0640 toll-free. TDD/TTY: 1 (877) 447-5990 toll-free.

Thank you for choosing HMSA.

HMSA is an independent licensee of the Blue Cross and Blue Shield Association.

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本文件包含關於 HMSA QUEST Integration 的重要資訊。您可索取本文件的繁體中文版本，無需費用。您可讓人唸給您聽。我們也提供大字版、點字版、手語版及錄音版。請撥打我們的電話 948-6486 或免付費電話 1 (800) 440-0640。TDD/TTY: 1 (877) 447-5990。

이 문서는 HMSA QUEST Integration에 대한 중요 정보를 제공합니다. 이 문서는 국어 버전으로 신청할 수 있고 무료로 제공되며, 받는 즉시 읽을 수 있습니다. 당사는 대형 인쇄물, 점자, 수화 및 오디오를 제공합니다. 948-6486 또는 무료 전화 1 (800) 440-0640. 로 문의하십시오. TDD/TTY: 1 (877) 447-5990。

Daytoy a dokumento ket naglaon iti napaget nga impormasyon manipud iti HMSA QUEST Integration. Mabalinyo a kiddawen a maisurat daytoy a dokumento iti Ilocano. Awan ti bayadna. Mabalinyo a kiddawen a maibasa daytoy kadakayo. Idiayami pay ti naisurat iti dadakkel a letra, braille, senyas a lengguwehe ken audio. Tawagandakami iti 948-6486 wenno iti awan-bayadna nga 1 (800) 440-0640. 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 try to meet that goal:

- Build and maintain mutually respectful relationships with our members and doctors. This helps promote effective, quality health care and service for our members.
- Focus on wellness and prevention. This approach helps keep our members healthy. It also lowers the risk of illness when it occurs. And 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 describe how the 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 program, 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 you may have. We will help you. Your questions may be about any of the following or another subject related to HMSA QUEST Integration:

- Benefits.
- A list of providers.
- Claims.
- How to get care.
- Your handbook.
- 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.

Call Us
Our office hours are 7:45 a.m. to 4:30 p.m., Monday through Friday, 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.

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

Visit Our Website
hmsa.com

Visit Us in Person
We have offices in all counties. You may visit us from 8 a.m. to 4 p.m., Monday through Friday.

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<tr>
<th>Main Office</th>
<th>Honolulu, HI 96814</th>
<th>948-6486</th>
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<tr>
<td>Oahu</td>
<td>818 Keeaumoku St.</td>
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<th>Neighbor Island Offices</th>
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<td>Hilo</td>
<td>303A E. Makaala St.</td>
<td>Hilo, HI 96720</td>
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<td>Kona</td>
<td>75-1029 Henry St., Suite 301</td>
<td>Kailua-Kona, HI 96740</td>
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<tr>
<td>Kauai</td>
<td>4366 Kukui Grove St., Suite 103</td>
<td>Lihue, HI 96766</td>
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<td>Maui</td>
<td>33 Lono Ave., Suite 350</td>
<td>Kahului, HI 96732</td>
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<td>P.O. Box 3520</td>
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<td>Honolulu, HI 96811-9972</td>
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Behavioral Health Questions
If you have a behavioral health question, call us and ask to speak to a behavioral health care coordinator at:

- 695-7700
- 1 (855) 856-0578 toll-free

If You are Hearing or Speech Impaired
If you are hearing or speech impaired and 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 speak a different language and need interpretation services or need your health plan information translated, please call us. This service is free of charge.

Questions for the State Department of Human Services (DHS)
If you have questions about your QUEST Integration 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 Integration application.
- You have questions about your eligibility for QUEST Integration 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 Integration.
- You don't know if your QUEST Integration membership was canceled.
<table>
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<tr>
<th>DHS Offices</th>
<th>Phone: 587-3521 or 587-3540, Fax: 587-3543</th>
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<tr>
<td>State Department of Human Services (DHS) Med-QUEST Division Oahu Applications Unit 801 Dillingham Boulevard, 3rd Floor Honolulu, HI 96817-4582</td>
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<tr>
<td>Kapolei Unit Kakuhihewa State Office Building 601 Kamokila Boulevard, Room 415 Kapolei, HI 96707-2021</td>
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<td>East Hawaii Section 88 Kanoelehu Avenue, Room 107 Hilo, HI 96720-4670</td>
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<td>West Hawaii Section Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633</td>
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<td>Kauai Unit 4473 Pahee St., Ste. A Lihue, HI 96766-2037</td>
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<td>Lanai Unit 730 Lanai Avenue Lanai City, HI 96763</td>
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<td>Maui Section Millyard Plaza 210 Imi Kala Street, Suite 101 Wailuku, HI 96793-1274</td>
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<tr>
<td>Molokai Unit State Civic Center 65 Makaena Place, Room 110 Kaunakakai, HI 96748</td>
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<td>DHS Call Centers</td>
<td>524-3370</td>
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<tr>
<td>Oahu</td>
<td>1 (800) 316-8005 toll-free</td>
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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 by filling out and signing an Authorization to Request or Release Member Information form and sending 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 to fill in the form.

Commonly Asked Questions
Here are some commonly asked questions about HMSA QUEST Integration. Contact information appears earlier in this chapter.

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<th>WHO TO CALL</th>
<th>Question</th>
<th>DHS</th>
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HMSA QUEST Integration: 948-6486 or 1 (800) 440-0640 toll-free • TTY: 1 (877) 447-5990 toll-free • hmsa.com/QUEST
Membership

Your Membership Card
When you join HMSA QUEST Integration, we'll send you an HMSA QUEST Integration membership card. If you lose your card, call us and we'll send you a new one. 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.

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.

Your card contains important information, such as:

- Your name.
- Your member number.
- The date the card was issued.
- The date of your DHS QUEST Integration eligibility renewal.
- Your benefit plan.
- Special info about your plan, like limits and benefits such as 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 TPL1 and TPL2 sections of your card. TPL stands for third-party liability. For most QUEST Integration members, these lines are blank. However, if you have other health insurance, the other plan is primary. Your QUEST Integration plan is secondary. You must use your primary plan first for payment before any QUEST Integration claims will be paid. If you don't use your primary plan first, you may have to pay for the services you get.

Information You Must Report to HMSA and DHS
You must tell us and DHS of any changes that may affect your QUEST Integration membership.

Here are some examples of when you need to contact us:

- Change in address or phone number.
- 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.
**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:

- PCP leaves the network.
- Benefits change.
- Plan’s operations change.

**Events That End Your QUEST Integration Coverage**
DHS can remove you and your family from HMSA QUEST Integration for these reasons:

- You move out of Hawaii.
- You don’t qualify for QUEST Integration anymore.
- You choose another plan during the QUEST Integration Hawaii Annual Plan Change period.
- 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 Integration plan.

If any of these events happen to you, DHS will send you a letter. The letter will state the reason why your plan is ending and give an end date. After the date on the letter, you may not use your HMSA QUEST Integration 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 only during the state’s QUEST Integration Hawaii Annual Plan Change period. DHS will send you information on how to change plans during this period.
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. Besides your PCP, the players on your team include 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 Integration is responsible for the overall coordination of your care.

When You are Also Covered by Medicare
If you have Medicare and QUEST Integration, Medicare pays your bills first. QUEST Integration pays after Medicare and any other health insurance you have. We will also pay the copayment to 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 Integration.

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. If you have a good relationship with your PCP, you can call your PCP to help you decide if you need care.

It's important for you to work closely with your doctor:
- Tell your doctor about changes in your health.
- Listen when your doctor tells you how to take care of yourself.
- Ask questions and be sure you 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 Integration 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 Integration plan covers.
- I always call my doctor to make an appointment first.
- I am always on time for my appointment.
- 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

QUEST Integration Member Delegate Information
Under HMSA QUEST Integration, HMSA may work with companies we’ve hired to provide some of your HMSA QUEST Integration benefits to you. They may need to contact you for HMSA.

• Beacon Health Strategies may contact you about behavioral health services and case management.
• CVS/caremark may contact you about your prescription drugs.
• Landmark may contact you about physical therapy or occupational therapy services.
• National Imaging Associates may contact you about radiology services, such as a CT scan or MRI.

Call us if you have questions about our partners and how we work together for you.

The Role of Your PCP
Your 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 help to make sure you get the health care you need. Your PCP will also help manage your health care needs and make the most of your plan benefits. So 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 regular doctor, 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 a traditional Medicare plan, you must choose a PCP, but the PCP you choose does not have to be in HMSA’s QUEST Integration provider network.

We’ll work with you and your Medicare PCP to coordinate your QUEST Integration 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 must arrange and make a referral for you to see a specialist. If your PCP does not arrange for the services, you may have to pay for charges yourself. 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 Integration 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?
PCP stands for 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 Integration, you must choose a PCP.

