Evidence of Coverage

HMSA Akamai Advantage
Dual Care (PPO D-SNP)

2026

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

MedicareRx
Prescription Drug Coverage

H8481_1150_8700_1395054_AA_Dual_Care_26_C

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of *HMSA Akamai Advantage® Dual Care (PPO D-SNP)*

This document gives the details about your Medicare health and drug coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost sharing
- Our medical and drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Customer Relations at 1-800-660-4672. (TTY users call 711). Hours are 7:45 am - 8:00 pm, 7 days a week. This call is free.

This plan, *HMSA Akamai Advantage Dual Care*, is offered by Hawai'i Medical Service Association (HMSA) (HMSA Akamai Advantage). (When this *Evidence of Coverage* says "we," "us," or "our," it means Hawai'i Medical Service Association (HMSA). When it says "plan" or "our plan," it means *HMSA Akamai Advantage Dual Care.*)

This document is available for free in Ilocano, Vietnamese, Chinese (Traditional), and Korean.

HMSA has free language interpreter services available for non-English speakers (phone numbers are printed on the back cover of this document).

Please contact the plan if you need information in an alternative format.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

OMB Approval 0938-1051 (Expires: August 31, 2026)

2026 Evidence of Coverage

Table of Contents

CHAPTER 1: Get started as a member

SECTION 1 You're a member of *HMSA Akamai Advantage Dual Care*

Section 1.1 You're enrolled in *HMSA Akamai Advantage Dual Care*, which is a Medicare Advantage Special Needs Plan

You're covered by both Medicare and Medicaid:

- **Medicare** is the federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You've chosen to get your Medicare and Medicaid health care and your drug coverage through our plan, *HMSA Akamai Advantage Dual Care*. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

HMSA Akamai Advantage Dual Care is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means benefits are designed for people with special health care needs. *HMSA Akamai Advantage Dual Care* is designed for people who have Medicare and are entitled to help from Medicaid.

Because you get help from Medicaid with Medicare Part A and B cost-sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare services. Medicaid may also provide other benefits by covering health care services that aren't usually covered under Medicare. You'll also get Extra Help from Medicare to pay for the costs of your Medicare drugs. *HMSA Akamai Advantage Dual Care* will help manage all these benefits, so you get the health services and payment help that you're entitled to.

HMSA Akamai Advantage Dual Care is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. Our plan also has a contract with the Hawaii Medicaid program to coordinate your Medicaid benefits. We're pleased to provide your Medicare and Medicaid coverage, including your drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how *HMSA Akamai Advantage Dual Care* covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs* (formulary), and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in *HMSA Akamai Advantage Dual Care* between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of *HMSA Akamai Advantage Dual Care* after December 31, 2026. We can also choose to stop offering our plan, in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve *HMSA Akamai Advantage Dual Care* each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare and the State of Hawai'i Department of Human Services Med-QUEST Division renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these requirements:

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.3). People who are incarcerated aren't considered to be living in the geographic service area even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States.
- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who get certain Medicaid benefits. (Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and Full Medicaid Benefits. Your Medicaid plan must be HMSA QUEST.

Note: If you lose your eligibility but can reasonably be expected to regain eligibility within six calendar month(s), then you're still eligible for membership (Chapter 4, Section 2.1 tells you about coverage and cost-sharing during a period of deemed continued eligibility).

Section 2.2 Medicaid

Medicaid is a joint federal and State government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who's eligible, what services are covered, and the cost for services. States also can decide how to run its program as long as they follow the federal guidelines.

In addition, Medicaid offers programs to help people pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB)**: Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

Section 2.3 Plan service area for *HMSA Akamai Advantage Dual Care*

HMSA Akamai Advantage Dual Care is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes the state of Hawaii.

If you plan to move to a new state, you should also contact your state's Medicaid office and ask how this move will affect your Medicaid benefits. Phone numbers for Medicaid are in chapter 2, Section 6 of this document.

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Relations at 1-800-660-4672 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.4 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify *HMSA Akamai Advantage Dual Care* if you're not eligible to stay a member of our plan on this basis. *HMSA Akamai Advantage Dual Care* must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card for services that are covered only by Medicaid. Sample membership card:

DON'T use your red, white, and blue Medicare card for covered medical services while a member of this plan. If you use your Medicare card instead of your *HMSA Akamai Advantage Dual Care* membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Customer Relations at 1-800-660-4672 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* (https://hmsa.com/search/providers/assets/pdf/AA-Medical-dual-care-Directory.pdf) lists our current network providers, pharmacies and durable medical equipment suppliers. This directory also identifies which providers participate with QUEST (Medicaid). You may see any provider in the directory for plan covered services even if they do not participate with QUEST (Medicaid). **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. **Network pharmacies** are pharmacies that have agreed to fill covered prescriptions for our plan members.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is situations where it's unreasonable or not possible to get services in-network), out-of-area dialysis services, and cases when *HMSA Akamai Advantage Dual Care* authorizes use of out-of-network providers.

Get the most recent list of providers, suppliers and pharmacies on our website at www.hmsa.com/advantage. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

If you don't have the *Provider and Pharmacy Directory*, you can get a copy (electronically or in hardcopy form) from Customer Relations at 1-800-660-4672 (TTY users call 711). Requests for hard copy *Provider and Pharmacy Directories* will be mailed to you within 3 business days.

Section 3.3 Drug List (formulary)

Our plan has a *List of Covered Drugs* also called the Drug List formulary. It tells which prescription drugs are covered under the Part D benefit included in *HMSA Akamai Advantage Dual Care*. The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The Drug list must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced described in Chapter 5, Section 6. Medicare approved the *HMSA Akamai Advantage Dual Care* Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit www.hmsa.com/advantage or call Customer Relations at 1-800-660-4672 (TTY users call 711).

SECTION 4 Summary of Important Costs

	Your costs in 2026
Monthly plan premium* *Your premium can be higher or lower than this amount. Go to Section 4.1 for details.	**$42.30**
Deductible	Our deductible amount for Medicare Part A covered services is **$1,676,** and our deductible amount for Medicare Part B covered services is **$257, except for insulin furnished through an item of durable medical equipment.** **These amounts may change for 2026.** **If you are eligible for Medicare cost-sharing help under Medicaid, you pay $0.**
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details).	**From network providers: $9,250** **You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.**
Primary care office visits	**In-Network** **$0 copayment per visit**
Specialist office visits	**In-Network** **$0 copayment per visit**
Inpatient hospital stays	**In-Network** **Days 1-60: $0 copayment per day** $0 copayment per Lifetime Reserve Day.

Part D drug coverage deductible (Go to Chapter 6 Section 4 for details.)	**$615, except for covered insulin products and most adult Part D vaccines.** **If you are eligible for Medicare cost-sharing help under Medicaid, you pay $0.**
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Cost sharing during the Initial Coverage Stage:** **Drug Tier 1: $0 copayment** **Drug Tier 2: $0 copayment** . **Drug Tier 3, 4, & 5:** **You pay $0, $1.60, or $5.10 for generic/preferred multi-source drugs.** **You pay $0, $4.90, or $12.65 for all other drugs.** **Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs.**

Your costs can include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium unless you qualify for Extra Help with your prescription drug costs. People with Medicare and Medicaid automatically qualify for Extra Help and do not pay a monthly plan premium. If you temporarily lose eligibility you will be responsible for the monthly plan premium. For 2026, the monthly premium for *HMSA Akamai Advantage Dual Care* is $42.30

If you *already* get help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you**. We sent you a separate document, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, please call Customer Relations at 1-800-660-4672 (TTY users call 711) and ask for the *LIS Rider*.

In some situations, our plan premium could be <u>less</u>

The Extra Help program helps people with limited resources pay for their drugs. Learn more about this program in Chapter 2, Section 7. If you qualify, enrolling in the program might lower your monthly plan premium.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2026* handbook, the section called *2026 Medicare Costs*. Download a copy from the Medicare website at (www.medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some members are required to pay other Medicare premiums. As explained in Section 2 above to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most *HMSA Akamai Advantage Dual Care* members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

If Medicaid isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Because you're dually-eligible, the LEP doesn't apply as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.
    - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan after you were eligible to enroll. Or count the number of full months you did not have creditable drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is $38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round to the nearest 10 cents. In the example, here it would be 14% times $38.99, which equals $5.4586. This rounds to $5.50. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year** because the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and currently enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

Important: Don't stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay our plan premiums.

Section 4.4 Income Related Monthly Adjustment Amount

If you lose eligibility for this plan because of changes in income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov.health-drug-plans/part-d/basics/costs.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay our plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay our plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay our plan premium

There are four ways you can pay our plan premium.

Option 1: Pay by check or in person

You may pay your monthly plan premium directly to our plan with cash, a check, or credit card. You can drop off a check in person at your nearest Neighborhood Center. Cash payments can only be made in person at our Neighborhood Centers. Checks can also be mailed to:

Hawai‘i Medical Service Association
P.O. Box 29810
Honolulu, HI 96820-2210

Your cash, check, or credit card payments must be received by the fifth day of the month. Checks should be made payable to HMSA. We will send you a bill monthly. To help us process your payment timely, please include your bill stub with your check and write your member ID number on your check.

If you are submitting a payment for multiple accounts, please include either both bill stubs or both member ID numbers and Account Numbers which is located on the upper right hand of your premium billing statement with the check and clear instructions on how much you would like credited to each account with your payment. If you choose your bank's bill payment service (sometimes called "online bill pay"), please ensure that your bank includes your member ID number and Account Number on the check. We can only accept payment for one account per check received if paying by bill payment service.

Option 2:Have our premium paid directly from your bank account

You can have your monthly plan premium automatically withdrawn from your bank checking or savings account each month. If you don't currently have your monthly plan premium automatically withdrawn from

your bank account but you want to, call Membership Services and ask about HMSA's Automatic Payment Service. This Automatic Payment Service is available only through banks located within the state of Hawaii.

Or, simply complete the HMSA Medicare Advantage Plans Automatic Payments form that is available at www.hmsa.com/help-center/need-a-form/. Processing can take up to 30 days. Deductions will occur on the fifth day of every month or the following business day if the fifth day falls on a weekend or holiday.

Option 3: Set up online bill pay

You can sign up for My Account using your HMSA membership card. In My Account, you can set up eInvoice Connect to make a one-time payment or recurring payments. Please visit our website at www.hmsa.com/payonline for more information.

Register on www.HMSA.com:

- Your My Account allows you to view claims, update personal information, and manage your health plan with ease. To sign up:
- Go to www.hmsa.com and click My Account Login.
- Click Create an Account and follow the instructions.
- You will need your subscriber ID number from your HMSA membership card and a valid email address to complete registration. For an example of the HMSA membership card, please see Chapter 1, Section 3.1.

Go paperless! You have the option to schedule a one-time payment or to set up recurring payments. You can also have notifications and bills emailed to you or view them in My Account. This is a completely free service to HMSA members and there are no additional charges for online payments.

To sign up for automatic payments:

- Log into your My Account using your Email Address and Password
- Click on Profile and select Pay My Bill. This will show a PDF copy of your bills and payment history.
- Add a form of payment on Payment Accounts using a Debit Card, Credit Card, US Checking Account, or US Savings Account.
- Then go to Automatic Payments to schedule the payment method to pay your bill every 1st of the month.

Option 4: Have our plan premium taken out of your monthly Social Security check

The Social Security deduction may take two or more months to begin after Social Security approves the deduction. In most cases, if Social Security accepts your request for automatic deduction, the first deduction from your Social Security benefit will include all premiums due from the point withholding begins. SSA only deducts plan premium amounts below $300.

Changing the way you pay your premium. If you decide to change the option by which you pay your plan premium, it can take up to three months for your new payment method to take effect. While we process your request for a new payment method, you are responsible for making sure our plan premium is paid on time. To change your payment method, send your written request to:

HMSA
ATTN: Membership Services

P.O. Box 860
Honolulu, HI 96808-0860

Or you may call HMSA's Membership Services at (808) 948-6174 on Oahu or 1-800-782-4672 toll-free on the Neighbor Islands or U.S. Mainland.

Should other payment options become available during the year, we will notify you.

If you have trouble paying our plan premium

Our plan premium payment is due in our office by the fifth day of the month. If don't get your payment by the fifth day of the month, we'll send you a notice letting you know our plan membership will end if we don't get your premium payment within 30 days.

If you are having trouble paying your premium on time, please contact Customer Relations at 1-800-660-4672 (TTY users call 711) to see if we can direct you to programs that will help with our plan premium.

If we end your membership because you didn't pay our plan premium, you'll have health coverage under Original Medicare. As long as you're getting Extra Help with your prescription drug costs, you'll continue to have Part D drug coverage. Medicare will enroll you into a new prescription drug plan for your Part D coverage.

At the time we end your membership, you may still owe us for unpaid premiums. If you want to enroll again in our plan (or another plan that we offer), you'll need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control and that made you unable to pay your plan premium within our grace period, you can make a complaint. For complaints, we'll review our decision again. Chapter 9 tells how to make a complaint or you can call us at (808) 948-6174 or 1-800-782-4672, between to 5:00 pm, Hawaii Standard Time, Monday through Friday. TTY users call 711. You must make your complaint no later than 60 calendar days after the date your membership ends.

Section 5.2 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

If you become eligible for Extra Help or lose your eligibility for Extra Help during the year, the part of our plan premium you have to pay may change. If you qualify for Extra Help with your drug coverage costs, Extra Help pays part of your monthly plan premiums. If you lose your eligibility for Extra Help during the year you'll need to start paying the full monthly plan premium. Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts.** Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number.
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid).
- Any liability claims, such as claims from an automobile accident.
- If you're admitted to a nursing home.
- If you get care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you participate in a clinical research study. (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in but we encourage you to do so.)

If any of this information changes, let us know by calling Customer Relations at 1-800-660-4672 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Relations at 1-800-660-4672 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the "primary payer") pays up to the limits of its coverage. The insurance that pays second, (the "secondary payer"), only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):

  - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
  - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
  - Workers' Compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare and/or employer group health plans have paid.

CHAPTER 2:
Phone numbers and resources

SECTION 1 *HMSA Akamai Advantage Dual Care* contacts

For help with claims, billing, or member card questions, call or write to *HMSA Akamai Advantage Dual Care* Customer Relations. We'll be happy to help you.

Customer Relations – Contact Information	
Call	From Oahu: (808) 948-6000, option 6 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 7:45 am - 8:00 pm, 7 days a week. Customer Relations at 1-800-660-4672 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. This number is available 7:45 am - 8:00 pm, 7 days a week.
Fax	(808) 948-6433
Write	HMSA Akamai Advantage Customer Relations P.O. Box 860 Honolulu, HI 96808-0860
Website	www.hmsa.com/advantage

Section 1.2 How to ask for a coverage decision or appeal about your medical care or Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information	
Call	From Oahu: (808) 948-6000, option 6 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 7:45 am - 8:00 pm, 7 days a week.
TTY	711 Calls to this number are free. This number is available 7:45 am - 8:00 pm, 7 days a week.
Fax	(808) 944-5611
Write	HMSA Akamai Advantage Medical Management P.O. Box 2001 Honolulu, HI 96805-2001
Website	https://www.hmsa.com/help-center/forms/medicare-precertification/
Coverage Decisions for Part D Prescription Drugs – Contact Information	
Call	1-855-479-3659 for standard and fast decisions, formulary and utilization management exceptions. Calls to this number are free. This number is available 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. This number is available 24 hours a day, 7 days a week.
Fax	1-855-633-7673 or after business hours, call the toll-free number above. Be sure to ask for a “fast,” “expedited”, or “24-hour” review.
Write	Medicare Coverage Determinations P.O. Box 52000 MC109 Phoenix, AZ 85072-2000
Website	https://www.hmsa.com/help-center/forms/medicare-drug-review

Appeals for Medical Care and Part D Prescription Drugs – Contact Information	
Call (during business hours)	From Oahu: (808) 948-5090 From the Neighbor Islands and U.S. Mainland: 1-800-462-2085 Calls to these numbers are free. These numbers are available 8:00 am - 8:00 pm, Monday through Friday.
Call (after business hours)	(808) 948-6483 Requests for fast appeals only. This is not a Customer Relations number. Calls to this number are not free.
TTY	711 Calls to this number are free. This number is available 8:00 am - 8:00 pm, Monday through Friday or after business hours.
Fax	(808) 952-7546 Send the fax to the attention of: *HMSA Akamai Advantage Dual Care* Appeals Coordinator.
Email	appeals@hmsa.com
Write	HMSA Medicare Advantage Attention: Appeals Coordinator P.O. Box 1958 Honolulu, HI 96805-1958
Website	www.hmsa.com/advantage

Section 1.3 How to make a complaint about your medical care or Part D prescription drugs

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care – Contact Information	
Call	From Oahu: (808) 948-6000, option 6 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 7:45 am - 8:00 pm, 7 days a week.
TTY	711 Calls to this number are free. This number is available 7:45 am - 8:00 pm, 7 days a week.
Fax	(808) 948-6433
Write	HMSA Akamai Advantage Customer Relations P.O. Box 860 Honolulu, HI 96808-0860
Medicare Website	You can submit a complaint about *HMSA Akamai Advantage Dual Care* directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.
Complaints about Part D prescription drugs – Contact Information	
Call	1-855-479-3659 Calls to this number are free. This number is available 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. This number is available 24 hours a day, 7 days a week.
Write	CVS Caremark-Grievances P.O. Box 30016 Pittsburg, PA 15222-0330
Medicare Website	You can submit a complaint about *HMSA Akamai Advantage Dual Care* directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Section 1.4 How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 for more information.

Payment Requests about Medical Care – Contact Information	
Call	From Oahu: (808) 948-6000, option 6 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 7:45 am - 8:00 pm, 7 days a week.
TTY	711 Calls to this number are free. This number is available 7:45 am - 8:00 pm, 7 days a week.
Fax	(808) 948-6433
Write	HMSA - CLAIMS P.O. Box 860 Honolulu, HI 96808-0860
Website	www.hmsa.com/advantage
Payment Requests about Part D Prescription Drugs – Contact Information	
Call	1-855-479-3659 Calls to this number are free. This number is available 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. This number is available 24 hours a day, 7 days a week.
Write	Medicare Part D Paper Claim P.O. Box 52066 Phoenix, AZ 85072-2066
Website	www.hmsa.com/advantage You can download the payment request form from our website at www.hmsa.com/help-center/how-to-get-copies-of-the-drug-claim-form/.
Payment Requests about Routine Vision Items and Services – Contact Information	
Call	From Oahu: (808) 948-6000, option 6 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 7:45 am - 8:00 pm, 7 days a week.
TTY	711 Calls to this number are free. This number is available 7:45 am - 8:00 pm, 7 days a week.

Write	First American Administrators, Inc. Attn: OON Claims PO Box 8504 Mason, OH 45040-7111
Website	You can download the payment request form at www.eyemedonline.com/managed-vision-care/member-forms/out-of-network-claim#/.

SECTION 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit www.Medicare.gov to tell Medicare about any complaints you have about *HMSA Akamai Advantage Dual Care*. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Hawaii, the SHIP is called Hawaii SHIP.

Hawaii SHIP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Hawaii SHIP counselors can help you understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. Hawaii SHIP counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

Hawaii SHIP – Contact Information	
Call	From Oahu: (808) 586-7299 From the Neighbor Islands: 1-888-875-9229 Calls to these numbers are free.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Write	Hawaii SHIP Executive Office on Aging Hawaii State Department of Health No. 1 Capitol District 250 South Hotel St. Suite 406 Honolulu, HI 96813-2831
Website	www.hawaiiship.org

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Hawaii, the Quality Improvement Organization is called Commence Health.

Commence Health has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

Contact Commence Health in any of these situations:

- You have a complaint about the quality of care you have got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.

- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

Commence Health (Hawaii's Quality Improvement Organization) – Contact Information	
Call	1-877-588-1123 Calls to this number are free. This number is available Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Sat/Sun and Holidays: 10:00 a.m. - 4:00 p.m. (local time) 24 hour voicemail service is available
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Fax	1-855-694-2929
Website	www.livantaqio.com/en/states/hawaii

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount, or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, contact Social Security to let them know.

Social Security – Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
Website	www.ssa.gov

SECTION 6 Medicaid

You are covered by both Medicare and Medicaid. Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs include:

- **Qualified Medicare Beneficiary (QMB)**: Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB)**: Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

If you have questions about the assistance you get from Medicaid, contact State of Hawai‘i Department of Human Services Med-QUEST Division.

QUEST (Medicaid): Hawaii's Medicaid program – Contact Information	
Call	From Oahu: (808) 524-3370 From the Neighbor Islands and U.S. Mainland: 1-800-316-8005 These numbers are available 7:45 am - 4:30 pm, Monday through Friday, except State Holidays.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Fax	For Oahu Office: (808) 587-3543
Write	QUEST Hawaii Medicaid Program P.O. Box 3490 Honolulu, HI 96811-3490
Website	www.medquest.hawaii.gov

The Hawaii Medicaid Ombudsman helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan. Hawaii Medicaid Ombudsman is the Hawaii State Medicaid Programs Ombudsman Office.

Hawaii Medicaid Ombudsman – Contact Information	
Call	From Oahu: (808) 746-3324 From the Neighbor Islands: 1-888-488-7988 Calls to these numbers are free. These number are available 7:45 am - 4:30 pm, Monday through Friday, excluding Hawaii State holidays.
Write	hiombudsman@koanrisksolutions.com

Website	www.himedicaidombudsman.com

The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Long Term Care Ombudsman Program – Contact Information	
Call	(808) 586-7268
Write	john.mcdermott@doh.hawaii.gov
Website	https://health.hawaii.gov/eoa/home/long-term-care-ombudsman-program/

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (www.Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and get Extra Help from Medicare to pay for your prescription drug plan costs. You don't need to do anything further to get this Extra Help.

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- The Social Security Office at 1-800-772-1213, between 8:00 am and 7:00 pm, Monday through Friday. TTY users call 1-800-325-0778; or
- Your State Medicaid Office at (808) 524-3370.

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of your proper copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- You can contact Customer Relations. Please have the following information available: Member name, member ID number, Extra Help information (such as the subsidy level), and any written documentation you have concerning the Extra Help you are eligible to receive. Customer Relations phone numbers are on the back cover of this document.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Customer Relations if you have questions.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the HIV Drug Assistance Program (HDAP).

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call:

HIV Drug Assistance Program (HDAP) – Contact Information	
Call	(808) 733-9360 This number is available 7:45 am - 4:30 pm, Monday through Friday, except State holidays.
TTY	711 Calls to this number are free. This number is available 7:45 am - 4:30 pm, Monday through Friday, except State holidays.
Write	Hawai‘i State Department of Health Harm Reduction Services Branch 3627 Kilauea Avenue, Suite 306 Honolulu, HI 96816
Website	https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn’t save you money or lower your drug costs. If you’re participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026**. Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call Customer Relations at 1-800-660-4672 (TTY users call 711) or visit www.Medicare.gov.

Medicare Prescription Payment Plan – Contact Information	
Call	1-855-479-3659 Calls to this number are free. This number is available 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. This number is available 24 hours a day, 7 days a week.

Write	HMSA Medicare Prescription Payment Plan P.O. Box 7 Pittsburgh, PA 15230
Website	https://caremark.com/mppp

SECTION 8 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families.

If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	https://RRB.gov

SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Relations at 1-800-660-4672 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Relations are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. The benefits administrator can help you understand how your current drug coverage will work with our plan.

CHAPTER 3:
Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for covered services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, *HMSA Akamai Advantage Dual Care* must cover all services covered by Original Medicare.

HMSA Akamai Advantage Dual Care will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider a (PCP) providing and overseeing your care.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (go to Section 2.1 for more information).
    - The providers in our network are listed in the *Provider and Pharmacy Directory* at https://www.hmsa.com/advantage.
    - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
    - While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare,

you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Use providers in our plan's network to get medical care

Section 2.1 You may choose a Primary Care Provider (PCP) to provide and oversee your care

What is a PCP and what does the PCP do for you?

A primary care provider (PCP) is your go-to doctor for basic care and annual checkups. Your PCP is licensed to practice in the state of Hawaii and will refer you to see specialists, when needed.

Having a PCP means having someone who knows your health needs and medical history. It's a doctor you can form a long-term relationship with who understands what's important to you. When you have a PCP you know and trust, you can speak openly about your health concerns and your routine exams, preventive care, and other treatments will go more smoothly.

What kind of doctors can I choose to be my PCP?

Your PCP can be a physician or practitioner. A practitioner is a physician assistant PCP (PAPCP) or an advanced practice registered nurse (APRN).

Usually, these providers practice in the areas of:

- Family practice
- General practice
- Internal medicine
- Obstetrics and gynecology

What can my PCP do for me?

Your PCP will provide most of your care and help you arrange or coordinate any covered services you need.

Services your PCP will help coordinate:

- Follow-up care.
- Hospital admissions.
- Laboratory tests.
- Therapist.
- Specialist care.
- X-rays.

How to choose a PCP?

There are several ways you can choose a PCP:

- Use the Find a Doctor search tool at www.hmsa.com/search/providers.
- Visit www.hmsa.com/advantage to view and download the *Provider and Pharmacy Directory*. Download the "HMSA Akamai Advantage Dual Care (PPO D-SNP)" *Provider and Pharmacy Directory*.
- Call us at the Customer Relations numbers on the back of this document.
- Visit your nearest HMSA Center or office. Locations and hours of operations are on the back of this document and on www.hmsa.com/contact.

If you have a favorite specialist or hospital: If you want to continue using these providers, check to see if your PCP can refer you to them.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose a new PCP or you'll pay more for covered services.

Call the Customer Relations phone numbers on the back of this document if you need help finding a new PCP. Once you call to change your PCP, you can start seeing your new PCP right away.

Tip: When you call us, give us the names of the specialists you're seeing or services you're receiving, such as home health services or medical equipment. We'll help make sure that you can continue seeing these providers or receiving the services you need. We'll send you a new HMSA membership card with your new PCP's information. You should make arrangements to have your medical records from other providers sent to your new PCP. Chapter 11 (*Legal Notices*) explains how we protect your personal health information and medical records.

Section 2.2 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

If you need specialized care, your PCP can refer you to a specialist or other network providers. Since you don't need a referral, you can choose your own specialist in our provider network.

Who will coordinate my care?

Your PCP will coordinate your care and consult with the other doctors and specialists on your health care team. Your PCP can also help you get laboratory tests and medical supplies.

What's prior authorization?

In some cases, you may need HMSA's approval in advance for you to receive certain services or supplies. This is called prior authorization. Your PCP, a specialist or a Medical Supplier are responsible for getting prior authorization from HMSA. See Chapter 4, Section 2.1 to find out which services need prior authorization.

Tip: Choose network providers to help save you money. These providers have an agreement with us to charge a negotiated fee. If you choose an out-of-network provider, your share of the costs for covered services may be higher.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. An in-network provider, such as your PCP, can request prior authorization so that we can cover the service at in-network cost sharing.
- If you find out that your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

How do I access palliative care?

As a member of our plan, you may access palliative care, which is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering, through the *Supportive Care* benefit depending on your eligibility. You should work with your primary care provider, specialists, and palliative care/hospice care provider to discuss how palliative care can integrate with your treatment plan. For more information on the *Supportive Care* benefit, see Chapter 4, Section 2.1 (*Medical Benefits Chart, what is covered and what you pay*).

Section 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services covered benefits and medically necessary. However, **if you use an out-of-network provider, your share of the costs for**

covered services may be higher. Here are more important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you get non-emergent care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers ask for a pre-visit coverage decision to confirm that the services you get are covered and are medically necessary (go to Chapter 9, Section 4) This is important because:
    - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or weren't medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you go, you have the right to appeal our decision not to cover your care (go to Chapter 9).
- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 7).
- If you're using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network.

Covered services in a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. If your care requires prior authorization, your PCP will work with us to get this approved. Your follow-up care will be covered by our plan.

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care thinking that your health is in serious danger and the doctor may say that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care only if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered "urgently needed services" and you follow the rules below for getting this urgent care (Section 3.2).

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Certain in-network urgently needed services can also be accessed via HMSA's Online Care at: https://hmsaonlinecare.com. See Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) for more information about HMSA's Online Care. You may also contact Customer Relations (phone numbers are located on the back cover of this document).

Our plan doesn't cover emergency services, urgently needed services, or any other services you get outside of the United States and its territories.

Section 3.3 Get care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit https://www.hmsa.com/health-plans/medicare/disaster-support/ for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan

HMSA Akamai Advantage Dual Care covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Any costs associated with services that you've received after you've reached your benefit limit do not count toward your out-of-pocket maximum.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study?

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more - for example, if you already paid the Original Medicare cost-sharing amount, we'll reimburse the difference between what

you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study ?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- An operation or other medical procedure if it is part of the research study
- Treatment of side effects and complications of the new care

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for the services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to see Chapter 7 for more information for submitting requests for payments.

> *Example of cost sharing in a clinical trial:* Let's say that you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

When you're part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.

- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at:www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that's **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *not voluntary* or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - *– and –* you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Our plan's coverage of non-religious services you receive as an inpatient at a religious non-medical health care institution is the same as inpatient hospital coverage. See the benefits chart in Chapter 4, *Inpatient hospital care*, for more information.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of *HMSA Akamai Advantage Dual Care*, you won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Ownership of DME will be at HMSA's discretion. Under some limited circumstances, we'll transfer ownership of the DME item to you. Examples include, but are not limited to the following:

Durable medical equipment items which are immediately owned by the member:

- Prosthetics and Orthotics
- Walkers
- Supply items

Durable medical equipment items which will have ownership transferred after the Medicare-defined rental period of 13 consecutive months:

- Wheelchairs
- Hospital beds
- Insulin pumps
- PAP devices

Durable medical equipment items which will never have ownership transferred:

- Continuous Passive Motion (CPM) devices
- Ventilators

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll have to make 13 payments to our plan before owning the item. There are no exceptions to this case when you return to Original Medicare.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage *HMSA Akamai Advantage Dual Care* will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave *HMSA Akamai Advantage Dual Care* or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart
(what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of *HMSA Akamai Advantage Dual Care.* This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Deductible:** the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your deductibles for certain categories of services.)
- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance**: the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Section 1.2 Our plan has a deductible for certain types of services

We have a deductible for certain types of services.

The plan has a deductible amount for the following types of services:

- Our deductible amount for Medicare Part A covered services is $1,676. This deductible is applied per hospital stay.
- Our deductible amount for Medicare Part B covered services is $257. This deductible does not apply to emergency or urgently needed care.

These amounts may change for 2026.

Until you have paid the deductible amount, you must pay the full cost for Medicare Part A and Part B covered services. Once you have paid your deductible, we will pay our share of the costs for these services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year. The benefits chart in Section 2 shows the service category deductibles.

If you are eligible for Medicare cost-sharing assistance under Medicaid, you have no deductible.

Section 1.3 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Note: Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. You're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Medicare Advantage Plans have limits on the amount you have to pay out-of-pocket each year for medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is $9,250**.

The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for plan premiums and Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $9,250, you won't have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services from in-network providers. If you reach the maximum out-of-pocket amount of $13,900, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services *HMSA Akamai Advantage Dual Care* covers and what you pay out-of-pocket for each service. Part D drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart by an endnote. Medicare Part A and Part B services that are rendered by out-of-network providers as a result of a referral from a network provider are covered at the lesser of the in-network or out-of-network cost-sharing only if prior authorization was approved by HMSA.

- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- You're covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost-sharing for Medicare services. Medicaid also covers services Medicare doesn't cover.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.
- If you're within our plan's 6 calendar month(s) period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will not pay the Medicare premiums or cost-sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. The amount you pay for Medicare covered services may increase during this period.
- You don't pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.
- The cost-sharing amounts listed under "In-Network" are shown **after** the Medicare cost-sharing assistance under Medicaid is paid. The cost-sharing amounts listed under "Out-of-network" are shown **before** the Medicare cost-sharing assistance under Medicaid is paid.
- If you're diagnosed with any of the chronic conditions listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
    - Diabetes, High Blood Pressure (Hypertension), High Cholesterol (Hyperlipidemia), Cardiovascular Disorders (i.e., Heart Problems), and Stroke. Other conditions may be eligible. For a full list of eligible chronic conditions, see https://hmsa.com/health-plans/medicare/extra-benefits-dual-care/.
    - All applicable eligibility requirements must be met before the benefit is provided. Not all members qualify.
- For more detail, go to the *Special Supplemental Benefits for the Chronically Ill* row in the Medical Benefits Chart below.
- Contact us to find out exactly which benefits you may be eligible for.

 This apple shows the preventive services in the Medical Benefits Chart.

* You will see this asterisk next to services that do not count toward your maximum out-of-pocket amount in the benefits chart. See Chapter 4, Section 1.3 for more information about the maximum out-of-pocket amount.

For information about the endnotes in the benefits chart, please see "Notes to the Benefits Chart" at the end of this chart.

Section 2.1 Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • A master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.	**In-Network** $0 copayment for each Medicare-covered acupuncture for chronic low back pain visit with a primary care provider in the primary care provider's office, or from an advanced practice registered nurse, nurse practitioner, or physician assistant. $0 copayment for each Medicare-covered acupuncture for chronic low back pain visit from a specialist. $0 copayment for each Medicare-covered acupuncture for chronic low back pain visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic. **Out-of-network** 30% of the cost for each Medicare-covered acupuncture for chronic low back pain visit with a primary care provider in the primary care provider's office, or from an advanced practice registered nurse, nurse practitioner, or physician assistant. 30% of the cost for each Medicare-covered acupuncture for chronic low back pain visit from a specialist. 30% of the cost for each Medicare-covered acupuncture for chronic low back pain visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic.