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

You must get all of your care from doctors who participate in HMSA's QUEST Integration network, except for emergencies. This includes prescriptions for medicine. If you get drugs from a doctor or pharmacy that is not in HMSA's QUEST Integration network, the plan won't pay for it. For information about emergencies, see Emergency Care starting on page 19.

If you are covered in a Medicare Part D Drug plan, your drugs may be covered under Medicare Part D.

Who Can Be a PCP?
• A licensed doctor (MD) or a doctor of osteopathy (DO) 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 State Board of Medical Examiners.
• Other qualified PCPs, 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 where you live.
• Tell us who you choose within 10 days of joining HMSA. Write or call us. If you write us, use the Primary Care Provider Selection form. We send this form to you in the mail when you first 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 Integration.
• If you have Original Medicare, you must choose a PCP. Your PCP doesn't have to be participating with HMSA QUEST Integration.
Tips for Choosing

- Do you already have a doctor you’d like to stay with? If so, check for the doctor’s name in the HMSA QUEST Integration Participating Provider Directory that we mailed to you when you first signed up.
- 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?

Call Us for Help

- When you need more information about a doctor.
- When you can’t decide on a PCP and need help to choose 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 are pregnant and need an ob-gyn.
- You wish to change doctors after your baby is born.
- You are not 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 the HMSA QUEST Integration program.
- You did not choose your PCP when you signed up because we assigned one to you.

When We Must Assign Your PCP

We’ll assign a PCP on your behalf if:

- You do not select a PCP within 10 days of becoming a member. The PCP’s name will be printed on your card.
- You do not choose a new PCP when the one you have now no longer contracts with us. We will 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’ll 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’ll send you a new 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 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 patient calls.

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 and we'll help you.

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate care for emergency services (no prior approval needed for emergency medical situations)</td>
<td>Go to the nearest emergency room right away</td>
</tr>
<tr>
<td>Urgent care and PCP pediatric sick visits</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>PCP adult sick visits</td>
<td>Within 72 hours</td>
</tr>
<tr>
<td>PCP routine visits</td>
<td>Within 21 days</td>
</tr>
<tr>
<td>Behavioral health routine visits for adults and children</td>
<td>Within 21 days</td>
</tr>
<tr>
<td>Specialist care or non-emergency hospital care</td>
<td>Within four weeks</td>
</tr>
</tbody>
</table>

Attending
On the day of your visit:

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

Canceling
If you can't go to a scheduled visit, 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 and we'll help you get the care you need.

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 Integration provider network.** If you see a doctor who's not in HMSA's QUEST Integration provider network, the plan won't pay for it and you'll have to pay for it yourself. For help finding an HMSA QUEST Integration doctor, call us.

You don't need a referral for the care listed in the following table.
<table>
<thead>
<tr>
<th>TYPE OF CARE</th>
<th>EXAMPLES OF SERVICES</th>
<th>FOR MORE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>WOMEN’S ROUTINE AND PREVENTIVE CARE</td>
<td>• Breast exams&lt;br&gt;• Breast X-rays (mammograms)&lt;br&gt;• Pap smears&lt;br&gt;• Pelvic exam&lt;br&gt;Follow-up care or care not related to the routine services should be performed or arranged by your PCP.</td>
<td>See QUEST Integration Benefits starting on page 21.</td>
</tr>
<tr>
<td>FAMILY PLANNING</td>
<td>Counseling to prevent pregnancy.</td>
<td>See QUEST Integration Benefits starting on page 21.</td>
</tr>
<tr>
<td>BEHAVIOR HEALTH AND SUBSTANCE ABUSE SERVICES</td>
<td>Behavioral health services provided by a licensed:&lt;br&gt;• Psychiatrist.&lt;br&gt;• Psychologist.&lt;br&gt;• Advanced practice registered nurse.&lt;br&gt;• Licensed clinical social worker.&lt;br&gt;• Licensed marriage and family therapist.&lt;br&gt;• Licensed mental health counselor.</td>
<td>Call 695-7700 or 1 (855) 856-0578 toll-free to speak to a behavioral health care coordinator. TTY users: 1 (855) 481-7040 toll-free.</td>
</tr>
<tr>
<td>VISION CARE</td>
<td>• Eye exams.&lt;br&gt;• Eyeglasses to correct vision.</td>
<td>See QUEST Integration Benefits starting on page 21.</td>
</tr>
</tbody>
</table>

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 charges yourself.
Services from a Nonparticipating Provider
Services you get from a nonparticipating provider (a provider who isn’t in the HMSA QUEST Integration 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 19.

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

Switching from Your Current QUEST Integration Plan to HMSA QUEST Integration
If you’re switching to HMSA QUEST Integration from another QUEST Integration 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 non-participating provider ) for at least 45 days after you enroll or until the PCP who authorized the services reassesses your medical needs.

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

Prior Approval
Some services your PCP suggests to you may need approval from us. In these cases, your PCP will send us an approval form 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’ll have to pay for all charges.

You don’t need prior approval for emergency services. If you have questions about emergency services, see Emergency Care starting on page 19.
Special Health Needs

Help Getting Care
If you have questions or problems about 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.

Service Coordination
If you have special health care needs or if you need special help getting the care you need, we will assign a service coordinator to you. Your service coordinator will meet with you in person to learn more about your health history. After that visit, your service coordinator will stay in touch with you and will visit you every six months to reassess your needs. If there's a significant change in your condition, your service coordinator will visit you within 10 days.

Your service coordinator is your primary contact and the first person you should go to if you have questions about your health care. Your service coordinator will:

- Coordinate your physical and behavioral health services and long-term services and supports.
- Make sure that 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.

If you're unhappy with your service coordinator or would like a different one, call us at 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 service coordinator. If this happens, we'll let you know who your new service 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 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.
- Placing your life or your unborn baby’s life in danger while you are pregnant.

Examples of conditions that require emergency services include:

- 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 even if it is not in our network. You do not need prior approval for emergency care.

If you aren’t 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 emergency room (ER), or care for yourself at home. The service is free for HMSA QUEST Integration 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’re also covered for care that keeps your condition stable after an emergency. This treatment is called post-stabilization services. Prior approval may be required.
Urgent Care

Urgent care is care for a medical condition that’s serious, but not life threatening, and that needs care 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’s after hours. If you don’t know who your PCP is, call us.

If you aren’t 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 (ER), or care for yourself at home. The service is free for HMSA QUEST Integration members.

Care Away from Home

Neighbor Islands

If you will be away from your home island and visiting a Neighbor Island for a long period of time, please call us. If you call us before you go, we can arrange for your care during your stay. You are also covered for emergency services while off-island.

If you need care that is not on your home island, your PCP may refer you to a specialist on a Neighbor Island. If this happens, your PCP will work with us to arrange your care. We will also arrange and pay for air, ground transportation, lodging, and meals while you are away from home. If there is a medical reason and we approve an attendant, 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.

U.S. Mainland

If you travel to the U.S. Mainland, you are covered for emergency care. 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 the state of Hawaii, your PCP must ask us for prior approval to see a specialist on the U.S. Mainland. If approved, we will work with you and your PCP to arrange your care. We will also arrange and pay for air, ground transportation, lodging, and meals while you are away from home getting prior approved care. If there is a medical reason and we approve an attendant, 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 United States

You are not covered for any services outside the United States. This includes care for both children and adults.
QUEST Integration Benefits
This chapter provides a list of your QUEST Integration benefits.

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

What Does Medically Necessary Mean?
Your plan covers care that’s medically necessary when you’re sick or hurt. This means that the service or supply meets all of the following criteria:

- The purpose of the service or supply is to treat your medical condition.
- The treatment is the most appropriate delivery or level of service, considering potential benefits and harm to you.
- The treatment is known to be effective to improve health outcomes if:
  - Effectiveness is determined first by scientific evidence;
  - If no scientific evidence exists, then by professional standards of care; and
  - If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion.
- The treatment is cost effective for the medical condition being treated compared to other health interventions, including no intervention. Cost effective doesn’t necessarily mean the lowest price.

Definitions of terms and additional information about this standard are in the Patients’ Bill of Rights and Responsibilities Act, Hawaii Revised Statutes § 432E-1.4. If you’d like a copy of this law, 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 don’t 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 56.

The care you get must be consistent with HMSA’s medical policies. Our policies are written by HMSA medical directors who are physicians. 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’d 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 don’t, you may be required to pay. For more information, see Choosing a PCP starting on page 12. This rule doesn’t apply to some self-referrals and any emergency.

- For information about self-referrals, see How to Access Care starting on page 14.
- For information about emergencies, see Emergency Care starting on page 19.
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 medicine you take.

The computer system contains information only on prescription drugs that you take while you're a member of an HMSA plan. 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'll have to wait until they can reach your doctor. You may have to pick up your prescription later.

What’s Covered
Your HMSA QUEST Integration 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 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.