Covered Service	What you pay
Acupuncture for chronic low back pain (continued) Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Transportation starts where an injury or illness took place or first needed emergency care. Transportation ends at the nearest appropriate facility that can provide care. Non-emergency air ambulance transportation between Hawaii and the Mainland U.S. requires prior authorization by the plan.	**In-Network** $0 copayment per one-way trip per ambulance provider per day for Medicare-covered ambulance benefits. Air ambulance is covered only in emergency situations based on Medicare guidelines. (1) **Out-of-network** 30% of the cost per one-way trip for Medicare-covered ambulance benefits.
Annual Routine Physical Exam An annual routine physical examination is provided by a qualified physician or non-physician practitioner. This is covered once every calendar year.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the annual routine physical exam benefit.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every calendar year. **Note:** Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the annual wellness visit.

Covered Service	What you pay
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every calendar year for women aged 40 and older • Clinical breast exams once every 24 months	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Cardiac rehabilitation is covered for a limited number of sessions when medically necessary.	**In-Network** $0 copayment for each Medicare-covered cardiac rehabilitation service ordered by your physician. $0 copayment for each Medicare-covered intensive cardiac rehabilitation service ordered by your physician. **Out-of-network** 30% of the cost for each Medicare-covered cardiac rehabilitation service ordered by your physician. 30% of the cost for each Medicare-covered intensive cardiac rehabilitation service ordered by your physician.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

Covered Service	What you pay
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test and pelvic exam every 12 months • We cover an HPV test once every five years for asymptomatic members aged 30 to 65 years in conjunction with the Pap smear test	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. There is no coinsurance, copayment, or deductible for a Medicare-covered preventive HPV test.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	**In-Network** $0 copayment for each visit for Medicare-covered services. **Out-of-network** 30% of the cost for each visit for Medicare-covered services.
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	**In-Network and Out-of-network** For cost-sharing for Chronic pain management and treatment services, see *Physician/Practitioner services, including doctor's office visit.* Cost sharing for this service will vary depending on individual services provided under the course of treatment.

Covered Service	What you pay
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay $0 for each Medicare-covered colorectal cancer screening exam for your doctor's services. In a hospital outpatient setting, you also pay the hospital $0 for each Medicare-covered colorectal cancer screening exam. The Part B deductible doesn't apply.

Covered Service	What you pay
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover: **Diagnostic and Preventive Dental Services: *** • Oral exams: 2 per calendar year • Cleanings: 2 per calendar year • Full mouth X-rays or Panoramic X-ray: 1 set per 5 calendar years • Bitewing X-rays: 1 set per calendar year except when performed within 12 months of full mouth x-rays or panoramic x-ray • Fluoride: 2 treatments per calendar year • Silver Diamine Fluoride: 2 treatments per calendar year **Comprehensive Dental Services: *** • Fillings: 2 per calendar year • Extractions (simple and surgical): 4 per calendar year • Removal of impacted tooth: 1 per tooth per lifetime • Root canal: 1 per calendar year • Crown: 1 per calendar year • Deep cleanings: 1 per quadrant every 24 months • Therapeutic cleanings: 2 per calendar year • Full mouth debridement: 1 per 3 calendar years • Complete denture or partial dentures: 1 per arch (upper/lower) per 5 calendar years • Immediate dentures: 1 per arch (upper/lower) per lifetime • Denture adjustments and/or repairs: 2 per arch (upper/lower) per calendar year • Denture rebase or reline: 1 per arch (upper/lower) per calendar year QUEST (Medicaid) will cover diagnostic, preventive, restorative, and some prosthodontic services.	**In-Network** $0 copayment for each visit for Medicare-covered dental services. $0 copayment for diagnostic and preventive dental services and comprehensive dental services.* (2) **Out-of-network** 30% of the cost for each visit for Medicare-covered dental services. 30% of the cost for diagnostic and preventive dental services and comprehensive dental services.* (2)

Covered Service	What you pay
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. There are quantity limits for diabetic test strips. If your doctor believes you require a higher number of test strips, they can request an exception. We cover the following preferred brands and manufacturers of Blood Glucose monitors (BGM) and related supplies to monitor your blood glucose: • Accu-Chek Aviva • Accu-Chek Guide • Accu-Chek SmartView • FreeStyle • FreeStyle InsuLinx • FreeStyle Lite • FreeStyle Precision Neo • Precision Xtra	**In-Network** $0 copayment for Medicare-covered blood glucose monitors, including continuous glucose monitors, and diabetes monitoring supplies. $0 copayment for Medicare-covered therapeutic shoes or inserts. $0 copayment for Medicare-covered diabetes self-management training. **Out-of-network** 20% of the cost for Medicare-covered blood glucose monitors, including continuous glucose monitors, and diabetes monitoring supplies. 20% of the cost for Medicare-covered therapeutic shoes or inserts. 20% of the cost for Medicare-covered diabetes self-management training.

Covered Service	What you pay
Diabetes self-management training, diabetic services, and supplies **(continued)** You can also ask your pharmacist to tell you which brands and manufacturers we cover. Generally, we will not cover other brands and manufacturers of diabetic supplies unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to *HMSA Akamai Advantage Dual Care* and are using a brand of diabetic supplies that is not preferred, we will continue to cover this brand for up to 100 days. During this time, you should talk with your doctor to decide the preferred brand that is medically appropriate for you after this 100-day period. • Other supplies to monitor your blood glucose: Continuous Glucose Monitoring System (CGMS), and related supplies. We cover the following preferred brands and manufacturers Continuous Glucose Monitoring System (CGMS), and related supplies to monitor your blood glucose: • Dexcom • Freestyle Libre • For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3) Covered items include, but are not limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.	**In-Network** $0 copayment for Medicare-covered durable medical equipment and related supplies. Your cost sharing for Medicare oxygen equipment coverage is $0 copayment, every rental payment. Your cost sharing won't change after you're enrolled for 36 months.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued) We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.hmsa.com/advantage.	If prior to enrolling in *HMSA Akamai Advantage Dual Care* you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in *HMSA Akamai Advantage Dual Care* is $0 copayment. Authorization rules may apply. (1) **Out-of-network** 20% of the cost for Medicare-covered durable medical equipment and related supplies. Your cost sharing for Medicare oxygen equipment coverage is 20% of the cost, every rental payment. Your cost sharing won't change after you're enrolled for 36 months. If prior to enrolling in *HMSA Akamai Advantage Dual Care* you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in *HMSA Akamai Advantage Dual Care* is 20% of the cost. For cost-sharing for home infusion therapy services (if billed separately), see *Home infusion therapy*.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.	**In-Network and Out-of-network** $0 copayment for each Medicare-covered emergency room visit. If you are admitted to the hospital within 24 Hours for the same condition, you pay $0 for the emergency room visit. If you get additional services at an out-of-network facility as part of your emergency room visit, your cost is the cost-sharing you would pay to a network provider. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network

Covered Service	What you pay
Emergency care **(continued)** Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. Emergency services are a covered benefit within the U.S.	hospital in order for your care to continue to be covered, *or* you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital. For cost-sharing for additional services received at the emergency room, see the following: • Inpatient care that began in an emergency room admission, see *Inpatient hospital care.* • Physician services (if billed separately), see *Physician/Practitioner services, including doctor's office visits*. • Services in an outpatient clinic, including same-day surgery, see *Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*. (1) • Laboratory tests, X-rays and other radiology services, and medical supplies such as splints and casts, see *Outpatient diagnostic tests and therapeutic services and supplies*. (1) • Certain drugs and biologicals that you can't give yourself, see *Medicare Part B drugs*. (1)
Fitness Program – The Silver&Fit® Healthy Aging and Exercise Program The Silver&Fit Healthy Aging and Exercise program provides you access to a Fitness Center Membership, Home Fitness Kit, and Well-Being Coaching, plus other features.	**In-Network and Out-of-network** The Silver&Fit Program Fitness Center Membership $0 monthly fee for Standard Network fitness centers $30-$580 monthly fee for Premium Network fitness centers.* (2) Home Fitness Kits $0 copayment for one Home Fitness Kit per calendar year.* (2)

Covered Service	What you pay
Fitness Program – The Silver&Fit® Healthy Aging and Exercise Program **(continued)** • Fitness Center Membership: You can access a no-cost Standard Fitness Network membership at one of thousands of participating fitness centers or select YMCAs nationally. (Non-standard membership services at participating fitness centers/YMCAs are not included in the Silver&Fit program.) If you choose a Standard Fitness Network membership, you may change your fitness center once per month. You can also access the Premium Fitness Network, which includes thousands of additional fitness centers, for a monthly buy-up fee. Fees vary by Premium fitness center. To find a participating fitness center/YMCA or change your fitness center/YMCA, visit www.silverandfit.com or call Silver&Fit Customer Service.* • Home Fitness Kits: You can receive one Home Fitness Kit per calendar year at no additional cost.* • Well-Being Coaching: You can access Silver&Fit Well-Being Coaching sessions by phone, video, or chat with a trained coach at no additional cost.* • Well-Being Club: By setting your preferences for well-being topics on the website, you can discover resources tailored to your interests and healthy aging goals including articles, videos, live virtual classes and events, and social groups. • Digital Workouts: You can view on-demand videos through the website's digital workout library, including Silver&Fit Signature Series Classes®. • Silver&Fit Connected!™: The Silver&Fit Connected! tool can assist with tracking your activity. Purchase of some wearable fitness trackers or apps may be required to use the Connected! tool and are not reimbursable by the Silver&Fit program. • Visit www.silverandfit.com to register and access online newsletters, on-demand workout videos, a fitness center search, and the Silver&Fit Connected!™ tool. You can also enroll online to obtain a Silver&Fit card and take it directly to a participating fitness center/YMCA. For details, visit www.silverandfit.com or call Silver&Fit Customer Service at 1-888-354-4934, Monday through Friday, 8 am to 5 pm HST (TTY/TDD 711). ***The Silver&Fit program is provided by American Specialty Health Fitness, Inc., (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit, Silver&Fit***	Healthy Aging Coaching $0 copayment for unlimited sessions of Well-Being Coaching.* (2)

Covered Service	What you pay
Fitness Program – The Silver&Fit® Healthy Aging and Exercise Program **(continued)** *Signature Series Classes, and Silver&Fit Connected! are trademarks of ASH and used with permission herein. Fitness center participation may vary by location and is subject to change. Kits are based on availability and subject to change.*	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. Go to Section 3.1 of this chapter for services we do not cover.	**In-Network** $0 copayment for each Medicare-covered diagnostic hearing and balance exam. **Out-of-network** 30% of the cost for each Medicare-covered diagnostic hearing and balance exam.
Help with Certain Chronic Conditions **Dental services – Oral Health for Total Health** This program focuses on health conditions such as diabetes, coronary artery disease, pregnancy, stroke, chronic obstructive pulmonary disease, end stage renal disease, metabolic syndrome, head and neck cancer, oral cancer and Sjögren's syndrome that affect oral health. Programs include additional dental benefits for members identified with specific health conditions and outreach activities to support members and promote oral health. For more information on this program, please visit www.hmsadental.com/members/oral-health-for-total-health/enroll or call Customer Relations (phone numbers are listed on the back cover of this document). Members diagnosed with diabetes, coronary artery disease, stroke, pregnancy, chronic obstructive pulmonary disease, end stage renal disease or metabolic syndrome are eligible for the following services in addition to the plan's dental benefits: **Dental Services: *** • Cleanings: 2 additional per calendar year • Dental full mouth debridement: 1 per 2 calendar years • Dental deep cleaning: 1 per quadrant per 2 calendar years Members diagnosed with head and neck cancer, oral cancer or Sjögren's syndrome are eligible for the following services in addition to the plan's dental benefits:	**In-Network** $0 copayment for additional dental benefits for members identified with specific health conditions.* (2) **Out-of-network** 30% of the cost for additional dental benefits for members identified with specific health conditions.* (2) For cost-sharing for the plan's dental benefits, see *Dental services*.

Covered Service	What you pay
Help with Certain Chronic Conditions **Dental services – Oral Health for Total Health (continued)** **Dental Services: *** • Cleanings: 2 additional per calendar year • Dental full mouth debridement: 1 per 2 calendar years • Fluoride: 2 additional treatments per calendar year at least 3 months apart • Oral exams: 2 additional per calendar year	
Help with Certain Chronic Conditions **In-home Health Assessments Program** This program provides an in-home health assessment once per calendar year. A nurse practitioner will conduct the visit, and may also provide health screening recommendations, health prevention tips, and care resource assistance. After the visit, the assessment summary will be shared with the member and the member's PCP or care team, as appropriate. Members who have been diagnosed with chronic conditions including diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, coronary artery disease (CAD), mood disorders, rheumatoid arthritis, dementia, cancer, vascular disease, chronic kidney disease (CKD), nutrition-related disorders, including obesity, or hematological disorders and who either do not have a PCP or need assistance managing their chronic condition with their PCP may be contacted to arrange an in-home health assessment.	**In-Network and Out-of-Network** There is no coinsurance, copayment, or deductible for the In-home Health Assessments Program.*
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	**In-Network and Out-of-network** There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.

Covered Service	What you pay
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**In-Network** $0 copayment for Medicare-covered home health agency services. Authorization rules may apply. (1) **Out-of-network** $0 copayment for Medicare-covered home health agency services.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	**In-Network** $0 copayment for Medicare-covered home infusion therapy services furnished by a qualified home infusion therapy supplier if billed separately. **Out-of-network** 30% of the cost for Medicare-covered home infusion therapy services furnished by a qualified home infusion therapy supplier if billed separately. For cost-sharing for durable medical equipment (DME) (if billed separately), see *Durable medical equipment (DME) and related supplies.* For cost-sharing for Medicare Part B prescription drugs (if billed separately), see *Medicare Part B drugs.*

Covered Service	What you pay
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services that are covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay cost-sharing under Original Medicare **For services covered by *HMSA Akamai Advantage Dual Care* but not covered by Medicare Part A or B:** *HMSA Akamai Advantage Dual Care* will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not *HMSA Akamai Advantage Dual Care.* For cost-sharing for hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit, see *Physician/Practitioner services, including doctor's office visits.*

Covered Service	What you pay
Hospice care **(continued)** **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7 for more information.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. For coverage of other vaccines (if you are at risk and the vaccine(s) meet Medicare Part B coverage rules), see *Medicare Part B drugs.* (1)

Covered Service	What you pay
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. The plan covers the following hospital days per stay: • The plan covers 90 hospital days. • The plan covers 60 Lifetime Reserve Days. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	**In-Network** For Medicare-covered hospital stays: Days 1-90: $0 copayment per day $0 copayment per Lifetime Reserve Day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Authorization rules may apply. (1) **Out-of-network** For Medicare-covered hospital stays: $1,676 deductible and Days 1-60: $0 copayment per day Days 61-90: $419 copayment per day $838 copayment per Lifetime Reserve Day. These are 2025 cost sharing amounts and may change for 2026. *HMSA Akamai Advantage Dual Care* will provide updated rates as soon as they are released. A deductible and/or other cost-sharing is charged for each inpatient stay. If you are transferred but not discharged, it counts as the same hospital stay.

Covered Service	What you pay
Inpatient hospital care (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If *HMSA Akamai Advantage Dual Care* provides transplant services at a location outside the pattern of care for transplants in your community and you chose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. Additionally, we will cover transplant at a distant location, as well as lodging and transportation costs for you and a companion if the transplant is not available in Hawaii or if the distant location is deemed more medically favorable, per HMSA's policy. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All other components of blood are covered starting with the first pint. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits.* This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you'd pay at a network hospital.

Covered Service	What you pay
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. The plan covers the following hospital days per stay: • The plan covers 90 hospital days. • The plan covers 60 Lifetime Reserve Days. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit doesn't apply to mental health care services provided in a psychiatric unit of a general hospital.	**In-Network** For Medicare-covered hospital stays: Days 1-90: $0 copayment per day $0 copayment per Lifetime Reserve Day Authorization rules may apply. (1) **Out-of-network** For Medicare-covered hospital stays: $1,676 deductible and Days 1-60: $0 copayment per day Days 61-90: $419 copayment per day $838 copayment per Lifetime Reserve Day. These are 2025 cost sharing amounts and may change for 2026. *HMSA Akamai Advantage Dual Care* will provide updated rates as soon as they are released. **In-Network and Out-of-network** After you exhaust your Medicare 190-day lifetime limit, for coverage of all other inpatient services, see *Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay*. A deductible and/or other cost-sharing is charged for each inpatient stay. If you are transferred but not discharged, it counts as the same hospital stay.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services	When your stay is no longer covered, these services will be covered as described in the following sections: For cost-sharing for physician services, see *Physician/Practitioner services, including doctor's office visits*. For cost-sharing for diagnostic tests (like lab tests), x-ray, radium and isotope therapy including technician materials and services, surgical dressings, splints, casts and other devices used to reduce fractures and dislocations, see *Outpatient*

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay **(continued)** • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	*diagnostic tests and therapeutic services and supplies.* (1) For cost-sharing for prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (or contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices, and for cost-sharing for leg, back, arm, back and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition, see *Prosthetic devices and related supplies*. (1) For cost-sharing for physical therapy, speech therapy, and occupational therapy, see *Outpatient rehabilitation services*. (1)
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Covered Service	What you pay
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.** MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi ®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision	**In-Network** $0 copayment for Medicare-approved charges for prescription drugs covered under Part B of Original Medicare. You won't pay more than $35 for a one-month supply of insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). Authorization rules may apply. (1) **Out-of-network** Up to 30% of the cost for Medicare-approved charges for prescription drugs covered under Part B of Original Medicare. Some drugs may be subject to step therapy. For cost-sharing for home infusion therapy services (if billed separately), see *Home infusion therapy.* You may pay a lower coinsurance for rebatable drugs. For a definition of "rebatable drugs," see Chapter 12 of this document.

Covered Service	What you pay
Medicare Part B drugs (continued) • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Prashiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Procrit®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) This link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.hmsa.com/part-b-step/. We also cover some vaccines under our Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains the Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.	

Covered Service	What you pay
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Online Care With HMSA's Online Care, you can see a doctor or other health care provider from the comfort and privacy of home, work, or anywhere you can go online. Medical doctors are available 24 hours a day, 7 days a week and can diagnose conditions, recommend treatment and prescribe medications if necessary. Online therapy and counseling sessions are available by appointment.* To get started, download the free Online Care mobile app or for more information, go to www.hmsaonlinecare.com from a computer. Sessions and eligibility are subject to the HMSA's Online Care Consumer User Agreement.	**In-Network and** **Out-of-network** **Non-Behavioral Health Visits:** $0 copayment. Maximum 15 minutes.* (2) **Behavioral Health Visits:** $0 copayment. Maximum 60 minutes.* (2)
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessment Also covered via telehealth from eligible network providers.	**In-Network** $0 copayment for Medicare-approved Opioid Treatment Program services. **Out-of-network** 30% of the cost for Medicare-approved Opioid Treatment Program services.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to:	**In-Network** $0 copayment for Medicare-covered X-rays.

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies **(continued)** • X-rays • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem o Advanced Imaging tests. Advanced imaging studies include MRI, MRA, CT, PET and nuclear cardiology services o Other Medicare-covered diagnostic radiology services (not including X-rays or Advanced Imaging) • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests, therapeutic services and supplies	$0 copayment for Advanced Imaging tests. (1) $0 copayment for Medicare-covered diagnostic radiology services (not including X-rays or Advanced Imaging). $0 copayment for Medicare-covered radiation therapy services. (1) $0 copayment for Medicare-covered surgical supplies such as dressings, and splints, casts and other devices used to reduce fractures and dislocations. $0 copayment for Medicare-covered lab services. $0 copayment for Medicare-covered blood. $0 copayment for other Medicare-covered diagnostic tests, therapeutic services and supplies. (1) Authorization rules may apply. (1) **Out-of-network** 30% of the cost for Medicare-covered X-rays. 30% of the cost for Advanced Imaging tests. 30% of the cost for Medicare-covered diagnostic radiology services (not including X-rays or Advanced Imaging). 20% of the cost for Medicare-covered radiation therapy services. 30% of the cost for Medicare-covered surgical supplies such as dressings, and splints, casts and other devices used to reduce fractures and dislocations. 30% of the cost for Medicare-covered lab services. 30% of the cost for Medicare-covered blood. 30% of the cost for other Medicare-covered diagnostic tests, therapeutic services and supplies.

Covered Service	What you pay
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	**In-Network** $0 copayment for Medicare-covered observation care. **Out-of-network** 30% of the cost for Medicare-covered observation care.
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you are an outpatient, you should ask the hospital staff.	**In-Network and Out-of-network** For cost-sharing for services in an emergency department, see *Emergency care.* For cost-sharing for services in an outpatient clinic, including same-day surgery, see *Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers.* (1) For cost-sharing for outpatient hospital observation services, see *Outpatient Hospital Observation.* For cost-sharing for laboratory tests, X-rays and other radiology services, and medical supplies such as splints and casts, see *Outpatient diagnostic tests and therapeutic services and supplies.* (1) For cost-sharing for mental health care, see *Outpatient mental health care*.

Covered Service	What you pay
Outpatient hospital services (continued)	For cost-sharing for partial hospitalization services, see *Partial hospitalization services and Intensive outpatient services*. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. For cost-sharing for certain drugs and biologicals that you can't give yourself, see *Medicare Part B drugs*. (1)
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. Also covered via telehealth from eligible network providers.	(3) **In-Network** $0 copayment for each Medicare-covered individual or group therapy visit. **Out-of-network** 30% of the cost for each Medicare-covered individual or group therapy visit.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-Network** $0 copayment for each Medicare-covered physical and/or speech and language therapy visit ordered by your physician. $0 copayment for each Medicare-covered occupational therapy visit ordered by your physician. Authorization rules may apply. (1) **Out-of-network** 30% of the cost for each Medicare-covered physical and/or speech and language therapy visit ordered by your physician. 30% of the cost for each Medicare-covered occupational therapy visit ordered by your physician.

Covered Service	What you pay
Outpatient substance use disorder services Our plan covers certain treatment services for substance abuse which are covered by Original Medicare. Also covered via telehealth from eligible network providers.	(3) **In-Network** $0 copayment for each Medicare-covered individual or group visit. **Out-of-network** 30% of the cost for each Medicare-covered individual or group visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**In-Network** $0 copayment for each Medicare-covered visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic. Authorization rules may apply. (1) **Out-of-network** 30% of the cost for each Medicare-covered visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic. **In-Network and Out-of-network** For cost-sharing for physician services (if billed separately), see *Physician/Practitioner services, including doctor's office visits*. For cost-sharing for other outpatient hospital services (if billed separately), see *Outpatient hospital services*.
Over-the-Counter (OTC) Health Products Allowance Your over-the-counter (OTC) health products allowance is loaded onto a HMSA Extra Benefits Debit Card. The allowance renews at the beginning of each calendar month and unused allowance balances do not carry over between months. You can use this allowance for covered brand name and generic OTC health products such as vitamins, pain relievers, and first aid products. You cannot use the allowance to buy tobacco or alcohol.	**In-Network** $0 copayment for up to $125 monthly of over-the-counter (OTC) health products. You may also be eligible for the Healthy Food and Home Utilities Allowance. For more information, see *Special Supplemental Benefits for the Chronically Ill (SSBCI) – Healthy Food and Home Utilities Allowance*.

Covered Service	What you pay
Over-the-Counter (OTC) Health Products Allowance (continued) You will receive your HMSA Extra Benefits Debit Card in the mail. You can use the card to purchase covered products available at select retail stores or through mail order with our mail order partner, Medline. If you order items online, by phone, or by mail, your items will be delivered to your door at no additional cost. Visit https://HMSAExtraBenefits.com to shop online or manage your Extra Benefits account, or call 1-800-790-6019 from 8:00 am - 8:00 pm Hawaii Standard Time, Monday through Friday.	
Partial hospitalization services and Intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	**In-Network** $0 copayment for Medicare-covered partial hospitalization program services. $0 copayment for Medicare-covered intensive outpatient program services. **Out-of-network** 30% of the cost for Medicare-covered partial hospitalization program services. 30% of the cost for Medicare-covered intensive outpatient program services.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment	**(3)** **In-Network** $0 copayment for each primary care provider visit in the primary care provider's office or in the member's home for Medicare-covered benefits. $0 copayment for each visit with an advanced practice registered nurse, nurse practitioner, or physician assistant in the provider's office or in the member's home for Medicare-covered benefits. $0 copayment for each specialist visit for Medicare-covered benefits.

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits **(continued)** • Certain telehealth services, including: primary care provider visits, specialist visits, mental health therapy or substance abuse therapy visits, visits with an advanced practice registered nurse, nurse practitioner, or physician assistant, or Opioid Treatment Program services o You have the option of receiving these services either through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, you must use a network provider who offers the service by telehealth • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	$0 copayment for certain telehealth services from eligible network providers. For a list of primary care providers, please refer to the *Provider and Pharmacy Directory*. **Out-of-network** 30% of the cost for each primary care provider visit for Medicare-covered benefits. 30% of the cost for each visit with an advanced practice registered nurse, nurse practitioner, or physician assistant for Medicare-covered benefits. 30% of the cost for each specialist visit for Medicare-covered benefits. **In-Network and Out-of-network** For cost-sharing for hearing and balance exams, see *Hearing services*. For cost-sharing for non-routine dental care covered by Medicare, see *Dental services.*

Covered Service	What you pay

Physician/Practitioner services, including doctor's office visits
(continued)
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
  o You're not a new patient **and**
  o The evaluation isn't related to an office visit in the past 7 days **and**
  o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record
• Second opinion by another network provider prior to surgery
• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician, including a dentist or dental surgeon, a non-physician practitioner, or other auxiliary personnel)	

Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	**In-Network** $0 copayment for each visit for Medicare-covered services. **Out-of-network** 30% of the cost for each visit for Medicare-covered services.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months.	**In-Network and** **Out-of-network** There is no coinsurance or copayment for the PrEP benefit.

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention (continued) • A one-time hepatitis B virus screening.	
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In-Network** $0 copayment for an annual digital rectal exam. **Out-of-network** $0 copayment for an annual digital rectal exam. **In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this section for more detail.	**In-Network** $0 copayment for Medicare-covered prosthetic devices and related supplies. Authorization rules may apply. (1) **Out-of-network** 20% of the cost for Medicare-covered prosthetic devices and related supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Pulmonary rehabilitation is covered for a limited number of sessions when medically necessary.	**In-Network** $0 copayment for each Medicare-covered pulmonary rehabilitation service ordered by your physician. Authorization rules may apply. (1) **Out-of-network** 30% of the cost for each Medicare-covered pulmonary rehabilitation service ordered by your physician.

Covered Service	What you pay
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years or who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening*: the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.
Screening for Hepatitis C Virus Infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for Medicare-covered screening for the Hepatitis C Virus.

Covered Service	What you pay
Screening for Hepatitis C Virus Infection (continued) If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 people 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies	**In-Network** $0 copayment for Medicare-covered renal dialysis services which includes but is not limited to: • Outpatient dialysis treatments • Self-dialysis training • Home dialysis equipment and supplies • Certain home support services $0 copayment for Medicare-covered kidney disease education services. $0 copayment for Medicare-covered inpatient dialysis. **Out-of-Network** 20% of the cost for Medicare-covered renal dialysis services which includes but is not limited to: • Outpatient dialysis treatments

Covered Service	What you pay
Services to treat kidney disease **(continued)** • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to, ***Medicare Part B drugs*** in this table.	• Self-dialysis training • Home dialysis equipment and supplies • Certain home support services 30% of the cost for Medicare-covered kidney disease education services. 30% of the cost for Medicare-covered inpatient dialysis. **In-Network and Out-of-network** For cost-sharing for physician services (if billed separately), see *Physician/Practitioner services, including doctor's office visits*.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.	**In-Network** For Medicare-covered SNF stays: Days 1-100: $0 copayment per day Days 101-180: $0 copayment per day Authorization rules may apply. (1) **Out-of-network** For Medicare-covered SNF stays: Days 1-20: $0 copayment per day Days 21-100: $209.50 copayment per day Days 101-180: $0 copayment per day These are 2025 cost sharing amounts and may change for 2026. *HMSA Akamai Advantage Dual Care* will provide updated rates as soon as they are released. **In-Network and Out-of-network** After you exhaust your Medicare SNF benefit, for coverage of other inpatient services, see *Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay*. No prior Medicare-covered acute level of care hospital stay is required. Cost-sharing for a SNF stay is based on a benefit period. For more information, see

Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	definition of a *Benefit Period* in Chapter 12.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling. We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Special Supplemental Benefits for the Chronically Ill (SSBCI) - Healthy Food and Home Utilities Allowance If you are eligible, a healthy food and home utilities allowance will be combined with your over-the-counter (OTC) health products allowance. Your healthy food and home utilities allowance is loaded onto a HMSA Extra Benefits Debit Card. The allowance renews at the beginning of each calendar month and unused allowance balances do not carry over between months. You can use the allowance for healthy food items, such as fruits, vegetables, meats, and canned goods, and home utilities, such as electricity, water, natural gas, and waste. The healthy food and home utilities allowance is a special supplemental benefit available only to chronically ill members with eligible chronic health conditions such as: • Diabetes • High Blood Pressure (Hypertension) • High Cholesterol (Hyperlipidemia) • Cardiovascular Disorders (i.e., Heart Problems) • Stroke	**In-Network** $0 copayment for up to $125 monthly allowance of healthy food and home utilities. Your Healthy Food and Home Utilities Allowance is combined with your Over-the-Counter (OTC) Health Products Allowance. For more information, see *Over-the-Counter (OTC) Health Products Allowance*

Covered Service	What you pay
Special Supplemental Benefits for the Chronically Ill (SSBCI) - Healthy Food and Home Utilities Allowance **(continued)** **Other chronic conditions qualify, and eligibility is not limited to the conditions listed above**. For a list of eligible chronic conditions, see https://hmsa.com/ExtraBenefits-DualCare. Your eligibility for the healthy food and home utilities allowance is determined after you enroll in the plan. Eligibility is not guaranteed solely based on your condition and other eligibility requirements apply. You must meet all applicable eligibility requirements to qualify. HMSA will determine whether you qualify for this benefit based on previous claims and diagnoses, and other applicable factors. You will receive your HMSA Extra Benefits Debit card in the mail. You can use the card to purchase covered products available at select retail stores or through mail order with our mail order partner, Medline. If you order items online, by phone, or by mail, your items will be delivered to your door at no additional cost. Visit https://HMSAExtrabenefits.com to shop online or manage your Extra Benefits account, or call 1-800-790-6019 from 8:00 am to 8:00 pm Hawaii Standard Time, Monday through Friday.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD	**In-Network** $0 copayment for each Medicare-covered SET for PAD service ordered by your physician. **Out-of-network** 30% of the cost for each Medicare-covered SET for PAD service ordered by your physician.

Covered Service	What you pay
Supervised Exercise Therapy (SET) (continued) • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Supportive Care services A comprehensive approach to care if you have a serious or advanced illness including Stage 3 or 4 cancer, advanced Congestive Heart Failure (CHF), advanced Pulmonary Disease (ie, COPD), or any advanced illness that meets the requirements of the Supportive Care policy. You will get comfort-directed care, while continuing to receive curative treatment from an interdisciplinary team of practitioners. Supportive Care is only available when you are referred by your physician. • We cover Supportive Care referral visits during which you are advised of Supportive Care options, regardless if you are later admitted to Supportive Care • Coverage is limited to 90 calendar days of services in a 12 month period that begins the first day Supportive Care services are provided* To receive Supportive Care, you must not be enrolled in a Medicare-certified hospice program. (For more information about the Medicare-certified hospice program, see *Hospice care*.)	**In-Network** Authorization rules may apply. (1) **In-Network and Out-of-network** $0 copayment for Supportive Care services*. (2)
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's-service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Urgently needed services are a covered benefit within the U.S	**In-Network and Out-of-network** $0 copayment to the facility for each covered urgently needed care visit. If you get additional services at an out-of-network facility as part of your urgently needed care visit, your cost is the cost-sharing you would pay to a network provider. For cost-sharing for physician services (if billed separately), see In-Network *Physician/Practitioner services, including doctor's office visits*.

Covered Service	What you pay
Vision care Medicare-covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk for glaucoma, we cover one glaucoma screening each calendar year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	**In-Network** $0 copayment for Medicare-covered eye exams to diagnose and treat diseases and injuries of the eye. $0 copayment for Medicare-covered glaucoma screening once per calendar year. $0 copayment for one Medicare-covered pair of eyeglasses with standard frames or contact lenses from a Medicare-approved provider after each Medicare-covered cataract surgery. **Out-of-network** 30% of the cost for Medicare-covered eye exams to diagnose and treat diseases and injuries of the eye. 30% of the cost for Medicare-covered glaucoma screening once per calendar year. 30% of the cost for one Medicare-covered pair of eyeglasses with standard frames or contact lenses from a Medicare-approved provider after each Medicare-covered cataract surgery. **In-Network and Out-of-network** See Chapter 12 for a definition of *Medicare-approved provider*. If you receive consultation, diagnosis, or treatment by a specialist, see *Physician/Practitioner services, including doctor's office visits* for cost-sharing.
Supplemental covered services include: • One routine eye exam every calendar year* • One refraction eye exam every calendar year* • The plan will pay up to $300 every calendar year for any combination of eyeglasses with standard frames, contact lenses, eyewear upgrades and contact lens fitting*	**In-Network** $0 copayment for one routine eye exam every calendar year.* $0 copayment for one refraction eye exam every calendar year.*

Covered Service	What you pay
Vision care **(continued)** • International travel solution: We cover the following services when you travel abroad*: o Receive a temporary pair of glasses in case of an emergency o Get help to find an eye doctor (Out-of-network benefits apply) (See Section 3.1 of this chapter for a list of exclusions)	**Out-of-network** 30% of the cost for one routine eye exam every calendar year.* 30% of the cost for one refraction eye exam every calendar year.* **In-Network and Out-of-network** 100% for any amounts above the plan coverage limit for routine eyewear. Plan pays up to $300 every calendar year, for any combination of frames, lenses, contact lenses, eyewear upgrades and contact lens fitting.*
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	**In-Network** $0 copayment for EKG service performed as a screening as part of the *Welcome to Medicare* preventive visit. **Out-of-Network** $0 copayment for EKG service performed as a screening as part of the *Welcome to Medicare* preventive visit. **In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.