If you have Medicare, your cost share for Medicare services will be covered by QUEST Integration except for prescription drugs.
## QUEST INTEGRATION BENEFITS PACKAGE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INPATIENT SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td><strong>INPATIENT STAY</strong></td>
<td>Treatment in a hospital, rehabilitation hospital, or other inpatient medical facility when your condition requires an inpatient stay.</td>
</tr>
<tr>
<td></td>
<td>• Inhalation therapy and physical therapy.</td>
</tr>
<tr>
<td></td>
<td>• Lab work, pathology, and X-rays.</td>
</tr>
<tr>
<td></td>
<td>• Medical and surgical intensive care and cardiac units.</td>
</tr>
<tr>
<td></td>
<td>• Operating room and specialized treatment rooms.</td>
</tr>
<tr>
<td></td>
<td>• Room and board for semi-private room.</td>
</tr>
<tr>
<td></td>
<td>• Surgical and anesthetic supplies, drugs, and medicines.</td>
</tr>
<tr>
<td></td>
<td><strong>Admissions</strong></td>
</tr>
<tr>
<td></td>
<td>You must notify us in advance if an admission is for:</td>
</tr>
<tr>
<td></td>
<td>• An elective procedure. It is expected that you will be admitted on the day the procedure is scheduled.</td>
</tr>
<tr>
<td></td>
<td>• Services that usually are done in an outpatient setting.</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>Women in good health with deliveries that are not complex may stay in the hospital for up to:</td>
</tr>
<tr>
<td></td>
<td>• 48 hours after a natural birth.</td>
</tr>
<tr>
<td></td>
<td>• 96 hours after a Caesarean section.</td>
</tr>
<tr>
<td><strong>OUTPATIENT HOSPITAL SERVICES</strong></td>
<td>Services to prevent, diagnose, or manage the pain of an illness or injury.</td>
</tr>
<tr>
<td><strong>OUTPATIENT HOSPITAL</strong></td>
<td>Prior approval from HMSA is needed if the service is usually done in an office setting.</td>
</tr>
<tr>
<td></td>
<td>• Audiology services.</td>
</tr>
<tr>
<td></td>
<td>• Blood storage and processing.</td>
</tr>
<tr>
<td></td>
<td>• Cardiology services.</td>
</tr>
<tr>
<td></td>
<td>• Lab studies.</td>
</tr>
<tr>
<td></td>
<td>• Oncology services.</td>
</tr>
<tr>
<td></td>
<td>• Outpatient surgery services.</td>
</tr>
<tr>
<td></td>
<td>• Respiratory services.</td>
</tr>
<tr>
<td></td>
<td>• Speech therapy.</td>
</tr>
<tr>
<td></td>
<td>• X-rays.</td>
</tr>
<tr>
<td></td>
<td>• Other services that may be allowed under federal Medicaid rules and regulations.</td>
</tr>
</tbody>
</table>
### QUEST INTEGRATION BENEFITS PACKAGE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REHABILITATION</strong></td>
<td>Therapy that helps restore function lost or impaired due to illness or injury.</td>
</tr>
<tr>
<td>• Occupational therapy.</td>
<td>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.</td>
</tr>
<tr>
<td>• Physical therapy.</td>
<td></td>
</tr>
<tr>
<td>• Speech therapy.</td>
<td></td>
</tr>
<tr>
<td><strong>EMERGENCY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>EMERGENCY ROOM SERVICES</strong></td>
<td>Services received in an emergency room for an emergency or urgent condition.</td>
</tr>
<tr>
<td></td>
<td>Your condition must be a medical emergency. See Emergency Care on page 19 for a definition. If the condition does not meet emergency criteria, you pay all charges related to the visit.</td>
</tr>
<tr>
<td></td>
<td>If you are a member with serious and persistent mental illness (SPMI) enrolled in Community Care Services (CCS), this service will not be covered by HMSA if the visit is related to behavioral health.</td>
</tr>
<tr>
<td><strong>OTHER FACILITY SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td><strong>SKILLED NURSING FACILITY</strong></td>
<td>Skilled nursing care provided in an acute care hospital or skilled nursing hospital.</td>
</tr>
<tr>
<td><strong>REHABILITATION SERVICES</strong></td>
<td>Services provided at a rehabilitation hospital:</td>
</tr>
<tr>
<td></td>
<td>• Corrective surgery.</td>
</tr>
<tr>
<td></td>
<td>• Durable medical equipment.</td>
</tr>
<tr>
<td></td>
<td>• Medical supplies.</td>
</tr>
<tr>
<td></td>
<td>• Occupational therapy.</td>
</tr>
<tr>
<td></td>
<td>• Physical therapy.</td>
</tr>
<tr>
<td></td>
<td>• Prostheses and orthoses.</td>
</tr>
<tr>
<td></td>
<td>• Respiratory services.</td>
</tr>
<tr>
<td></td>
<td>• Speech therapy.</td>
</tr>
<tr>
<td></td>
<td>Services must be provided by any of the following licensed providers:</td>
</tr>
<tr>
<td></td>
<td>• Physical therapist (PT).</td>
</tr>
<tr>
<td></td>
<td>• Occupational therapist (OTR).</td>
</tr>
<tr>
<td></td>
<td>• Audiologist.</td>
</tr>
<tr>
<td></td>
<td>• Speech pathologist.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>
### QUEST INTEGRATION BENEFITS PACKAGE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
</table>
| HOSPICE    | Services for patients with six months or less to live. Services can be provided in the home, outpatient, or inpatient:  
  • Appliances.  
  • Counseling.  
  • Drugs.  
  • Home health aide.  
  • Home health services.  
  • Inpatient care for pain control and medical management.  
  • Medical social services.  
  • Medical supplies.  
  • Nursing care.  
  • Physician 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. |

<table>
<thead>
<tr>
<th>PHYSICIAN SERVICES</th>
</tr>
</thead>
</table>
| PHYSICIAN SERVICES  | Services provided by or under the direct supervision of a physician.  
  • 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 Integration covers one visit per day per doctor. |
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
</table>
| **GOOD HEALTH WHEN YOU ARE PREGNANT** | Services provided for pregnancy and maternity care:  
• Classes to help inform you about your pregnancy.  
• Regular visits to your doctor to make sure you and your unborn child are OK.  
• Diagnosis of premature labor.  
• Diagnostic amniocentesis.  
• Diagnostic ultrasound.  
• Fetal stress and non-stress testing.  
• Services related to labor and delivery.  
• Delivery.  
• Fetal development screenings.  
• Health education.  
• Postpartum care.  
• Prenatal visits as often as is recommended by the American College of Obstetrics and Gynecology.  
• Prenatal vitamins.  
• Treatment of missed or threatened abortions.  
• X-ray and lab tests.  
• Breastfeeding support.  