Notes to the Benefits Chart

(1) **Authorization**: Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Since your doctor will provide and coordinate your medical care, you should have all your past medical records sent to your doctor's office. Covered services that need prior authorization are marked in the above Benefits Chart. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary. You do not need prior authorization to obtain out-of-network services.

(2) **Eligible charge:** HMSA provides coverage for services beyond what Original Medicare provides through special plan benefits. For these services, HMSA bases payments on eligible charges. We calculate our payment and your copayment/coinsurance based on the eligible charge. The eligible charge is the lower of either the provider's actual charge or the amount we establish as the maximum allowable fee. The maximum allowable fee is the maximum dollar amount paid for a covered service, supply and/or treatment.

Note: Eligible charge doesn't include excise or other tax. You are responsible for all taxes associated with the non-Medicare-covered services, supplies and/or treatment you receive. Our Customer Relations department may be able to provide you with a general estimate of your eligible charge.

(3) For office visits you receive in a facility setting, you are responsible for the cost-sharing as shown under *Physician/Practitioner services, including doctor's office visits* for each primary care provider visit or specialist visit, or *Outpatient mental health care,* or *Outpatient substance use disorder services* for each individual or group therapy visit on the Medical Benefits Chart. For example: You visit your primary care provider in a satellite office. Your primary care provider charges for the office visit and the facility charges a separate facility fee. You will owe up to the primary care provider cost-share only.

SECTION 3 Services covered outside of *HMSA Akamai Advantage Dual Care*

The following services aren't covered by *HMSA Akamai Advantage Dual Care* but are available through QUEST (Medicaid):

- Transportation to get medical care.

Note: This is not a complete list. For services that are not covered by *HMSA Akamai Advantage Dual Care* but are available through QUEST (Medicaid) please see your HMSA QUEST Member Handbook.

SECTION 4 Services that aren't covered by our plan

This section tells you what services are *excluded*.

The chart below lists some services and items that aren't covered by our plan under any conditions or are covered by Medicare only under specific conditions. The chart also tells you if the service or item is covered under Medicaid.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	• Available for people with chronic low back pain under certain circumstances

Services not covered by Medicare	Covered only under specific conditions
Cosmetic surgery or procedures	• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Not covered under any condition
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	• Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet	• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Medicare	Covered only under specific conditions
Outpatient prescription drugs received in a foreign country	Not covered under any condition
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	• Covered only when medically necessary
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	• Manual manipulation of the spine to correct a subluxation is covered
Routine dental care, such as cleanings, fillings or dentures	Routine dental care is covered as a supplemental benefit. See *Dental services* for more information about the services we cover.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	• One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. Routine eye exam and any combination of eyeglasses with standard frames, contact lenses, and contact lens fitting are covered as supplemental benefit. See *Vision care* for more information about the services we cover. No payment will be made for: broken, lost or stolen lenses, contact lenses or frames; sunglasses; prescription inserts for diving masks and any protective eyewear; non-prescription industrial or safety glasses; non-standard items for lenses including tinting, blending, oversized lenses and invisible bifocal and trifocals, repair and replacement of frame parts and accessories.
Routine foot care	• Some limited coverage provided according to Medicare guidelines, (e.g., if you have diabetes)

Services not covered by Medicare	Covered only under specific conditions
Routine hearing exams, hearing aids, or exams to fit hearing aids	Not covered under any condition
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:
Using plan coverage for Part D drugs

How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you're in the Extra Help program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, please call Customer Relations and ask for the *LIS Rider*. (Phone numbers for Customer Relations are printed on the back cover of this document.)

SECTION 1 Basic rules for our plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. Our Drug List tells you how to find out about your Medicaid drug coverage. You can learn more about your Medicaid drug coverage by contacting your Medicaid health plan or State of Hawai‘i Department of Human Services Med-QUEST Division. See Chapter 2, Section 6 of this document for contact information.

Our plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (Go to Section 2 or you can fill your prescription through our plan's mail-order service.)
- Your drug must be on our plan's Drug List (Go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information)

SECTION 2 Fill your prescription at a network pharmacy or through our plan's mail-order service

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.5 for information about when we cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered drugs. The term "covered drugs" means all the Part D drugs on our plan's Drug List.

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Provider and Pharmacy Directory*, visit our website (www.hmsa.com/advantage), and/or call Customer Relations at 1-800-660-4672 (TTY users call 711).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy use leaves the plan's network, you'll have to find a new pharmacy that is in the network. To find another pharmacy in your area, get help from Customer Relations at 1-800-660-4672 (TTY users call 711)or use the *Provider and Pharmacy Directory*. You can also find information on our website at www.hmsa.com/advantage.

Specialized pharmacies

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy. Home infusion pharmacies service all islands even though they may not be physically located on each island.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting your Part D drugs in an LTC facility, call Customer Relations at 1-800-660-4672 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Provider and Pharmacy Directory* or call Customer Relations at 1-800-660-4672 (TTY users call 711).

Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs that aren't available through our plan's mail-order service are marked with "NM" in our Drug List.

Our plan's mail-order service allows you to order **up to a 100-day supply**.

To get order forms and information about filling your prescriptions by mail, log on to your HMSA MyAccount and go to Drug Benefits, or call Customer Care at 1-855-479-3659. This toll-free number is available 24 hours a day, 7 days a week. TTY users should call 711.

Usually a mail-order pharmacy order will be delivered to you in no more than 10 days. If the mail-order pharmacy expects the order to be delayed, they will notify you of the delay. If you need to request a rush order because of a mail-order delay, you may contact Customer Care toll-free at 1-855-479-3659 to discuss options which may include filling at a local retail pharmacy or expediting the shipping method. TTY users should call 711. Provide the representative with your ID number and prescription number(s). If you want second day or next day delivery of your medications, you may request this from the Customer Care representative for an additional charge.

New prescriptions the pharmacy gets directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You can ask for automatic delivery of specific drugs at any time by logging in to your HMSA MyAccount and going to Drug Benefits, or by calling Customer Care toll-free at 1-855-479-3659. TTY users should call 711.

If you get a prescription automatically by mail that you don't want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by logging into your HMSA MyAccount and going to Drug Benefits or by calling Customer Care toll-free at 1-855-479-3659. TTY users should call 711.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It's important to respond each time you're contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

To opt out of our program that automatically prepares mail order refills, contact us by logging in to your HMSA MyAccount and going to Drug Benefits, or by calling Customer Care toll-free at 1-855-479-3659. TTY users should call 711.

Refills on mail order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 15 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail order refills, contact us by logging in to your HMSA MyAccount and going to Drug Benefits, or by calling Customer Care toll-free at 1-855-479-3659. TTY users should call 711.

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost-sharing may be lower. Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Provider and Pharmacy Directory* at https://www.hmsa.com/advantage tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Relations at 1-800-660-4672 (TTY users call 711) for more information.

2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in the plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Check first with Customer Relations** at 1-800-660-4672 (TTY users call 711) to see if there is a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- Prescriptions you get in connection with emergency care (does not apply outside of the U.S.).
- Prescriptions you get in connection with urgently needed care when network providers are not available (does not apply outside of the U.S.).
- Part D vaccines provided in your physician's office.
- Other in-network pharmacies do not have your prescribed drug in stock.
- A Federal Disaster or Public Health Emergency has been declared. In this case, the plan may lift restrictions on impacted areas.

Even if we do cover the drugs you get at an out-of-network pharmacy, you may still pay more than you would have paid if you had gone to an in-network pharmacy.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask the plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

SECTION 3 Your drugs need to be on our plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, **we call it the Drug List** .

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug List only shows drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. The Drug List tells you how to find out about your Medicaid drug coverage, including drugs that are covered by Medicaid, but not by Medicare Part D.

We generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and use of the drug for a medically accepted indication. A medically accepted indication is a use of the drug that's *either*:

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biosimilar products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

Over-the-counter drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Customer Relations at 1-800-660-4672 (TTY users call 711). See Chapter 4, Section 2.1 for information about our over-the-counter benefit.

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. For more information, go to Section 7).
- In other cases, we decided not to include a particular drug on the Drug List.

- In some cases, you may be able to obtain a drug that isn't on the Drug List. (For more information, go to Chapter 9.)

Section 3.2 5 cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug list is in one of five cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug.

- **Cost-Sharing Tier 1: Preferred Generic**
  Tier 1 is the lowest tier and includes preferred generic drugs and may include some brand drugs.
- **Cost-Sharing Tier 2: Generic**
  Tier 2 includes generic drugs and may include some brand drugs.
- **Cost-Sharing Tier 3: Preferred Brand**
  Tier 3 includes preferred brand drugs and non-preferred generic drugs.
- **Cost-Sharing Tier 4: Non-Preferred Drug**
  Tier 4 includes non-preferred brand drugs and non-preferred generic drugs.
- **Cost-Sharing Tier 5: Specialty Tier**
  Tier 5 is the highest tier. It contains very high cost brand and generic drugs, which may require special handling and/or close monitoring.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit the plan's website (www.hmsa.com/advantage). The Drug List on the website is always the most current.
- Call Customer Relations at 1-800-660-4672 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or to ask for a copy of the list.
- Use the plan's "Real-Time Benefit Tool" (through your HMSA MyAccount to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Customer Relations at 1-800-660-4672 (TTY users call 711 . To get to the "Real-Time Benefit Tool", log into your HMSA MyAccount and go to Manage My Drugs Online. Then, click on "Plan & Benefits", "Rx Savings" from the drop down menu, and select "Check Drug Cost & Coverage".

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions?

If there's is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Call Customer Relations at 1-800-660-4672 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Customer Relations at 1-800-660-4672 (TTY users call 711) or on our website www.hmsa.com/advantage.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Customer Relations at 1-800-660-4672 (TTY users call 711) or on our website www.hmsa.com/advantage.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be..

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an exception and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug that you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on our plan's Drug List** OR is **now restricted in some way**.

- **If you're a new member,** we'll cover a temporary supply of your drug during the first 90 days of your membership in our plan.
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of one 30-day supply. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of one 30-day supply of medication. The prescription must be filled at a network pharmacy. (Note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away**:
  We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.
- **For those members who are in the plan and experience a level of care change:**
  We will cover up to a 31-day supply of a particular drug (depending on whether you reside in an LTC facility or not), or less if your prescription is written for fewer days within the first 90 days of the level of care change.

For questions about a temporary supply, call Customer Relations at 1-800-660-4672 (TTY users call 711).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Customer Relations at 1-800-660-4672 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask our plan to cover a drug even though it is not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

If you're a current member and a drug you take will be removed from the formulary or restricted in some way for next year, we'll tell you about any change before the new year. You can ask for an exception before next year and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement). If we approve your request, we'll authorize coverage for the drug before the change takes effect.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 to learn what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Customer Relations at 1-800-660-4672 (TTY users call 711 to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 (Specialty Tier) aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

SECTION 6 Our Drug List can change during this year

Most changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

We must follow Medicare requirements before we change our plan's Drug List.

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes were made for a drug that you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and <u>immediately</u> removing or making changes to a like drug on the Drug List.**
    - We may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We may make these changes immediately and tell you later, even if you are taking the drug that we remove or make changes to. If you are taking the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List.**
    - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We'll make these changes only if we are add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We'll tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you're taking
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**

- Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you're taking that drug, we'll tell you after we make the change.

- **Making other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you take.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or ask for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug List that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are excluded. This means Medicare does not pay for these drugs.

If you appeal and the drug asked for is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover off-label use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. Off-label use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs listed below aren't covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. Learn more about Medicaid drug coverage by contacting HMSA or the State of Hawai'i Department of Human Services Med-QUEST Division. See Chapter 2, Section 6 of this document for contact information.

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for our share of the costs of your drug. You'll need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. You can then **ask us to reimburse you** for our share. go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this chapter.

Section 9.2 As resident in a long-term care (LTC) facility

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Provider and Pharmacy Directory* at https://hmsa.com/advantage to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Customer Relations at 1-800-660-4672 (TTY users call 711. If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that isn't on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also get drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group contact **that group's benefits administrator**. They can help you understand how your current drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage pays first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells you if your drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that our plan has drug coverage that's expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems like:

- Possible medication errors
- Drugs that may not be necessary because you are taking another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take.
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you may get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end of life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) program to help members manage medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases take medications that exceed a specific amount of drug costs or are in a DMP to help members use their opioids safely may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. If you have any questions about this program, call Customer Relations at 1-800-660-4672 (TTY users call 711).

CHAPTER 6:
What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

We use *drug* in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Medicaid.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage through your HMSA MyAccount, the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided in the "Real Time Benefit Tool" by calling Customer Relations at 1-800-660-4672 (TTY users call 711).

How can you get information about your drug costs?

Because you're eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you have Extra Help, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs** may not apply to you.

Section 1.1 Types of out-of-pocket costs you may pay for covered drugs

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments <u>are included</u> in your out-of-pocket costs

<u>Your out-of-pocket costs include</u> the payments listed below (as long as they're for covered Part D drugs and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage

- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,100 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Your monthly plan premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Drugs covered by Medicaid only. To learn more drugs covered by Medicaid only, see your *List of Covered Drugs* or formulary.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward drugs not normally covered in a Medicare Drug Plan.
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA).
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).
- Payments made by drug manufacturers under the Manufacturer Discount Program.

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Customer Relations at 1-800-660-4672 (TTY users call 711) .

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,100, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for *HMSA Akamai Advantage Dual Care* members

There are 3 **drug payment stages** for your drug coverage under *HMSA Akamai Advantage Dual Care.* How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your Part D Explanation of Benefits (EOB) explains which payment stage you're in

Our plan keeps track of your prescription drugs costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs**: this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs**: this is the total of all payments made for your covered Part D Drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month we'll send you a *Part D EOB*. The *Part D EO*B includes:

- **Information for that month**. This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost-sharing for each prescription claim, if applicable.

Section 3.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
  - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
  - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
  - Any time you buy covered drugs at out-of-network pharmacies pay the full price for a covered drug under special circumstances.
  - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get a Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing, or have questions, call Customer Relations at 1-800-660-4672 (TTY users call 711). Be sure to keep these reports.

SECTION 4 The Deductible Stage

Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage doesn't apply to most members. If you get Extra Help, this payment stage doesn't apply to you.

If you don't get Extra Help, the Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you're in this payment stage, **you must pay the full cost of your drugs** until you reach our plan's deductible amount, which is $615 for 2026. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines. The **full cost** is usually lower than the normal full price of the drug since our plan negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay $615 for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment *or* coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has five cost-sharing tiers

Every drug on our plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug.

- **Cost-Sharing Tier 1: Preferred Generic**
  Tier 1 is the lowest tier and includes preferred generic drugs.
- **Cost-Sharing Tier 2: Generic**
  Tier 2 includes generic drugs.
- **Cost-Sharing Tier 3: Preferred Brand**
  Tier 3 includes preferred brand drugs and non-preferred generic drugs. You pay the lesser of $35 and 25% per month supply of each covered insulin product on this tier.
- **Cost-Sharing Tier 4: Non-Preferred Drug**
  Tier 4 includes non-preferred brand drugs and non-preferred generic drugs.
- **Cost-Sharing Tier 5: Specialty Tier**
  Tier 5 is the highest tier. It contains very high-cost brand and generic drugs, which may require special handling and/or close monitoring. You pay the lesser of $35 and 25% per month supply of each covered insulin product on this tier.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Provider and Pharmacy Directory* at https://hmsa.com/advantage.

Section 5.2 Your costs for a *one-month* supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

The amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

If you qualify for Extra Help from Medicare to help pay for your drug costs, your costs for your Medicare Part D drugs will be lower than the amounts listed in the chart below. If you have coverage with QUEST (Medicaid), you automatically qualify for Extra Help.

For members that qualify for Extra Help:

For Generic/Preferred or Multi-Source drugs you will pay:
$0, $1.60, or $5.10.

For all Other Drugs you will pay:
$0, $4.90, or $12.65.

We send you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low Income Subsidy Rider or the LIS Rider*), which tells you about your drug coverage. Consult your *LIS Rider* for more information about what you will pay for prescription drugs.

For members that DO NOT Qualify for Extra Help:

You will pay the following for your covered prescription drugs if you DO NOT qualify for Extra Help from Medicare to help pay for your drug costs:

Your costs for a *one-month* supply of a covered Part D drug

Tier	Standard retail in-network cost sharing (up to a 30-day supply)	Mail-order cost-sharing (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 *(Preferred Generic)*	$0 copayment	$0 copayment	$0 copayment	$0 copayment

Cost-Sharing Tier 2 *(Generic)*	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Cost-Sharing Tier 3 *(Preferred Brand)*	25% of the cost	25% of the cost	25% of the cost	25% of the cost
Cost-Sharing Tier 4 *(Non-Preferred Drug)*	30% of the cost	30% of the cost	30% of the cost	30% of the cost
Cost-Sharing Tier 5 *(Specialty Tier)*	25% of the cost	25% of the cost	25% of the cost	25% of the cost

You won't pay more than the lesser of $35 and 25% for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

Go to Section 7 for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 Your costs for a *long-term* (100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is a 100-day supply.

If you qualify for Extra Help from Medicare to help pay for your drug costs, your costs for your Medicare Part D drugs will be lower than the amounts listed in the chart below. If you have Medicare and QUEST (Medicaid) you automatically qualify for Extra Help.

For members that qualify for Extra Help:

For Generic/Preferred or Multi-Source drugs you will pay:
$0, $1.60, or $5.10.

For all Other Drugs you will pay:
$0, $4.90, or $12.65.

We send you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. Consult your *LIS Rider* for more information about what you will pay for prescription drugs.

For members that DO NOT Qualify for Extra Help:

You will pay the following for your covered drugs if you DO NOT qualify for Extra Help from Medicare to help pay for your drug costs:

The table below shows what you pay when you get a long-term supply of a drug.

Your costs for a *long-term* supply of a covered Part D prescription drug

	Standard retail cost-sharing (in-network)	Mail-order cost-sharing
	(100-day supply)	(100-day supply)
Cost-Sharing Tier 1 *(Preferred Generic)*	$0 copayment	$0 copayment
Cost-Sharing Tier 2 *(Generic)*	$0 copayment	$0 copayment
Cost-Sharing Tier 3 *(Preferred Brand)*	25% of the cost	25% of the cost
Cost-Sharing Tier 4 *(Non-Preferred Drug)*	30% of the cost	30% of the cost
Cost-Sharing Tier 5 *(Specialty)*	25% of the cost	25% of the cost

You won't pay more than the lesser of $70 and 25% for up to a two-month supply or the lesser of $105 and 25% for up to a three-month supply of each covered insulin product, even if you haven't paid your deductible.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,100. You then move to the Catastrophic Coverage Stage.

The *Part D EOB* that you get will help you keep track of how much you, our plan, and any third parties, have spent on your behalf for your drugs during the year. Not all members will reach the $2,100 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,100 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you stay in this payment stage until the end of the calendar year. During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Go to our plan's Drug List or call Customer Relations at 1-800-660-4672 (TTY users call 711) for coverage and cost sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself**.
- The second part is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccine depends on 3 things:

1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).

- Most adult Part D vaccines are recommended by ACIP and cost you nothing.

2. Where you get the vaccine.

- The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.

3. Who gives you the vaccine.

- A pharmacist or another provider may give the vaccine in the pharmacy. Or, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times when you get a vaccine, you pay only your share of the cost. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy for the vaccine itself which includes the cost of giving you the vaccine.

- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccine at your doctor's office.

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at the network pharmacy and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance for the vaccine administration, and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help we'll reimburse you for this difference.)

CHAPTER 7:
Asking us to pay our share of a bill for covered medical services or drugs

SECTION 1 Situations when you should ask us to pay our share for covered services or drugs

Our network providers bill our plan directly for your covered services and drugs – you shouldn't get a bill for covered services or drugs. If you get a bill for medical care or drugs you got send this bill to us so that we can pay it. When you send us the bill, we'll look at the bill and decide whether the services and drugs should be covered. If we decide they should be covered, we will pay the provider directly.

If you already paid for services or drugs covered by our plan, you can ask our plan to pay you back (paying you back is often called reimburse you). It is your right to be paid back by our plan whenever you've paid for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter. When you send us a bill you've already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got.

1. When you got emergency or urgently needed medical care from a provider who's not in our plan's network

- You can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill our plan.
- If you pay the entire amount yourself at the time you get the care, ask us to pay you back. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you owe. Send us this bill, along with documentation of any payments you made.
    - If the provider is owed anything, we'll pay the provider directly.
    - If you already paid for the service, we'll pay you back.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- Whenever you get a bill from a network provider, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made. Ask us to pay you back for your covered services.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

4. When you use an out-of-network pharmacy to fill a prescription

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.5 to learn more about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have our plan membership card with you

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for the cost of the drug. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you got

You can ask us to pay you back by either calling us or sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records.

For Part D prescription drugs, you may submit a prescription claim request by mail or online.

When submitting a request through mail, to ensure we have all the information we need to make a decision, please complete our drug claim form to make your request for payment.

- You don't have to use the drug claim form, **but it will help us process the information faster**.
- Either download a copy of the drug claim form from our website (www.hmsa.com/help-center/how-to-get-copies-of-the-drug-claim-form/) or call Customer Relations and ask for the drug claim form.

Mail your request for payment together with any bills or paid receipts to us at this address:

Part D Prescription drugs:

Medicare Part D Paper Claim
P.O. Box 52066
Phoenix, AZ 85072-2066

To submit a request online, log into your HMSA MyAccount and go to Drug Benefits or Caremark mobile app and follow the directions on how to submit your prescription claim.

You must submit your Part D (prescription drug) claim to us within 36 months of the date you received the service, item, or drug.

For Part C medical claims, routine hearing items and services, (not including routine vision items and services), there is no form for you to fill out. A provider statement is required to process your claim for services. The provider statement must include all of the information below:

- Provider's full name, phone number and address
- Patient's name and birth date
- Date(s) of services
- Date(s) of the injury or start of illness
- The charge for each service
- Diagnosis or type of illness or injury
- Where the service was received (for example, an office, outpatient clinic, or hospital)

Please include a cover letter with:

- Your name, date of birth, and HMSA membership number
- A daytime phone number where you can be reached
- Date(s) of service
- A brief description of each service and/or why the service was needed
- The charge for each service

- Your signature

Mail your request for payment together with any bills or receipts to us at this address:

Hospital, Physician, Lab, Routine hearing items and services, etc.:

HMSA - Claims
P.O. Box 860
Honolulu, HI 96808-0860

For more information about the process for filing Part C medical claims, visit our website: www.hmsa.com/help-center/filing-medical-claims-for-services-from-nonparticipating-providers/.

You must submit your Part C (medical) or routine hearing items and services claim to us within 12 months of the date you received the service, item, or drug.

For routine vision items and services, to ensure we have all the information we need to make a decision, please complete our claim form to make your request for payment.

- You don't have to use the routine vision claim form, **but it will help us process the information faster**.
- Either download a copy of the claim form from our website (www.eyemedonline.com/managed-vision-care/member-forms/out-of-network-claim#/) or call Customer Relations and ask for the claim form for routine vision. (Phone numbers for Customer Relations are printed on the back cover of this document.)

Mail your request for payment together with any bills or receipts to us at this address:

Routine vision items and services:

First American Administrators, Inc.
Attn: OON Claims
PO Box 8504
Mason, OH 45040-7111

You must submit your claim for routine vision items and services to us within 12 months of the date you received the service or item.

SECTION 3 We'll consider your request for payment and say yes or no

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for the service or drug. If you already paid for the service or drug, we'll mail your reimbursement to you. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.

If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for the care or drug. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you we won't pay for the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

CHAPTER 8:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but aren't limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in languages other than English including Ilocano, Vietnamese, Chinese (Traditional), and Korean, and braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, call Customer Relations at 1-800-660-4672 (TTY users call 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, HI 96805-1958, 1-800-462-2085, TTY users call 711, Fax: (808) 952-7546, Email: appeals@hmsa.com. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

섹션 1.1 저희는 귀하에게 적합하고 귀하의 문화적 감수성에 부합하는 방식으로 (영어 이외의 다른 언어, 점자, 큰 활자 또는 기타 대체 형식 등) 정보를 제공해야 합니다

저희 플랜은 모든 임상 및 비임상 서비스를 문화적으로 적합한 방식으로 제공해야 하며 영어 능력이 제한적이거나, 읽기 능력이 제한적이거나, 청각 장애가 있거나, 다양한 문화적, 인종적 배경을 가진 가입자를 포함한 모든 가입자가 이용할 수 있도록 보장해야 합니다. 저희 플랜이 이러한 접근성 요건을 충족하는 방법의 예로는 번역 서비스, 통역 서비스, 텔레타이프라이터 또는 TTY(문자 전화 또는 텔레타이프라이터 전화) 연결 제공 등이 포함되나 이에 국한되지 않습니다.

저희 플랜에는 영어를 사용하지 않는 회원의 질문에 답변하기 위해 제공되는 무료 통역 서비스가 있습니다. 또한 필요한 경우 영어 이외의 다른 언어(일로카노어, 베트남어, 중국어(번체), 한국어 등), 점자, 대형 활자 또는 다른 대체 형식으로 제작된 자료를 무료로 제공해 드릴 수 있습니다. 저희는 귀하에게 접근 가능하고 적절한 형식으로 저희 플랜의 혜택에 대한 정보를 제공해야 합니다. 귀하에게 적합한 방식으로 정보를 제공받으려면 고객관리부에 1-800-660-4672(TTY 사용자는 711)번으로 문의하시기 바랍니다.

저희 플랜은 여성 가입자에게 여성의 정기 검진 및 예방적 건강 관리 서비스를 위해 네트워크 내 여성 건강 전문의를 직접 방문할 수 있는 옵션을 제공해야 합니다.

플랜의 서비스 제공자 네트워크에 해당 전문의가 없는 경우, 가입자에게 필요한 치료를 제공할 수 있는 네트워크 외부의 전문의 제공자를 찾는 것은 저희 플랜의 책임입니다. 이 경우, 가입자는 네트워크 내 비용 분담금만 지불하게 됩니다. 저희 플랜의 네트워크에 필요한 서비스를 보장하는 전문의가 없는 상황에 처한 경우, 저희 플랜에 전화하여 네트워크 내 비용 분담금으로 해당 서비스를 받을 수 있는 곳에 대한 정보를 요청하십시오.

저희 플랜으로부터 귀하에게 접근 가능하고 적절한 형식으로 정보를 받는 데 어려움이 있거나, 여성 건강 전문의를 만나거나 네트워크 전문의를 찾는 데 어려움이 있는 경우, HMSA 가입자 권익 보호 및 이의제기 부서(HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, HI 96805-1958, 전화: 1-800-462-2085(TTY 사용자는 711), 팩스: (808) 952-7546, 이메일: appeals@hmsa.com)에 민원을 제기하십시오. 또한 1-800-MEDICARE(1-800-633-4227)로 전화하거나 민권 사무국(Office for Civil Rights) 1-800-368-1019번 또는 TTY 1-800-537-7697번으로 직접 전화하여 Medicare에 불만 제기를 하실 수도 있습니다.

Phần 1.1 Chúng tôi phải cung cấp thông tin theo cách phù hợp với quý vị và phù hợp với văn hóa của quý vị (bằng các ngôn ngữ khác ngoài tiếng Anh, bằng chữ nổi braille, bản in cỡ chữ lớn hoặc các định dạng thay thế khác, v.v.)

Chương trình của chúng tôi được yêu cầu đảm bảo rằng tất cả các dịch vụ, cả lâm sàng và phi lâm sàng, được cung cấp theo cách phù hợp về văn hóa và tất cả những người ghi danh có thể tiếp cận được, bao gồm những người có trình độ tiếng Anh hạn chế, kỹ năng đọc hạn chế, người bị khiếm thính hoặc những người có nền tảng văn hóa và dân tộc đa dạng. Ví dụ về cách một chương trình của chúng tôi có thể đáp ứng các yêu cầu về khả năng tiếp cận này bao gồm, nhưng không giới hạn ở việc cung cấp dịch vụ biên dịch viên, dịch vụ thông dịch viên, máy đánh chữ từ xa hoặc kết nối TTY (điện thoại nhắn tin hoặc điện thoại máy đánh chữ từ xa).

Chương trình của chúng tôi có dịch vụ thông dịch miễn phí để trả lời các thắc mắc của hội viên không nói tiếng Anh. Chúng tôi cũng có thể cung cấp cho quý vị tài liệu bằng các ngôn ngữ khác ngoài tiếng Anh và quý vị không phải trả chi phí, bao gồm tiếng Ilocano, tiếng Việt, tiếng Trung (phồn thể) và tiếng Hàn và chữ nổi braille, bản in cỡ chữ lớn hoặc các định dạng thay thế khác nếu quý vị cần. Chúng tôi phải cung cấp cho quý vị thông tin về các quyền lợi của chương trình của chúng tôi ở định dạng có thể truy cập và phù hợp với quý vị. Để nhận thông tin từ chúng tôi theo cách phù hợp với quý vị, vui lòng gọi cho Bộ phận Quan hệ Khách hàng theo số 1-800-660-4672 (người dùng TTY xin gọi 711).

Chương trình của chúng tôi bắt buộc phải cung cấp cho những người ghi danh là phụ nữ quyền lựa chọn tiếp cận trực tiếp với chuyên gia sức khỏe phụ nữ trong mạng lưới các dịch vụ chăm sóc sức khỏe định kỳ và phòng ngừa cho phụ nữ.

Nếu không có nhà cung cấp trong mạng lưới của chương trình cho một chuyên khoa, thì trách nhiệm của chương trình của chúng tôi là tìm nhà cung cấp chuyên khoa bên ngoài mạng lưới và họ sẽ cung cấp cho quý vị dịch vụ chăm sóc cần thiết. Trong trường hợp này, quý vị sẽ chỉ phải chi trả khoản chia sẻ chi phí trong mạng lưới. Nếu quý vị gặp trường hợp không có bác sĩ chuyên khoa trong mạng lưới của chương trình bao trả cho dịch vụ quý vị cần, hãy gọi cho chương trình của chúng tôi để biết thông tin về nơi cần đến để nhận dịch vụ này với khoản chia sẻ chi phí trong mạng lưới.

Nếu quý vị có bất kỳ khó khăn nào trong việc nhận thông tin từ chương trình của chúng tôi ở định dạng có thể truy cập và phù hợp với quý vị, gặp bác sĩ chuyên khoa về sức khỏe phụ nữ hoặc tìm bác sĩ chuyên khoa trong mạng lưới, vui lòng gọi để nộp đơn khiếu nại với HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, HI 96805-1958, 1-800-462-2085, người dùng TTY xin gọi 711, Fax: (808) 952-7546, Email: appeals@hmsa.com. Quý vị cũng có thể nộp đơn khiếu nại với Medicare bằng cách gọi 1-800-MEDICARE (1-800-633-4227) hoặc trực tiếp tới Văn phòng Dân quyền 1-800-368-1019 hoặc TTY 1-800-537-7697.

第 1.1 部分　我們必須以適用於您且符合您文化敏感性的方式提供資訊（英文以外的語言、點字版、大字版或其他替代格式等）

我們的計劃必須確保所有臨床和非臨床服務均以有文化能力的方式提供，且所有投保人均可取得，包括英語能力有限、閱讀能力有限、聽力喪失或文化和族裔背景不同的投保人。我們的計劃滿足這些無障礙要求的方式範例包括但不限於提供翻譯服務、傳譯服務、電傳打字機或聽障熱線 (TTY)（文字電話或電傳打字機電話）連線。

我們的計劃提供免費傳譯服務，回答非英語會員的問題。如有需要，我們也可以免費為您提供英文以外的其他語言版本，包括伊洛卡諾文、越南文、中文（繁體）、韓文和點字版、大字版或其他替代格式的資料。我們必須以對您而言是可用及合適的格式，向您提供我們的計劃的福利相關資料。如欲以適合您的方式向我們索取資訊，請致電顧客關係部，電話 1-800-660-4672（聽障熱線 (TTY) 使用者請致電 711）。

我們的計劃需要讓女性投保人選擇直接去網絡內的女性健康專科醫生處就診，以接受女性例行和預防性健康護理服務。

如果本計劃網絡內的專科醫療服務提供者無法使用，我們的計劃有責任尋找網絡外的專科醫療服務提供者，由其為您提供必要的護理。在此情況下，您將僅支付網絡內分攤費用。如果您發現自己在我們的計劃網絡內沒有承保您所需服務的專科醫生，請致電我們的計劃，了解到哪裡可以按網絡內分攤費用獲得此項服務的資訊。

如果您在以下方面遇到任何困難，包括取得我們的計劃以無障礙且適合您的方式提供資訊、會見女性健康專科醫生或尋找網絡內專科醫生，請提出申訴，您可聯絡 HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, HI 96805-1958, 1-800-462-2085，聽障熱線 (TTY) 使用者請致電 711，傳真：(808) 952-7546，電郵：appeals@hmsa.com 。您也可以致電 1-800-MEDICARE (1-800-633-4227) 或直接向民權辦公室（電話號碼為 1-800-368-1019 或聽障熱線 (TTY) 1-800-537-7697）提出投訴。

Seksion 1.1 Masapul nga ipaaymi ti impormasion iti wagas nga mayatpara kenka ken maitunos kadagiti kultural a sensibilidadmo (kadagiti pagsasao malaksid iti Ingles, iti braille, iti dakkel a letra (large print), wenno dadduma pay a kasukat a pormat, kdpy.)