Mothers have breastfeeding counseling and breast pump rental for up to six months. Mothers with premature babies may request an extension.
### QUEST INTEGRATION BENEFITS PACKAGE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
</table>
| **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.  
- Counseling.  
- Diagnosis and treatment of acute and chronic medical and behavioral health conditions.  
- Diagnosis and treatment of eye or ear problems.  
- Help scheduling an appointment.  
- Lab tests.  
- 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 screenings.  
  Your doctor may need to contact us before you get these services.  
  Call us at 948-6486 or 1 (800) 440-0640 toll-free. TTY users, call 1 (877) 447-5990 toll-free. |
| **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 treatment plan for diabetes.  
- The services are available for other medical conditions.  
- It must be medically necessary. |
# QUEST INTEGRATION BENEFITS PACKAGE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FAMILY PLANNING SERVICES</strong></td>
<td>Services are provided to members who are sexually active and of child-bearing age. All family planning services are voluntary.</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Services provided for family planning:</td>
</tr>
<tr>
<td></td>
<td>• Consultations.</td>
</tr>
<tr>
<td></td>
<td>• Contraceptive pills, devices, and supplies.</td>
</tr>
<tr>
<td></td>
<td>• Emergency contraception.</td>
</tr>
<tr>
<td></td>
<td>• Counseling.</td>
</tr>
<tr>
<td></td>
<td>• Infertility diagnosis, but not treatment.</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy testing.</td>
</tr>
<tr>
<td></td>
<td>• Medical exams.</td>
</tr>
<tr>
<td></td>
<td>• Sterilizations.</td>
</tr>
<tr>
<td></td>
<td>• Diagnosis and treatment of sexually transmitted diseases.</td>
</tr>
<tr>
<td>Sterilization</td>
<td>Sterilizations need your written consent at least 30 days before the procedure is done. They are not covered if you are:</td>
</tr>
<tr>
<td></td>
<td>• Less than age 21.</td>
</tr>
<tr>
<td></td>
<td>• Judged mentally incompetent.</td>
</tr>
<tr>
<td></td>
<td>• Institutionalized.</td>
</tr>
<tr>
<td>Implants</td>
<td>Reinsertion of contraceptives that are implanted requires approval if done within five years of a previous insertion.</td>
</tr>
<tr>
<td>Over-the-counter Supplies</td>
<td>Any over-the-counter supply must be prescribed by your doctor.</td>
</tr>
<tr>
<td></td>
<td>Your doctor may need to contact us before you get these services. Call us at 948-6486 or 1 (800) 440-0640 toll-free. TTY users, call 1 (877) 447-5990 toll-free.</td>
</tr>
<tr>
<td><strong>BEHAVIORAL HEALTH</strong></td>
<td>Inpatient behavioral health services provided by a licensed psychiatrist such as:</td>
</tr>
<tr>
<td>Inpatient Psychiatric Hospitalizations</td>
<td>• Psychiatric services.</td>
</tr>
<tr>
<td></td>
<td>• Substance abuse treatment services.</td>
</tr>
<tr>
<td></td>
<td>These services aren't covered by HMSA if you're a member with SPMI enrolled in CCS.</td>
</tr>
<tr>
<td>SERVICE</td>
<td>DESCRIPTION AND LIMITATIONS</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **OUTPATIENT BEHAVIORAL HEALTH SERVICES** | Services for outpatient behavioral health include:  
• Individual or group psychiatric or psychological evaluation and treatment.  
• Crisis management.  
• Medically necessary alcohol and chemical dependency services.  
• Medications and medication management.  
• Day treatment.  
• Ambulatory mental health services.  
• Methadone management.  
Behavioral health services must be provided by a licensed:  
• Psychiatrist.  
• Psychologist.  
• Advanced practice registered nurse.  
• Clinical social worker.  
• Marriage and family therapist.  
• Mental health counselor.  
These services aren’t covered by HMSA if you’re a member with SPMI enrolled in CCS. |
| **PRESCRIPTION DRUGS**           | Prescription drugs and certain over-the-counter drugs that are:  
• On the QUEST Integration list of approved drugs. Most of these drugs are generic.  
• Prescribed by your doctor who’s licensed to prescribe.  
If the drug you need isn’t on the QUEST Integration list of approved drugs, your doctor must request approval for the drug. To determine if it’s covered, we ask these questions:  
• Are there comparable drugs on the list that were used to treat your condition?  
• Have you taken all the comparable drugs for a meaningful trial period?  
• If you have, did you have a bad reaction or did they not work for you?  
Drugs to treat behavioral health conditions aren’t covered by HMSA if you’re a member with SPMI enrolled in CCS because CCS will cover these drugs.  
A drug formulary exception won’t be approved for the following:  
• When there’s an FDA-approved A-rated generic equivalent.  
• Controlled substances (i.e., Schedule II, III, IV, V drugs.), except topical testosterone.  
Prescription mail order is available for most drugs. See Mail-order Pharmacy Program on page 50. |
**QUEST INTEGRATION BENEFITS PACKAGE**

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THERAPY TO REHABILITATE</strong></td>
<td></td>
</tr>
</tbody>
</table>
| COGNITIVE REHABILITATION                     | Assess and treat problems with:  
• Communicating.  
• Thinking.  
• Memory.  
• Paying attention.  
• Doing everyday tasks.  
An assessment is done to determine need and to come up with a treatment plan. Reassessments are done regularly to check on progress. Treatment may last up to one year. |
| 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. Devices are covered only when medically necessary and not already covered. Devices used only for activities at school aren't covered. |
| PHYSICAL AND OCCUPATIONAL THERAPY            | Therapy that helps restore function lost or impaired due to illness or injury.  
These services require referral from your doctor and prior approval must be obtained by the treating provider. Therapy services are covered as described in HMSA’s medical policy. |
| SPEECH THERAPY                               | Treatment of communication impairment or swallowing function that has been lost or impaired by injury, illness, or surgery.  
These services require referral from your doctor and are covered as described in HMSA’s medical policy. Prior approval must be obtained by the treating provider. |
### QUEST INTEGRATION BENEFITS PACKAGE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROSTHESSES AND ORTHOSES</strong></td>
<td>Prostheses and orthoses that help restore function or replace the function of a body part.</td>
</tr>
<tr>
<td></td>
<td>You must get prior approval by the treating doctor if:</td>
</tr>
<tr>
<td></td>
<td>• The total cost to HMSA of the item is more than $500; or</td>
</tr>
<tr>
<td></td>
<td>• The total cost to HMSA of buying or renting the item is more than $500.</td>
</tr>
<tr>
<td></td>
<td>Some items for which the cost to HMSA is less than $500 also require prior approval. Penile and testicular prostheses and related services aren't covered.</td>
</tr>
<tr>
<td><strong>MEDICAL EQUIPMENT</strong></td>
<td>Durable medical equipment needed to:</td>
</tr>
<tr>
<td></td>
<td>• Reduce a medical disability.</td>
</tr>
<tr>
<td></td>
<td>• Restore or improve function.</td>
</tr>
<tr>
<td></td>
<td>The items can be rented or purchased.</td>
</tr>
<tr>
<td></td>
<td>You must get prior approval by the treating doctor before you purchase or rent items if:</td>
</tr>
<tr>
<td></td>
<td>• The total cost to HMSA of the item is more than $500; or</td>
</tr>
<tr>
<td></td>
<td>• The total cost to HMSA for renting the item for the entire time you need it is more than $500.</td>
</tr>
<tr>
<td></td>
<td>Some items for which the cost to HMSA is less than $500 also require prior approval. Limit to one small volume nebulizer per lifetime. You must get prior approval to replace a nebulizer that is broken, lost, or stolen.</td>
</tr>
<tr>
<td><strong>MEDICAL SUPPLIES</strong></td>
<td>Medical supplies as prescribed by your doctor to diagnose and treat a medical condition.</td>
</tr>
<tr>
<td></td>
<td>You must get prior approval by the treating doctor before you purchase or rent items if:</td>
</tr>
<tr>
<td></td>
<td>• The total cost to HMSA of buying the item is more than $500; or</td>
</tr>
<tr>
<td></td>
<td>• The total cost to HMSA for renting the item for the entire time you need it is more than $500.</td>
</tr>
<tr>
<td></td>
<td>Some items for which the cost to HMSA is less than $500 also require prior approval.</td>
</tr>
</tbody>
</table>
## QUEST INTEGRATION BENEFITS PACKAGE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OTHER SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>AMBULANCE SERVICES</td>
<td>Ground and air ambulance services. Prior approval is needed for air ambulance to the U.S. Mainland.</td>
</tr>
</tbody>
</table>
| 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. |
| MEDICAL SERVICES RELATING TO DENTAL NEEDS | Covered by the state:  
• Emergency dental services to relieve dental pain and treat infections and acute injuries to teeth and jaw.  
Community Case Management Corporation (CCMC) provides dental services for the state. Call toll-free at 1 (866) 486-8030.  
Covered by HMSA QUEST Integration:  
• 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 physicians such as plastic surgeons, otolaryngologists (ear, nose, and throat), and general surgeons due to a traumatic injury such as car accident are covered.  
Prior approval is required. The provider must contact HMSA QUEST Integration for approval or referral to CCMC within 48 hours. |
| SMOKING CESSATION COUNSELING     | Services are provided by licensed providers:  
• Psychologist.  
• Clinical social worker in behavioral health.  
• Advanced practice registered nurse.  
• Marriage family therapist.  
• Mental health counselor.  
Limited to four in-person counseling sessions per quit attempt. Medications are those recommended in the most current Public Health Service guidelines.  
See Smoking Cessation Program on page 49. |
# QUEST INTEGRATION BENEFITS PACKAGE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
</table>
| NON-EMERGENCY TRANSPORTATION SERVICES | Transportation is provided when your medical condition requires treatment that is not available in the area where you are. 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. |
### QUEST INTEGRATION BENEFITS PACKAGE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>VISION SERVICES</td>
<td>Vision services include:</td>
</tr>
<tr>
<td></td>
<td>• Eye exams to test for refraction.</td>
</tr>
<tr>
<td></td>
<td>• Eyeglasses to improve vision.</td>
</tr>
<tr>
<td></td>
<td>• Visits to your eye doctor if you have an eye condition or if you notice a change in your vision.</td>
</tr>
<tr>
<td></td>
<td>Vision services are limited as listed here:</td>
</tr>
<tr>
<td></td>
<td>• One routine eye exam every 24 months for adults and every 12 months for children under age 21. You must select frames from your vision provider’s designated assortment.</td>
</tr>
<tr>
<td></td>
<td>• Contact lenses are covered if you have a condition that can't be corrected with glasses.</td>
</tr>
<tr>
<td></td>
<td>• Your doctor may need prior approval before you get contact lenses unless you have a specific medical condition that doesn't require prior approval.</td>
</tr>
<tr>
<td></td>
<td>• Your plan covers either one pair of glasses or one pair of contact lenses (not both) for every 24 months.</td>
</tr>
<tr>
<td></td>
<td>• Persons under age 40 who need bifocal lenses require a medical reason.</td>
</tr>
<tr>
<td></td>
<td>If there's a change in an adult's vision within 24 months after receiving glasses or contact lenses, contact your doctor because your vision change may make you eligible to get a new pair of glasses or contact lenses. Prior approval is required.</td>
</tr>
<tr>
<td></td>
<td>The following requires prior approval:</td>
</tr>
<tr>
<td></td>
<td>• Contact lenses, except for certain medical conditions.</td>
</tr>
<tr>
<td></td>
<td>• Polycarbonate glasses for adults.</td>
</tr>
<tr>
<td></td>
<td>• Replacement for glasses or contacts that are lost, stolen, or damaged before glasses or contacts are 24 months old.</td>
</tr>
<tr>
<td></td>
<td>Eye surgery to improve vision so glasses are no longer needed and tinted lenses used for cosmetic reasons aren't covered.</td>
</tr>
</tbody>
</table>
### QUEST INTEGRATION BENEFITS PACKAGE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
</table>
| HEARING SERVICES              | Hearing services include:  
• Hearing exams.  
• Unilateral 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. |
| DIALYSIS                      | A treatment that is needed when your kidneys can no longer take care of your body's needs. Services include:  
• Hospital inpatient.  
• Hospital outpatient.  
• Non-hospital renal dialysis facility.  
• Doctor visits.  
• Lab work.                                                                                                                   |
| CANCER CARE                   | Treatment for cancer. Services include:  
• Inpatient hospital care.  
• Provider services.  
• Outpatient hospital services.  
• Chemotherapy.  
• Radiation therapy.  
• Hospice.                                                                                                                        |
| DIAGNOSTIC AND THERAPEUTIC SERVICES | Medically necessary diagnostic or therapeutic radiology or lab services. Diagnostic tests must be done along with a doctor visit. Some services need prior approval.                                                                 |
| SLEEP LAB TEST                | Diagnoses sleep-related disorders. Prior approval needed.                                                                                                              |
# QUEST INTEGRATION BENEFITS PACKAGE