Masapul ti planomi tapno masigurado nga amin a serbisio, agpadpada iti klinikal ken saan a klinikal, ket maited iti wagas a makabael iti kultura ken mabalin a magun-od ti amin nga agpalista, agraman dagidiay addaan iti limitado a kinalaing iti Ingles, limitado a paglaingan iti panagbasa, kinaawan kabaelan iti panagdengngeg, wenno dagidiay addaan iti nadumaduma a kultura ken etniko a nalikudan. Dagiti pagarigan no kasano a ti planomi ket mabalin a makasangpet kadagitoy a kasapulan ti pannakagun-od ket mairaman, ngem saan a limitado iti panangipaay kadagiti serbisio ti agipatpatarus, serbisio ti agipatarus, teletypewriter, wenno koneksion ti TTY (text telephone wenno teletypewriter phone).

Ti planomi ket addaan kadagiti libre a serbisio ti agipatarus a magun-od a mangsungbat kadagiti saludsod manipud kadagiti saan nga agsasao iti Ingles a miembro. No masapulyo, mabalindakayo nga itedan ti materyales nga agusar ti pagsasao nga malaksid iti Ingles, agraman iti Ilocano, Vietnamese, Chinese (Tradisional), ken Korean, ken braille, iti dakkel a letra (large print), wenno dadduma pay a kasukat a porma, nga awan bayad na. Masapul nga itedmi kadakayo ti impormasion maipapan kadagiti benepisio ti planomi iti pormat a makadanon ken maitutop kadakayo. Tapno makaala iti impormasion manipud kadakami iti wagas nga mayat para kenka, tawaganyo ti Customer Relations iti 1-800-660-4672 (para dagiti agusar ti TTY, tawaganyo iti 711) .

Masapul ti planomi a mangted kadagiti babbai nga agpalista iti pagpilian a direkta a makastrek iti espesialista iti salun-at dagiti babbai iti uneg ti network para kadagiti gagangay ken panglapped a serbisio ti panangtaripato ti salun-at dagiti babbai.

No dagiti mangipapaay para iti especialidad ket saan a magun-od iti network ti plano, responsabilidad ti planomi a mangbirok kadagiti mangipapaay iti espesialidad iti ruar ti networka mangipaay kenka iti kasapulan a panangaywan. No kastoy, agbayadka laeng iti in-network cost sharing. No masarakam ti bagim iti kasasaad nga awan dagiti espesialista iti network ti plano a mangsaklaw iti serbisio a kasapulam, tawagam ti planomi para kadagiti impormasion no sadino ti papananyo tapno magun-odyo daytoy a serbisio iti in-network cost sharing.

No marigatankayo a makagun-od iti impormasion manipud iti planomi iti wagas a makadanon ken maitutop kenka, agpakonsulta iti espesialista iti salun-at dagiti babbai (women's health specialist) wenno agsapul iti espesialista iti network, agtawagkayo tapno mangipila iti reklamo HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, HI 96805-1958, 1-800-462-2085, para dagiti agusar ti TTY, tawaganyo iti 711, Fax: (808) 952-

7546, Email: appeals@hmsa.com. Mabalinkayo pay nga mangipila iti reklamo iti Medicare babaen ti panagtawag iti 1-800-MEDICARE (1-800-633-4227) wenno direkta iti Office for Civil Rights 1-800-368-1019 wenno TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services and drugs

You have the right to choose a provider in our plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a **Notice of Privacy Practice**, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you've given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held at our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or

corrections to your medical records. If you ask us to do this, we'll work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Customer Relations at 1-800-660-4672 (TTY users call 711).

For more information about our plan's privacy practices, go to Chapter 11.

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of *HMSA Akamai Advantage Dual Care*, you have the right to get several kinds of information from us.

I If you want any of the following kinds of information, call Customer Relations at 1-800-660-4672 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something isn't covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know about your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it

- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home

If you know ahead of time that you're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital did not follow the instructions in it, you can file a complaint with the appropriate state agency below.

For a complaint about a doctor not following an advance directive, you have the right to make a complaint with the State of Hawaii, Department of Commerce and Consumer Affairs (DCCA), Regulated Industries Complaint Office (RICO).

Method	Advance Directive Complaints About Doctors – Contact Information
CALL	Oahu: (808) 587-4272 Hawaii (Hilo): (808) 933-8846 Hawaii (Kona): (808) 327-9590 Kauai: (808) 241-3300 Maui: (808) 243-5808 These numbers are available 7:45 am - 4:30 pm, Monday through Friday, except State and most Federal holidays.
TTY	711
WRITE	Regulated Industries Complaints Office Administration - Attn Consumer Projects Attorney 235 S. Beretania Street, 9th Floor Honolulu, HI 96813 Email: rico@dcca.hawaii.gov
WEBSITE	https://cca.hawaii.gov/rico/

However, if you have a problem or concern about a health care facility (including hospitals, nursing homes, home health agencies, end-stage renal disease (ESRD) facilities, and other facilities serving Medicare and

Medicaid members), contact Office of Health Care Assurance (OHCA) through any of the methods listed below.

Method	Advance Directive Complaints About Hospitals – Contact Information
CALL	(808) 692-7420 Calls to this number are free. This number is available 7:45 am - 4:30 pm, Monday through Friday, except State and federal holidays.
TTY	711 Calls to this number are free. This number is available 7:45 am - 4:30 pm, Monday through Friday, except State and federal holidays.
FAX	(808) 692-7447
WRITE	Department of Health Medicare Section 601 Kamokila Boulevard, Room 395 Kapolei, HI 96707
WEBSITE	https://health.hawaii.gov/ohca/

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we're required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call our plan's Customer Relations** at 1-800-660-4672 (TTY users call 711).
- **Call your local SHIP** at (808) 586-7299 or 1-888-875-9229 (TTY users call 1-866-810-4379).
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227)(TTY users call 1-877-486-2048).

Section 1.8 How to get more information about your rights

You have a right to make recommendations regarding the organization's member rights and responsibilities policy.

Get more information about your rights from these places:

- **Call Customer Relations** at 1-800-660-4672 (TTY users call 711).

- **Call your local SHIP** at (808) 586-7299 or 1-888-875-9229 (TTY users call 1-866-810-4379).
- **Contact Medicare**
  - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at: Medicare Rights & Protections). (The publication is available at: .)
  - Call 1-800-MEDICARE (1-800-633-4227 TTY users call 1-877-486-2048).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Relations at 1-800-660-4672 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - You must pay our plan premiums.
  - You must continue to pay your Medicare stay to remain a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't a member of our plan.**
- I**f you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9:
If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you're having:

- For some problems, you need to use the **process for coverage decisions and appeals**.

For other problems, you need to use the **process for making complaint**s (also called grievances).

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 3 will help you identify the right process to use and what you should do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Relations at 1-800-660-4672 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program isn't connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. Call Hawai'i SHIP at (808) 586-7299 or 1-888-875-9229 (TTY users call 1-866-810-4379).

Medicare

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit www.Medicare.gov

You can get help and information from Medicaid

For more information and help in handling a problem, you can also contact State of Hawai‘i Department of Human Services Med-QUEST Division. Here are two ways to get information directly from State of Hawai‘i Department of Human Services Med-QUEST Division:

- You can call 1-800-316-8005. TTY users should call 1-800-603-1201.
- You can visit the State of Hawaii Department of Human Services Med-QUEST Division website (www.medquest.hawaii.gov).

SECTION 3 Understanding Medicare and Medicaid complaints and appeals

You have Medicare and get help from Medicaid. Information in this chapter applies to **all** your Medicare and Medicaid benefits. This is called an integrated process because it combines, or integrates, Medicare and Medicaid processes.

Sometimes the Medicare and Medicaid processes aren’t combined. In those situations, use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in **Section 6.4.**

SECTION 4 Which process to use for your problem

If you have a problem or concern, read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Medicaid.**

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way in which they’re covered, and problems related to payment for medical care.

Yes.

Go to **Section 5, A guide to coverage decisions and appeals.**

No.

Go to **Section 11 How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 5 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment. To keep things simple, we generally refer to medical items, services and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 6.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed in Section 7 of this chapter.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 5.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Customer Relations** at 1-800-660-4672 (TTY users call 711)
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer Relations at 1-800-660-4672 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
    - For medical care, your doctor or other health care provider can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it'll be automatically forwarded to Level 2.
    - If your doctor or other health provider asks that a service or item that you're already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
    - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your **representative** to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Customer Relations at 1-800-660-4672 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.hmsa.com/help-center/froms/medicare-appoint-representative/.) This form gives that person permission to act on your behalf. It must be signed by you and the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you

free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.2 Rules and deadlines for different situations

SECTION 6 Medical care: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**

2. Our plan won't approve the medical care your doctor or other medical health care provider wants to give you, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**

3. You got medical care that you believe our plan should cover, but we said we won't pay for this care. **Make an appeal. Section 6.3.**

4. You got and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**

5. You're told that coverage for certain medical care you've been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Section 8 and 9. Special rules apply to these types of care.

Section 6.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A **fast coverage decision** is called **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules,14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, 24 hours for Part B drugs.

- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request **for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days** after we get your request. If your request is for **a Part B drug**, we'll give you an answer **within 72 hours** after we get your request.

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 calendar more days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 11 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we should *not* take extra days, you can file a fast complaint. (Go to Section 11 for information on complaints.) We'll call you as soon as we make the decision.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 6.3 How to make a Level 1 Appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan reconsideration.

A fast appeal is also called an **expedited reconsideration**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.

The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** ***If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.***

- If we decided to change or stop coverage for a service or item that you currently get, we'll send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We'll continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You'll also keep getting all other services or items (that aren't the subject of your appeal) with no changes.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed, and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal.** We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit your, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we *shouldn't* take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, go to Section 11.)
    - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal you have additional appeal rights.**
- If we say no to part or all of what you asked for, we'll send you a letter.
    - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
    - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 The Level 2 appeal process

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

- If your problem is about a service or item that's usually **covered by** Medicare, we'll automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that's usually covered by Medicaid, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you'll automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to Section 6.3 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that's usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that's usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after getting our plan's decision letter.

If your problem is about a service or item Medicare usually covers:

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a free copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal within 72 hours of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests.** For **expedited requests,** we have **72 hours** from the date we get the decision from the independent review **organization.**
- **If the independent review organization says yes to part or all of a request for a Part B drug,** we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization**.**
- **If the independent review organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.). In this case, the independent review organization will send you a letter that:
    - Explains the decision.
    - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
    - Tells you how to file a Level 3 appeal.
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.

    - The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item Medicaid usually covers:

Step 1: Ask for a Fair Hearing with the state.

- Level 2 of the appeals process for services usually covered by Medicaid is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone within 120 calendar days of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

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

Mail the appeal to:

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

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

Step 2: The Fair Hearing office gives you its answer.

The Fair Hearing office will tell you its decision in writing and explain the reasons for it.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service**, we must authorize or provide the service or item within 72 hours after we get the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal**, they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision or turning down your appeal**.)

If the decision is no for all or part of what you asked for, you can make another appeal

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, **you have additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

Go to **Section** 10 for more information on your appeal rights after Level 2.

Section 6.5 If you're asking us to pay you back for our share of a bill you got for medical care

If you have already paid for a Medicaid service or item covered by our plan, ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. When you send us a bill you already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this coverage decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

If you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a Medicaid service or item you paid us to make this coverage decision. We'll check to see if the medical care you paid for is a covered service. We'll also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request**: If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- **If we say no to your request:** If the medical care isn't covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we'll not pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 6.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 30 calendar days after we get your appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the health care provider within 60 calendar days.

SECTION 7 Part D drugs: How to ask for a coverage decision or make an appeal

Section 7.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term *Drug List* instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Terms

An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that isn't on our plan's Drug List. **Ask for an exception. Section 7.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 7.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 Asking for an exception

Legal Terms:

Asking for coverage of a drug that's not on the Drug List is a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 2 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to all of our drugs. You can't ask for an exception to the cost sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.

    - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
    - If the drug you're taking is a biological product, you can ask us to cover your drug at a lower cost-sharing. This would be the lowest tier that contains biological product alternatives for treating your condition.
    - If the drug you're taking is a brand name drug, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
    - If the drug you're taking is a generic drug, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.

You can't ask us to change the cost-sharing tier for any drug in Tier 5 (Specialty Tier).

- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're asking for and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally won't approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 7.4 How to ask for a coverage decision, including an exception

Legal term:

A fast coverage decision is called on **expedited coverage determination**.

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a drug you *didn't get yet* . (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
    - Explains that we'll use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
    - Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request form*, or our plan's form which is available on our website at https://www.hmsa.com/help-center/forms/medicare-drug-review. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement,** which is the medical reason for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed **to within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request.

If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for**, we are also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked** for, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Section 7.5 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a Part D drug coverage decision is called a plan redetermination.

A fast appeal is called an expedited redetermination.

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request** or call us. Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at** (808) 948-6000. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website at https://www.hmsa.com/help-center/forms/medicare-drug-review/. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7.6 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we have agreed to provide within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
    - If we don't give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
    - If we don't meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we are also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked** for, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Legal Term:

The formal name for the independent review organization is the I**ndependent Review Entity**. It is sometimes called the **IRE**

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you'll include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.

- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we'll automatically forward your claim to the IRE.
- We'll send the information about your appeal to this organization. This information is called your **case file. You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the independent review organization agrees to give you a fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet . If you're asking us to pay you back for a drug you have already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.

- ***For fast appeals*:**
    - **If the independent review organization says yes to part or all of what you asked for,** we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.
- ***For standard appeals:***
    - **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
    - **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If the independent review organization says no **to part or all of** your appeal**,** it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision. It's also called turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.

- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 talks more about the process for Level 3, 4, and 5 appeals.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice.

If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Relations at 1-800-660-4672 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.

- Your right to **ask for an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so we'll cover your hospital care for a longer time.

2. You'll be asked to sign the written notice to show that you got it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the ***notice doesn't*** **mean** you're agreeing on a discharge date.

3. Keep your copy of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Customer Relations at 1-800-660-4672 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227. TTY users call 1-877-486-2048. You can also get the notice online at https://www.cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 8.2 How to make a Level 1 Appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help call Customer Relations at 1-800-660-4672 (TTY users call 711). Or call your State Health Insurance Assistance Program, (SHIP) for personalized help. Hawaii SHIP is available at 1-888-875-9229, TTY users should call 1-866-810-4379. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge date.**
  - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you don't meet this deadline**, contact us. If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.

Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're are contacted , we'll will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the Detailed Notice of Discharge by calling Customer Relations at 1-800-660-4672 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227. (TTY users call 1-877-486-2048.) Or you can get a sample notice online at https://www.cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the 1-888-875-9229 hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**.
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the **hospital, you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to **Level 2** of the appeals process.

Section 8.3 How to make a Level 2 Appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, **we'll stop paying our share of the cost** *for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 9.1 We'll tell you in advance when your coverage will be ending

Legal Terms:
Notice of Medicare Non-Coverage. It tells you how you can request a **fast-track appeal.** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. You get a notice in writing at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:

- The date when we'll stop covering the care for you.
- How to ask for a fast track appeal to ask us to keep covering your care for a longer period of time.

2. You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it. Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it *doesn't* mean you agree** with our plan's decision to stop care.

Section 9.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help , call Customer Relations at 1-800-660-4672 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. Hawaii SHIP is available at 1-888-875-9229, TTY users should call 1-866-810-4379. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of

doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.)

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Terms

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (*the reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers told us of your appeal, you'll get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you its decision.

What happens if the reviewers say yes?

If the reviewers say *yes* to your appeal, then **we must keep providing your covered service for as long as it is medically necessary**.

You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you**.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage **ends, you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 9.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you its decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.

- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, *independent* need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2 for a total of 5 levels of appeal. If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about the process for Levels 3, 4, and 5 appeals.

SECTION 10 Taking your appeal to Levels 3, 4, and 5

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar Level 3 decision that's Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
    - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the federal District will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An Administrative Law Judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the Administration Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare** Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with your Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Relations? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Relations or other staff at our plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal* and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms:
A **complaint** is also called a **grievance.**
Making a complaint is called **filing a grievance.**
Using the process for complaints is called **using the process for filing a grievance.**
A **fast complaint** is called an **expedited grievance.**

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Customer Relations** at 1-800-660-4672 (TTY users call 711) **is usually the first step.** If there's anything else you need to do, Customer Relations will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- If you call us or send us your complaint in writing, we will file your complaint for you. To process your complaint, we will need the following information:
    - Your full name.
    - Your member ID number.
    - A daytime telephone number where we can reach you.
    - A description of the complaint, including the date it occurred.
    - Address of office location, and name of practitioners, providers, or their staff who were involved, if applicable.
    - Any documents you would like us to consider when resolving your complaint.
    - Your signature or the signature of your representative, if the complaint is sent to us in writing. (Addresses are printed on the back cover of this document).