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
</table>
| **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 mental retardation.  

Custodial and homemaker services are not covered. |
| **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. |
## Routine Care – Adults

Your health is important. 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 illness. They also help find illness early and can make treatment easier. If you have an illness, see your PCP.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION</th>
<th>RECOMMENDATIONS/ LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLOOD PRESSURE</td>
<td>Blood pressure measurement</td>
<td>• Once per office visit, or&lt;br&gt;• Every two years or more frequently for members with high blood pressure.</td>
</tr>
<tr>
<td>BREAST CANCER</td>
<td>Mammogram with or without clinical breast exam</td>
<td>• Yearly for women ages 50 to 69.&lt;br&gt;• For women ages 40 to 49, yearly breast exam and mammogram every one to two years.&lt;br&gt;• For women ages 70-72, mammogram every one to two years.&lt;br&gt;• As often as your doctor suggests.</td>
</tr>
<tr>
<td>CERVICAL CANCER</td>
<td>Pap test and pelvic exam</td>
<td>Yearly for:&lt;br&gt;• Women ages 18-65 who are sexually active, or&lt;br&gt;• Earlier if sexually active.</td>
</tr>
<tr>
<td>CHOLESTEROL</td>
<td>Total cholesterol level blood</td>
<td>Once every five years for:&lt;br&gt;• Men ages 35 to 65.&lt;br&gt;• Women ages 45 to 65.</td>
</tr>
<tr>
<td>COLORECTAL CANCER</td>
<td>Sigmoidoscopy or fecal occult blood test</td>
<td>Starting at age 50:&lt;br&gt;• Fecal occult blood or stool blood test yearly; or&lt;br&gt;• Sigmoidoscopy at age 50, then every 10 years.</td>
</tr>
<tr>
<td>WEIGHT</td>
<td>Weight measurement</td>
<td>Once every two years.</td>
</tr>
</tbody>
</table>
**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.

**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 all QUEST Integration 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.
- Oral checkups.
- Lab tests.
- Immunizations.
- Lead and TB (tuberculosis) assessments and screening.
- Mental and physical assessment.
- Screening for behavioral health or substance abuse.
- Medicines, including fluoride and multivitamins.
- Referrals to specialist for problems found during the exam.
- 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 Integration 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 age 2.
- A few more are needed between ages 4 and 6.
- Children get remaining immunizations between the ages of 11 to 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.

You should 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 Ages 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 ages 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.
- 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) that are 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 and health.
- Home-delivered meals.
- Personal care assistance.
- Personal emergency response system.
- Skilled nursing services.

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

Service Coordination

When you become eligible for long-term services and supports, we will assign a service coordinator to you. Your service coordinator is your primary contact and the first person you should go to if you have questions about your health care. Your service coordinator will:

- Coordinate your physical and behavioral health and long-term services and supports.
- Make sure that 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 service coordinator will arrange to meet you in person to learn more about your health history and to work with you to develop a service plan to ensure you receive the services you need. After that visit, your service coordinator will stay in touch with you and reassess your needs every three months. If there’s a significant change in your condition, your service coordinator will meet with you within 10 days. A significant change could be a change in living arrangements, being placed in an institution, or a change in provider who’s not in your service plan.

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

All LTSS services require prior approval and must be included as part of the service plan. Working with your service coordinator will ensure that the services you receive are approved.
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION AND LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADULT DAY CARE</td>
<td>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 service plan. • Therapeutic, social, educational, recreational, and other activities. Prior approval is required.</td>
</tr>
<tr>
<td>ADULT DAY HEALTH</td>
<td>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. • Physician services. • Pharmaceutical services. • Psychiatric or psychological services. • Recreational and social activities. • Social services. • Speech-language pathology. • Transportation services. Prior approval is required.</td>
</tr>
<tr>
<td>ASSISTED LIVING SERVICES</td>
<td>Assisted living services include: • Personal care. • Supportive care (homemaker, chore, personal care services, and/or meal preparation). Room and board aren't covered. Prior approval is required.</td>
</tr>
<tr>
<td>COMMUNITY CARE MANAGEMENT AGENCY (CCMA)</td>
<td>Care coordination services you will receive when you live in a community care foster family home or other community setting. Prior approval is required.</td>
</tr>
<tr>
<td>LONG-TERM SERVICES AND SUPPORTS BENEFITS</td>
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<tr>
<td>-----------------------------------------</td>
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</tr>
</tbody>
</table>
| **COMMUNITY CARE FOSTER FAMILY HOME (CCFFH) SERVICES** | Services include:  
  • Personal care.  
  • Nursing.  
  • Homemaker services.  
  • Chore.  
  • 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 CCMA services.  

Prior approval is required. |
| **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 service 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 member's deteriorating functional, medical, or mental status.  

Counseling and training is a service provided to:  
  • Members.  
  • Families/caregivers on behalf of the member.  

Prior approval is required. |
## LONG-TERM SERVICES AND SUPPORTS BENEFITS

| ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS | These adaptations are necessary changes made to your home to ensure the health, welfare, and safety of the member or to enable the member to function with greater independence in the 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 the health and safety of the member.  
Prior approval is required. |
| HOME-DELIVERED MEALS | Nutritional meals delivered to where you live (excluding residential and institutional settings). The meals will not replace or substitute for a full day’s nutrition.  
Prior approval is required and no more than two meals per day. |
| HOME MAINTENANCE | Home maintenance services are services 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. |
| MOVING ASSISTANCE | This service is provided when a service coordinator assesses that a member needs to move to a new home to remain healthy.  
Circumstances are:  
- Unsafe home due to deterioration.  
- The member is wheelchair bound, living in a building with no elevator, multi-story building with no elevator, or he/she lives above the first floor.  
- Home unable to support member’s equipment needs.  
- Member is evicted.  
- Member is unable to afford the home due to rent increase.  
When possible, family members, neighbors, or others who can provide this service without cost must be used.  
Prior approval is required. |
# LONG-TERM SERVICES AND SUPPORTS BENEFITS

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NON-MEDICAL TRANSPORTATION</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **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. Nursing facilities 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

Personal 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.** Non-medical care that includes supervising and socializing with the member. A companion may assist or supervise with making meals and doing laundry, shopping, and errands. A companion may do light housekeeping when it’s incidental to the care and supervision of the member.

**Homemaker/chore services.** Covers for the person who’s responsible for routinely providing these services for the member, but is unable to care for self and others right now, or is absent for a short time. The services are routine and don’t require special training or need the professional skills of a nurse or home health aide. Services are only for the member, 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 rubbish).
- Wash, dry, iron, or mend clothing.
- Shop for member’s household and personal needs.
- Light yard work (mowing the lawn).
- Make home repairs (changing light bulbs).
- Make meals.
- Run errands to pay bills or pick up medication.
- Go with member to medical visits.
- Help with or supervise member’s bathing, dressing, grooming, eating, and moving around.
- Check and document when member does treatments and takes medication.
- Report changes in member’s need for more or less service.

Prior approval is required.
## LONG-TERM SERVICES AND SUPPORTS BENEFITS

| PERSONAL ASSISTANCE SERVICES — LEVEL 2 | Personal Assistance Services Level 2 are 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, which 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 isn’t covered if you’re living in a nursing home or hospital. Prior approval is required. |

<p>| 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. |</p>
<table>
<thead>
<tr>
<th>LONG-TERM SERVICES AND SUPPORTS BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LICENSED RESIDENTIAL CARE</strong></td>
</tr>
<tr>
<td>Residential care is a service provided in a licensed private home by a principle care provider who lives in the home. Residential care services include:</td>
</tr>
<tr>
<td>• Personal care services.</td>
</tr>
<tr>
<td>• Nursing, homemaker, chore, attendant care, and companion services.</td>
</tr>
<tr>
<td>• Medication oversight (to the extent allowed by law).</td>
</tr>
<tr>
<td>Prior approval is required.</td>
</tr>
<tr>
<td><strong>RESPITE CARE</strong></td>
</tr>
<tr>
<td>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:</td>
</tr>
<tr>
<td>• Your home or place of residence.</td>
</tr>
<tr>
<td>• Foster home or expanded-care adult residential care home.</td>
</tr>
<tr>
<td>• Medicaid certified nursing facility.</td>
</tr>
<tr>
<td>• Licensed respite day care facility.</td>
</tr>
<tr>
<td>• Other community care residential facility approved by HMSA.</td>
</tr>
<tr>
<td>Prior approval is required.</td>
</tr>
<tr>
<td><strong>SPECIALIZED MEDICAL EQUIPMENT WARRANTY AND SUPPLIES</strong></td>
</tr>
<tr>
<td>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 service plan. This also includes:</td>
</tr>
<tr>
<td>• Items necessary for life support.</td>
</tr>
<tr>
<td>• Supplies and equipment needed to support the proper functioning of such items.</td>
</tr>
<tr>
<td>Examples may include:</td>
</tr>
<tr>
<td>• Specialized infant car seats.</td>
</tr>
<tr>
<td>• Modification of a parent-owned motor vehicle to accommodate the child, i.e., wheelchair lifts.</td>
</tr>
<tr>
<td>• Shower seat.</td>
</tr>
<tr>
<td>• Portable humidifiers.</td>
</tr>
<tr>
<td>• Medical supplies.</td>
</tr>
<tr>
<td>• Heavy duty items.</td>
</tr>
<tr>
<td>Prior approval is required.</td>
</tr>
</tbody>
</table>
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.

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’re pregnant, connect with your 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.

Positively Pregnant
HMSA works with Kapiolani Medical Center for Women and Children to offer free workshops at various places on Oahu. Positively Pregnant is a community program open to women who are pregnant or thinking of starting a family. Partners are urged to come, too.

Call 535-7474 if you have any questions. You can sign up online on the Kapiolani Medical Center website at hawaiipacifichealth.org/health-wellness/classes/maternity-family/positively-pregnant.

Diabetes during pregnancy
Diabetes during pregnancy is an important issue to be monitored with your physician. For women who develop diabetes while pregnant (this is called gestational diabetes), their physician may refer them to community resources to help manage and monitor their health. These services give pregnant women 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 moms. The new mom and her physician will work together on her postpartum needs, including helping her if she develops serious depression after giving birth. These women are at risk for depression:

- Women who gave birth within the last year.
- Women who had a miscarriage.
- Women 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 don't 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 physician. If you have any questions or would like information, call 1 (855) 329-5461 toll-free.
Smoking Cessation Program
If you’re a smoker and you’re thinking of quitting, we can give you a better chance of success than doing it alone. You choose the approach that’s best for you. We’ll work with you to create a personalized quit plan. You can get expert support by phone and one-on-one.

Services are available statewide and limited to two quit attempts per benefit year.

Medications covered are those recommended by the most current Public Health Service guidelines.

Call 1 (855) 329-5461 toll-free to start your journey to a smoke-free you. TTY users, call 1 (877) 447-5990 toll-free.

Disease Management Program
HMSA’s approach to disease management supports working with you and your doctor on improving and/or maintaining good health. HMSA’s provider network is made of independent physicians linked with physician organizations (PO). HMSA’s focus on disease management emphasizes the following:

- Provide member-centric care and services.
- Focus on coordination and integration.
- Strengthen the patient-provider relationship.
- Promote evidence-based medicine.
- Identify and act on opportunities for improvement.

Key strategies used to implement disease management include:

- The Patient-centered Medical Home.
- Pay-for-quality programs.
- Cozeva, HMSA’s population health management tool, which provides patient registries, gaps in care resources, and a communication platform for interacting with patients and other providers.

Disease management helps members with asthma, diabetes, cardiovascular disease, and chronic obstructive pulmonary disease (COPD). The programs encourage you to take an active role in taking care of yourself, which includes preventive care, self-care, and outpatient services. If you have questions about any of the programs listed here, call us at 1 (855) 329-5461 toll-free. TTY users, call 1 (877) 447-5990 toll-free.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASTHMA AND COPD</td>
<td>If you’ve been treated for asthma or COPD, we automatically enroll you in the program.</td>
</tr>
<tr>
<td>CARDIAC CONDITIONS</td>
<td>If you’ve been treated for coronary artery disease, heart failure, or hypertension, we automatically enroll you in the program.</td>
</tr>
<tr>
<td>DIABETES</td>
<td>If you’ve been treated for diabetes, we automatically enroll you in the program.</td>
</tr>
<tr>
<td>CHRONIC KIDNEY DISEASE</td>
<td>If you’ve been treated for chronic kidney disease, we automatically enroll you in the program.</td>
</tr>
</tbody>
</table>
Mail-order Pharmacy Program
If you take prescribed drugs to keep you healthy and well, you may not like the monthly trips to the pharmacy for refills. To avoid that chore, have them delivered to your door.

Sign up for CVS/caremark Mail Service Pharmacy program. Once you sign up, you can get a 30-day supply by mail at no charge. Prescriptions are typically mailed out on the same day and you can expect it at your door in one or two business days.

You can still have your prescriptions sent to a local retail pharmacy if you need a medication right away at no charge.

Controlled substances are excluded.

For more information, or to enroll, call the CVS/caremark Customer Care team at 1 (855) 479-3656, option 1, toll-free.

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. As an HMSA member, you can come to our workshops at no charge.

HMSA Well-Being Connection offers workshops that can help you reach your well-being goals.

If you have questions about these workshops or want to sign up, call us at 1 (855) 329-5461 toll-free. TTY users, call 1 (877) 447-5990.

Or find out more at hmsa.com/wellbeing/workshops.

<table>
<thead>
<tr>
<th>CLASS</th>
<th>DESCRIPTION</th>
<th>WHAT YOU WILL LEARN</th>
</tr>
</thead>
<tbody>
<tr>
<td>DISEASE AWARENESS</td>
<td>Learn about chronic diseases and how to prevent them.</td>
<td>• How to lower risks for chronic diseases.</td>
</tr>
<tr>
<td></td>
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<td>• Preventive immunizations and screenings.</td>
</tr>
<tr>
<td>NUTRITION</td>
<td>Learn what your body needs and how to make smart food choices.</td>
<td>• Basics of nutrition.</td>
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<td>• Healthy meal and snack options.</td>
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<tr>
<td></td>
<td></td>
<td>• Meal planning.</td>
</tr>
<tr>
<td>PHYSICAL ACTIVITY AND</td>
<td>Physical activity can help your body perform better. Learn how to be</td>
<td>• Basic exercises.</td>
</tr>
<tr>
<td>EXERCISE</td>
<td>more active.</td>
<td>• Safe exercising.</td>
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<td></td>
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<td>• Staying on track.</td>
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<tr>
<td>STRESS MANAGEMENT</td>
<td>Manage stress to improve your well-being.</td>
<td>• Stress reduction.</td>
</tr>
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<td>• Breathing exercises.</td>
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<td>• Relaxation techniques.</td>
</tr>
<tr>
<td>WEIGHT AWARENESS</td>
<td>Reach your weight-loss goals with good nutrition, exercise, and other</td>
<td>• Factors that cause weight gain.</td>
</tr>
<tr>
<td></td>
<td>healthy behaviors.</td>
<td>• Healthy eating and exercise habits.</td>
</tr>
</tbody>
</table>
HMSA365
As an HMSA member, you can get more, 365 days a year. Be your best and pay less with HMSA365, HMSA's member discount program.

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:

- Exercise classes.
- Fitness centers.
- Massage therapy.
- 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. So tap into those great deals today!

HMSA365 is managed by HMSA Well-Being Connection. Please call 1 (855) 329-5461 toll-free if you have questions. TTY users, call 1 (877) 447-5990. Or go to hmsa.com/hmsa365.

ExtraCare Health Card
The ExtraCare® Health Card is provided at no cost to HMSA members and saves you money through discounts on CVS/pharmacy Brand health-related items purchased at Longs Drugs stores or online at cvs.com. Each household is mailed two key tags for the whole family to use. Newly enrolled members receive their card within six weeks of their plan effective date. Members can call the number on the back of the card, 1 (888) 543-5938 toll-free, with any questions. TTY users, call 1 (877) 447-5990 toll-free.
**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.

<table>
<thead>
<tr>
<th>PROGRAM NAME</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| **EARLY INTERVENTION** | The Department of Health's Early Intervention programs are for children from age 0 to 3 who:  
  • Have delays in development.  
  • May be at risk to develop a delay and need special medical care and services.  
  Ground transportation for covered services. |
| **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. |
| **SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)** | The Department of Health's Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a national program that helps pregnant women, new mothers, and young children eat well and stay healthy. If you qualify for this program, you get special checks to buy healthy foods such as milk, juice, eggs, cereal, cheese, and peanut butter. You also can 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)** | The Department of Human Services (DHS) will cover all services relating to ITOPs. This includes procedures, medications, transportation, meals, and lodging.  
For transportation, call Community Case Management Corporation (CCMC) at 1 (866) 486-8030 toll-free. |
<table>
<thead>
<tr>
<th>PROGRAM NAME</th>
<th>DESCRIPTION</th>
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</table>
| SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES/ INTELLECTUAL DISABILITIES (DD/ID) | The Department of Health Developmental Disability Division (DOH/DDD) provides services for persons who require DD/ID services to assist them to 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 service plan to carry out needed services. The DDD case manager ensures that there is good coordination with the health plan service coordinators. Services may include:  
• Adult day health.  
• Assistive technology.  
• Chore services.  
• DD/MR emergency services.  
• Environmental accessibility adaptations.  
• Personal assistance/habilitation (PAB).  
• Personal emergency response system (PERS).  
• Respite care.  
• Residential habilitation (RESHAB).  
• Supported employment.  
• Skilled and/or private nursing.  
• Specialized medical equipment and supplies.  
• Transportation.  
• Training and consultation.  
• Modifications to vehicles.  
• Speech, physical, and occupational therapy.  
• Monitoring and supervision of member. |
<table>
<thead>
<tr>
<th>PROGRAM NAME</th>
<th>DESCRIPTION</th>
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</table>
| BEHAVIORAL HEALTH SERVICES FOR CHILDREN/ SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT (SEBD) PROGRAM | Children ages 3 through 20 years who have significant problems with different areas of life such as home and school, have a qualifying primary DSM-IV Axis I diagnosis, and qualify for QUEST Integration are eligible for the SEBD program. SEBD is part of the state of Hawaii’s Department of Health Child and Adolescent Mental Health Division (CAMHD). 

Call the nearest Family Guidance Center and ask to speak to 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.
- Intensive case management.
- Psychosexual assessment.
- Intensive home and community base intervention.
- Functional family therapy.
- Multidimensional treatment foster care.
- Multisystemic therapy.
- Respite home.
- Therapeutic group home.
- Community-based residential programs.
- Hospital-based residential services.

Family Guidance Centers

Central Oahu—Pearl City
860 Fourth Street, 2nd Floor
Pearl City, HI 96782
Ph.: 453-5900
Fax: 453-5940

Windward Oahu—Kaneohe
45-691 Keaahala Road
Kaneohe, HI 96744
Ph.: 233-3770
Fax: 233-5659

Leeward Oahu
601 Kamokila Boulevard, Suite 355
Kapolei, HI 96707
Ph.: 692-7700
Fax: 692-7712

Honolulu
3627 Kilauea Ave., Room 401
Honolulu, HI 96816
Ph.: 733-9393
Fax: 733-9377

Family Court Liaison Branch
42-470 Kalanianoa Highway, Bldg. 3
Kailua, HI 96734
Ph.: 266-9922
Fax: 266-9933
<table>
<thead>
<tr>
<th>PROGRAM NAME</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MAUI</strong></td>
<td>Ph.: 243-1252</td>
</tr>
<tr>
<td>Maui (Wailuku)</td>
<td>Fax: 243-1254</td>
</tr>
<tr>
<td>270 Waiehu Beach Road, Suite 213</td>
<td>Wailuku, HI 96793</td>
</tr>
<tr>
<td>Maui (Lahaina)</td>
<td>Ph.: 662-4045</td>
</tr>
<tr>
<td>1830 Honoapiilani Highway</td>
<td>Fax: 661-5450</td>
</tr>
<tr>
<td>Lahaina, HI 96761</td>
<td></td>
</tr>
<tr>
<td><strong>Molokai</strong></td>
<td>Ph.: 553-7878</td>
</tr>
<tr>
<td>65 Makaena Place</td>
<td>Fax: 553-7874</td>
</tr>
<tr>
<td>Kaunakakai, HI 96748</td>
<td></td>
</tr>
<tr>
<td><strong>LANAI</strong></td>
<td>Ph.: 662-4045</td>
</tr>
<tr>
<td>c/o Lahaina Office</td>
<td>Fax: 661-5450</td>
</tr>
<tr>
<td>1830 Honoapiilani Highway</td>
<td>Lanai City, HI 96763</td>
</tr>
<tr>
<td><strong>HAWAII</strong></td>
<td>Ph.: 933-0610</td>
</tr>
<tr>
<td>Hawaii (Hilo)</td>
<td>Fax: 933-0558</td>
</tr>
<tr>
<td>88 Kanoeluhua Street, Suite A-204</td>
<td>Hilo, HI 96720</td>
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<tr>
<td>Hawaii (Kona)</td>
<td>Ph.: 322-1541</td>
</tr>
<tr>
<td>81-980 Halekii Street, Room 101</td>
<td>Fax: 322-1543</td>
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<tr>
<td>Kealakekua, HI 96750</td>
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<tr>
<td>Hawaii (Waimea)</td>
<td>Ph.: 887-8100</td>
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<tr>
<td>65-1230 Mamalahoa Highway, Suite A-1</td>
<td>Fax: 887-8113</td>
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<tr>
<td>Kamuela, HI 96743</td>
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<tr>
<td><strong>KAUAI</strong></td>
<td>Ph.: 274-3883</td>
</tr>
<tr>
<td>3-3204 Kuhio Highway, Room 104</td>
<td>Fax: 274-3889</td>
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<tr>
<td>Lihue, HI 96766</td>
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**COMMUNITY CARE SERVICES (CCS)**

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're eligible for these services, call 'Ohana Community Care Services at 1 (888) 846-4262. If you're enrolled in this program, all your care related to behavioral health will be covered by CCS.
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 Integration won’t pay for inpatient hospital services related to a medical condition that wasn’t present when admitted to the hospital. Members also aren’t required to pay for these services.

The following treatments, services, supplies, and drugs aren’t covered:

- 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 Band-Aids.
- Non-medical items such as books, telephones, beepers, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, fans, household items, motor vehicles, and furnishings.
- Experimental and/or investigational services, procedures, drugs, devices, and treatments, and drugs not approved by the Food and Drug Administration (FDA).
- Treatment of complications resulting from previous cosmetic, experimental, or investigative services, and other services that aren’t covered.
- Surgery or treatment that only improves physical appearance and doesn’t restore or materially improve a bodily function (e.g., hair transplants, piercing of ears or other body areas, electrolysis).
- Treatment of baldness, including hair transplants, topical medications, wigs, and hairpieces.
- Treatment of persons confined to public institutions.
- All medical and surgical procedures, therapies, supplies, drugs, and equipment for the treatment of sexual dysfunction or inadequacies.
- 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.
- 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.
- Routine foot care and treatment of flat feet.
- Swimming lessons, summer camp, gym membership, and weight control classes.
- 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.
- Contact lenses for cosmetic purposes and bifocal contact lenses for adults.
- 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.
- Refractive eye surgery.
• Physical exams for employment when the member is self-employed or as a requirement for continuing employment (i.e., 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 and immunizations for travel – domestic or foreign.
• 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.
• Organ transplants that don't meet the guidelines established by Medicaid and organ transplants that aren't specifically identified as a Medicaid benefit.
• Services provided by a medical professional to a member of the professional’s immediate family or household.
• 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 Integration medical benefits, but are available as a community education service to all HMSA QUEST Integration members.)
• Treatment for obesity, weight loss programs, food, and food supplements, including prepared-formula health foods. (HMSA QUEST Integration 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.)
• Ambulance wait time, physician wait time, stand-by services, telephone consultations, telephone calls, writing of prescriptions, and stat charges.
• Treatment of pulmonary tuberculosis when treatment is available at no charge to the general public.
• Treatment of Hansen’s disease after a definite diagnosis has been made except for surgical or rehabilitative procedures to restore useful function.
• Topical application of oxygen.
• Chiropractic services unless covered by Medicare or prescribed to treat conditions detected under EPSDT.
• Orthoptic training.

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

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 62.

Exercising your rights will not affect in a negative way how we or network providers treat you. This is true regardless of race, color, ancestry, sex (including gender identity or expression), sexual orientation, 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.

**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.
- Doesn’t restrain or keep you away from others unless it’s medically necessary or for safety.
- Won’t be used to control, punish, or retaliate. Nor will it be for convenience only.

**Privacy and Information**

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 why a service isn’t covered.
- Voice grievances or appeals about HMSA or the care we provide.
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
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.

Care
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 Integration members to be the same as the provider office hours for all other patients.
- Access to care that's without barrier 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’s not in the network if:
  - A network doctor isn’t available.
  - A network doctor doesn’t have the skills to treat your condition.
  - You have a medical emergency and can’t reach a network provider.
  - In these cases, you won’t 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 in your condition. This right is without regard to cost or coverage.
- 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 69.
- Transfer your rights to a person who has legal authority to make medical decisions on your behalf.

Right to Financial Protection
You aren’t responsible for:

- HMSA debts in the event we go out of business.
- Services that we choose to cover even though the DHS doesn’t pay HMSA.
- Covered services you get that the DHS or HMSA doesn’t pay the provider for.
- Charges for covered services that are more costly than covered services provided by a network provider due to the fact that 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 Integration 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.
- 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.

Inquiries
We welcome any questions you may have about your health plan, our operations, our partners, and your relationship with us. We'll answer any questions you may have. Please call us with your questions or if you want to let us know how we're doing.
Grievances & Appeals

If you have questions, suggestions, or a grievance about QUEST Integration services, we can help you with most of your questions over the phone. Please call us or send your inquiries in writing.

Sometimes, you may tell us that you're not happy with our responses to your questions. We will tell you, an 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 by working with you to write a summary of your grievance or appeal.

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 help us know that we have the right person, be prepared to give your consent in writing.

For members whose first language isn't English, we'll give the answers in your native language either through a written translation or an oral interpretation. For those who are hearing impaired and are TTY users, call 1 (877) 447-5990 toll-free for help.

Your grievance or appeal will be reviewed by someone who hasn't been involved in deciding anything about your case earlier.

For an appeal that deals with clinical services, such as 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 so for any of the following:

- A grievance or appeal that deals with clinical issues.
- 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 children under age 21 will be reviewed and approved by the medical director.

Grievances

When to File
You 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.

Who Can File
You, a person you choose, or your doctor can file a grievance either verbally or in writing. 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
If you need help writing a grievance, we can help. 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 don't speak English. If you're hearing impaired and a TTY user, call 1 (877) 447-5990 toll-free.

The grievance must include:
- Your name, address, phone number, and HMSA membership number.
- The date of the grievance.
- An account of 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 won't return the packet to you.

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

We have five business days from the date we receive your grievance to let you know 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 in writing the results of the decision and the date of the decision.

Grievance 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 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 our grievance decision, 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 692-8094 on Oahu.
- To submit a written 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: 692-8094

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

Grievance Review Decision
The DHS, Med-QUEST Division, will respond within 90 days after receiving your grievance review request. The grievance review decision made by the DHS, Med-QUEST Division, is final.
Appeals

When to File
You may file an appeal with us when one of the following actions has occurred:

- 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. You or your authorized representative must give us written consent before a doctor can file an appeal on your behalf. 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.
- An account of 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 have the right to ask to review your case file, including medical records and any other documents that are part of your appeal.

We Can Help You Write Your Appeal
Appeals that are called in must be followed by a request in writing with your signature. If you need help writing an appeal, we can help. 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 a TTY user, call 1 (877) 447-5990 toll-free.

Timeframe for Our Response
You have 30 days after an action occurs to file an appeal.

We have five business days from the date we receive your appeal to let you know that we received it.

We have 30 calendar days from the date we receive your appeal to give you our decision. 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 and what additional information is required.

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 or fax us the information.

**Mail:**

HMSA QUEST Integration  
P.O. Box 860  
Honolulu, HI 96808-0860  
Attn: QUEST Integration Grievance Coordinator

Fax: 948-8224  
1 (800) 960-4672 toll-free

**Phone Number**
For grievances or appeals over the phone, contact the grievance coordinator. The phone number is:

- 952-7843
- 1 (800) 440-0640, ext. 7843, toll-free

**Expedited Appeals**

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

- Could seriously jeopardize your life or 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 are 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 membership 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.
- An account of 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 a TTY user, 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**

You have 30 calendar days from the date of your denial letter to file an expedited appeal.

We have no more than three business days 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 and what additional information is required. 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. 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 also inform you in writing. 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 three business days 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 appeal decision. The appeal must be in writing. You must submit the appeal to the DHS Administrative Appeals Office within 30 days from the time you received our appeal decision.

Mail the appeal to:

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

DHS will make its decision within 90 days from the date the request was filed. The DHS administrative hearing decision will prevail and be in effect.

**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 30 days from the date you received our decision.

Send the letter to:

State of 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 have the right to request that we continue to pay for covered services when:

- You filed your appeal or expedited appeal within 10 days from the mail date of the denial or before the effective date of the proposed adverse action.
- The appeal or expedited appeal is in regard to 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.

To request to continue coverage while the appeal is being decided, contact us. If the appeal or expedited appeal decision is upheld, you may have to pay us back for the services you received during the review period.
Medicaid Ombudsman Program
The state of Hawaii's Department of Human Services has the Medicaid ombudsman program to help you with any problems with QUEST Integration.

The Medicaid ombudsman phone numbers are:
- Oahu: 791-3467
- Maui and Lanai: 270-1536
- Kauai: 240-0485
- Hawaii: 333-3053
- Molokai: 660-0063

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 and Abuse
We don’t tolerate fraud or abuse. Examples of fraud and abuse include:

- Letting someone else use your HMSA QUEST Integration membership card to get health care services.
- Giving or selling your drugs or supplies that were paid by your HMSA QUEST Integration plan to someone else.
- Using false information to qualify for HMSA QUEST Integration membership.

We need your help to spot fraud and abuse. If you think a provider, HMSA staff, or another
QUEST Integration member is committing fraud or abuse, contact us. Call HMSA’s confidential fraud hotline immediately:

- 948-5166
- 1 (888) 398-6445 toll-free

**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, and
- Your family and friends who might be involved in caring for you.

If you’d like a copy of an advance directive optional 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 Integration 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 Integration 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 Integration plan. Our phone number is 948-6422 or you can call your local HMSA office.
Terms

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

Authorized representative: The person you tell HMSA in writing who acts on your behalf if you’re not able to act on your own.

Benefits: The health services you can get under QUEST Integration and how much HMSA pays for them.

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

DHS: The state Department of Human Services.

Doctor: A physician M.D. or D.O. who provides care. Doctors 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.

EPSDT: A federal program that provides preventive health care for children. EPSDT stands for Early and Periodic Screening, Diagnostic, and Treatment.

Emergency: A sudden and unexpected problem that puts your life or health in danger and you need care right away.

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

Family planning: Services to prevent an unplanned pregnancy.

Grievance: A problem or concern resolved through a procedure.

Medical equipment: Durable medical equipment (DME) 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.

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.

Orthosis: 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.

Primary care provider (PCP): The provider you choose as your personal doctor. The provider must be licensed in the state of Hawaii and be a physician, M.D., or D.O.; an advanced practice registered nurse (APRN) who can write prescriptions; or a physician’s assistant. Your PCP will care for you and arrange for hospital care or specialists when needed.

Plan change period: An annual time period established by DHS when QUEST Integration members can change health plans. Also known as open enrollment.
**Participating provider or facility:** A doctor or facility that contracts with HMSA to care for QUEST Integration members. HMSA will only pay for covered services from these contracted providers.

**Physician:** A licensed doctor of medicine, osteopathy, or podiatric medicine.

**Prior approval:** Special approval from HMSA before you can get certain services. Your doctor will send the prior approval form to HMSA for review.

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

**Provider:** A person or institution that provides health services under a health plan. Providers include doctors, nurses, specialists, and hospitals that are recognized by HMSA. Care should be provided for a condition that they have the appropriate license and/or accreditation for.

**Specialist:** A doctor, surgeon, or osteopath who’s board certified or board eligible in a specialty listed by the American Medical Association or who is recognized as a specialist by HMSA.

**Urgent care:** Care for medical conditions that are serious, but not life threatening, and need care within 24 hours.
Notes:
HMSA's mission is to provide the people of Hawaii access to a sustainable, quality health care system that improves the overall health and well-being of our state.