  If you want a friend, relative, your doctor or other provider, or other person to be your representative, then you will need to submit an "Appointment of Representative" form. The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. To obtain the form you can do the following:

    - Download the form on our website at www. hmsa.com/help-center/forms/medicare-appoint-representative/
    - Call Customer Relations (phone numbers are printed on the back cover of this document) and ask for the "Appointment of Representative" form.
    - Download the form on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf

  Reminder: A representative form is valid for one year from the date it has signatures for both the enrollee and the appointee, unless revoked. For example, if the enrollee signs the form on January 1, 2026 and the representative signs on January 3, 2026 (or vice versa), the form is effective for one year starting on January 3, 2026.

- **Whether you call or write, you should contact Customer Relations right away.** You can make the complaint any time after you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.

- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 11.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.**
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 11.4 You can also tell Medicare and Medicaid about your complaint

You can submit a complaint about *HMSA Akamai Advantage Dual Care* directly to Medicare. To submit a complaint to Medicare, https://www.medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

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

- To file your grievance by phone, call DHS, Med-QUEST Division, at:
  Med-QUEST Division
  Health Care Services Branch
  P.O. Box 700190
  Kapolei, HI 96709-0190
  Phone: (808) 692-8094

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

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

CHAPTER 10:
Ending membership in our plan

SECTION 1 Ending membership in our plan

Ending your membership in *HMSA Akamai Advantage Dual Care* may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* t to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

- Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan by choosing one of the following Medicare options in any month of the year.
- Original Medicare *with* a separate Medicare prescription drug plan.
    - Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
    - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- Call your State Medicaid Office at 1-800-316-8005 to learn about your Medicaid plan options.
- Other Medicare health plan options are available during the **Open Enrollment Period**. Section 2.2 tells you more about the Open Enrollment Period.
- **Your membership will usually end on the first day of the month after we get your request to change your plans**. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the Open Enrollment Period each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without drug coverage.
  - Original Medicare *with* a separate Medicare drug plan.

OR

  - Original Medicare *without* a separate Medicare drug plan.
  - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

You get Extra Help from Medicare to pay for your prescription drugs: If you switch to Original Medicare and don't enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you've opted out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open** E**nrollment Period**, you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit www.Medicare.gov:

- Usually, when you move
- If you have QUEST (Medicaid)
- If you're eligible for Extra Help with paying for your Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- **Note:** If you're in a drug management program, you may only be eligible for certain Special Enrollment Periods. Chapter 5, section 10 tells you more about drug management programs.
- **Note**: Section 2.1 tells you more about the special enrollment period for people with Medicaid.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage.
- Original Medicare *with* a separate Medicare drug plan.
- - *or* - Original Medicare *without* a separate Medicare drug plan.
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you get Extra Help from Medicare to pay for your drug coverage drugs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Your membership will usually end on the first day of the month after your request to change our plan .

Note: Section 2.4 tells you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Customer Relations at** 1-800-660-4672 (TTY users call 711).
- Find the information in the ***Medicare & You 2026*** handbook.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.)

SECTION 3 How to end your membership in our plan?

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan.	• Enroll in the new Medicare health plan. . • You'll automatically be disenrolled from *HMSA Akamai Advantage Dual Care* when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan.	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from *HMSA Akamai Advantage Dual Care* when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan.	• **Send us a written request to disenroll.** Call Customer Relations at 1-800-660-4672 (TTY users call 711) if you need more information on how to do this. • You also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from *HMSA Akamai Advantage Dual Care* when your coverage in Original Medicare starts.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage , no longer receive Extra Help, for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your QUEST (Medicaid) benefits, contact State of Hawai‘i Department of Human Services Med-QUEST Division using the contact information in Chapter 2, Section 6 of this document. Ask how joining another plan or returning to Original Medicare affects how you get your QUEST (Medicaid) coverage.

SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership *HMSA Akamai Advantage Dual Care* ends, and your new Medicare and Medicaid coverage starts, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 *HMSA Akamai Advantage Dual Care* must end our plan membership in certain situations

***HMSA Akamai Advantage Dual Care* must end your membership in the plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B.
- If you're no longer eligible for QUEST (Medicaid). As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and QUEST (Medicaid). If you lose your full QUEST (Medicaid) status, you will be given six calendar months to regain your full QUEST (Medicaid) status. If after six calendar months, you have not regained your full QUEST (Medicaid) status and you have not enrolled in a different plan, you will be disenrolled from *HMSA Akamai Advantage Dual Care* at the end of the month.
  - If you are within our plan's six calendar month(s) period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will not pay the Medicare premiums or cost-sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. The amount you pay for Medicare covered services may increase during this period.
- If you're no longer enrolled in HMSA QUEST.
- If you move out of our service area
- If you're away from our service area for more than 6 months.
  - If you move or take a long trip, call Customer Relations at 1-800-660-4672 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides drug coverage
- If you intentionally give us incorrect information make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

- If you don't pay our premiums for two calendar months.
  - We must notify you in writing that you have two calendar months to pay the plan premium before we end your membership.

If you have questions or want more information on when we can end your membership call Customer Relations at 1-800-660-4672 (TTY users call 711)

Section 5.1 We can't ask you to leave our plan for any health-related reason

HMSA Akamai Advantage Dual Care isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11: Legal Notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Customer Relations 1-800-660-4672 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Relations can help.

HMSA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 1-800-660-4672 toll-free. TTY 711.

Filing a Grievance with HMSA
If you believe that HMSA has discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with HMSA's HMSA Member Advocacy and Appeals:

HMSA Member Advocacy and Appeals

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

Toll-Free Phone: 1-800-462-2085

TTY: 711

Fax: 808-952-7546

Email: appeals@hmsa.com

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

Mail: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201,

Phone: 1-800-368-1019 toll-free; TDD users, call 1-800-537-7697 toll-free.

You can review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html. Complaint forms are available at http://hhs.gov/ocr/office/file/index.html.

Such complaints must be filed within 180 days of the date of the alleged discrimination.

SECTION 3 Notice about member non-liability

In the event HMSA fails to reimburse a Network provider's charge for covered services, you will not be liable for any sums owed by HMSA.

SECTION 4 Notice about when others are responsible for injuries

We do not pay medical expenses which are covered by workers' compensation insurance or automobile insurance coverage required by Hawaii state law. When others may be responsible for payment of your medical expenses or prescription drugs (due to tort liability, insurance or otherwise), our third-party liability rules apply and you should request a copy of these rules from us. You must give us prompt written notice of your injuries, claims, and demands for recovery and recoveries received, and must promptly fill out and return to us all papers we require to determine coverage and to secure our reimbursement rights for any

amounts we pay. Medicare and HMSA have liens and rights of reimbursement to the full extent of any expenses paid.

SECTION 5 Notice about our privacy policies and practices for personal financial information required by law

(Privacy of Consumer Financial Information, H.R.S. Chapter 431, Article 3A, eff. July 1, 2002) HMSA is required by state law to provide an annual notice of our privacy policies and practices for personal financial information to members who are enrolled in our individual health plans. This section contains information regarding how we collect and disclose personal financial information about our members to our affiliates and to nonaffiliated third parties. This applies to former as well as current HMSA members.

HMSA and our affiliated organizations throughout the state of Hawaii have established the following policies and practices:

- Maintain physical, technical and administrative safeguards to protect the privacy, confidentiality, and integrity of personal information.
- Ensure that those in our workforce who have access to or use your personal information need that information to perform their jobs and have been trained to properly handle personal information. Our employees are fully accountable to management for following our policies and practices.
- Require that third parties who access your personal information on our behalf comply with applicable laws and agree to HMSA's strict standards of confidentiality and security.

Collection of personal financial information

HMSA collects personal financial information about you that is necessary to administer your health plan. We may collect personal financial information about you from sources such as applications or other forms that you complete and your transactions with us, our affiliates, or others.

Sharing of personal financial information

HMSA may share with our affiliates and with nonaffiliated third parties any of the personal financial information that is necessary to administer your health plan as permitted by law. Nonaffiliated third parties are those entities that are not part of HMSA and its affiliates. We do not otherwise share your personal financial information with anyone without your permission.

SECTION 6 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, *HMSA Akamai Advantage Dual Care,* as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

In some situations, other parties should pay for your medical care before your Medicare Advantage health plan. In those situations, your Medicare Advantage plan may pay, but have the right to get the payments back from these other parties. Medicare Advantage plans may not be the primary payer for medical care you

receive. These situations include those in which the Federal Medicare Program is considered a secondary payer under the Medicare Secondary Payer laws. For information on the Federal Medicare Secondary Payer program, Medicare has written a document with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First (publication number 02179).* You can get a copy by calling 1-800-MEDICARE, 24 hours a day, 7 days a week, or by visiting the www.medicare.gov web site.

Our rights to recover in these situations are based on the terms of this health plan contract, as well as the provisions of the Federal statutes governing the Medicare Program. Your Medicare Advantage plan coverage is always secondary to any payment made or reasonably expected to be made under:

- A workers compensation law or plan of the United States or a State,
- Any non-fault based insurance, including automobile and non-automobile no-fault and medical payments insurance,
- Any liability insurance policy or plan (including a self-insured plan) issued under an automobile or other type of policy or coverage, and
- Any automobile insurance policy or plan (including a self-insured plan), including, but not limited to, uninsured and underinsured motorist coverages.

Since your Medicare Advantage plan is always secondary to any automobile no-fault (Personal Injury Protection) or medical payments coverage, you should review your automobile insurance policies to ensure that appropriate policy provisions have been selected to make your automobile coverage primary for your medical treatment arising from an automobile accident.

SECTION 7 Notice about Subrogation and Third Party Liability

We do not pay any medical expenses which are covered by workers' compensation insurance or automobile insurance coverage required by Hawaii state law.

If you suffer an injury or illness for which a third party is responsible due to a negligent or intentional act, you must promptly notify us. If we make any payment on your behalf for covered services when others are responsible for the illness or injury, we have the right to be repaid the full cost of benefits provided or paid by us. You are required to cooperate with us in pursuing such recoveries.

You must also notify us of any claims or demands for recoveries and recoveries received. HMSA has a right to restitution or reimbursement from any recovery obtained by you or on your behalf from any third party responsible for your injury or illness.

As outlined herein, in these situations, we may make payments on your behalf for this medical care, subject to the conditions set forth in this provision for us to recover these payments from you or from other parties. Immediately upon making any conditional payment, we shall be subrogated to (stand in the place of) all rights of recovery you have against any person, entity or insurer responsible for causing your injury, illness or condition or against any person, entity or insurer listed as a primary payer above.

In addition, if you receive payment from any person, entity or insurer responsible for causing your injury, illness or condition or you receive payment from any person, entity or insurer listed as a primary payer

above, we have the right to recover from, and be reimbursed by you for all conditional payments we have made or will make as a result of that injury, illness or condition.

We will automatically have a lien to the extent of benefits it paid for the treatment of the injury, illness or condition, upon any recovery whether by settlement, judgment or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits we have paid including, but not limited to, you, your representatives or agents, any person, entity or insurer responsible for causing your injury, illness or condition or any person, entity or insurer listed as a primary payer above. By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds.

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any health care provider) from your Medicare Advantage plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be paid to the plan before any other claim for your damages. We shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery to you which is insufficient to make you whole or to compensate you in part or in whole for the damages you sustained. We are not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

We are entitled to full recovery regardless of whether any liability for payment is admitted by any person, entity or insurer responsible for causing your injury, illness or condition or by any person, entity or insurer listed as a primary payer above. We are entitled to full recovery regardless of whether the settlement or judgment received by you identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. We are entitled to recover from any and all settlements or judgments, even those designated as for pain and suffering, non-economic damages and/or general damages only.

You, and your legal representatives, shall fully cooperate with our efforts to recover the benefits that we paid. It is your duty to notify us within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by us or our representatives. You shall do nothing to prejudice our subrogation or recovery interest or to prejudice our ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

Failure to provide requested information or failure to assist us in pursuit of its subrogation or recovery rights may result in you being personally responsible for reimbursing us for benefits paid relating to the injury, illness or condition as well as for our reasonable attorney fees and costs incurred in obtaining reimbursement from you. For more information, see 42 U.S.C. § 1395y(b)(2)(A)(ii) and the Medicare statutes.

SECTION 8 Notice about Reporting Fraud, Waste, and Abuse

HMSA is committed to identifying and preventing fraud, waste and abuse under Medicare. You can assist us by reporting any potential cases of health care fraud to us. If you notice any suspicious activity, such as falsified claims, unnecessary services, or misuse of your Medicare ID, please report it immediately. Please review your Explanation of Benefits (EOB) statements for any discrepancies, such as services or supplies

you did not receive. If you notice any suspicious activity, please report it immediately. You can report Fraud, Waste, and Abuse (FWA) confidentially by calling our hotline at (808) 948-5166 or toll-free at 1-888-398-6445. Your vigilance helps protect your benefits and maintain the integrity of our healthcare system.

CHAPTER 12: Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Benefit Period – The way your use of skilled nursing facility (SNF) services is measured. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

Biological Product – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to "Original Biological Product" and "Biosimilar").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that's manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,1000 for Part D covered drugs during the covered year. During this payment stage, our plan pays the full cost for your covered Part D drugs.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan (C-SNP) - C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.)

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used only for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are gotten. (This is in addition to our plan's monthly plan premium.) Cost-sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the drugs covered by our plan.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care provided by people who don't have professional skills or training includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Relations – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Relations.

Daily Cost-sharing Rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that's ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional equivalent SNPs (IE-SNPs), Hybrid SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Integrated D-SNP – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of people eligible for both Medicare and Medicaid. These people are also known as full-benefit dually eligible people.

Institutional Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Integrated Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This type of complaint doesn't involve coverage or payment disputes.

Integrated Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Lifetime Reserve Days – You are eligible for an additional 60 Medicare-covered inpatient hospital days after the first 90 days of your Medicare-covered hospital stay. These 60 reserve days can be used only once during your lifetime.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for our plan premiums, Medicare Part A and Part B premiums, and prescription drugs don't count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.) See Chapter 4, Section 1.3 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that's either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service drug information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel its plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug coverage**.

Medicare-approved Provider – A Medicare-approved provider is a Medicare-enrolled DMEPOS supplier or any eligible professional or practitioner eligible to bill for Medicare services and supplies. Certain durable equipment, prosthetics, orthotics, and supplies are dispensed by these Medicare-approved providers. To find a Medicare-approved provider near you, go to www.medicare.gov/medical-equipment-suppliers/.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Drug coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan isn't a Medigap policy.)

Member (member of our plan, or plan member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they're filled at one of our network pharmacies.

Network Provider – **Provider** is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Observation Care – A stay in a hospital for less than 48 hours if: (1) You have not been admitted for an inpatient stay; (2) you are physically detained in an emergency room, treatment room, observation room, or other such area; or (3) you are being observed to determine whether an inpatient confinement will be required.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (**Traditional Medicare or Fee-for-service Medicare**) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

Palliative Care – Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care involves addressing physical, intellectual, emotional, social, and spiritual needs to facilitate patient autonomy, access to information, and choice.

Part C –Go to Medicare Advantage (MA) plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

Preferred Provider Organization (PPO) plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that's designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

"Real Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rebatable drugs – The Inflation Reduction Act of 2022 requires drug companies to pay a rebate if they raise their prices for certain drugs faster than the rate of inflation. If you receive any of these Part B medications, you may pay a lower coinsurance. If you pay more on the date of services, our plan must issue you a refund.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits, (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Discrimination is against the law

HMSA complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). HMSA does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Services HMSA provides

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

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

If you need modifications, appropriate auxiliary aids and services, or language assistance services, please call 1 (800) 776-4672. TTY users, call 711.

How to file a grievance or complaint

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1 (800) 368-1019, 1 (800) 537-7697 (TDD)

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

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

(continued on next page)

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

1020-1276050 6.25 LE

Commercial/ACA/Medicare
H3832_1020_1276050_L3G4AH716_26_C
S3994_1020_1276050_L3G4AH717_26_C
H8481_1020_1276050_L3G4AH718_26_C

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

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

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

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

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

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

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

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

ພາສາລາວ
ຊຶ່ນຊາບ: ຖ້າທ່ານບໍ່ເວົ້າພາສາອັງກິດແມ່ນມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍພ້ອມໃຫ້ທ່ານ. ນອກຈາກນັ້ນກໍ່ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມເພື່ອໃຫ້ຂໍ້ມູນແກ່ທ່ານໃນຮູບແບບທີ່ ເຊົ້າເຖິງໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ສະມາຊິກ QUEST ແມ່ນໂທບໍ່ເສຍຄ່າໄດ້ທີ່ ເບີ 1 (800) 440-0640, TTY 1 (877) 447-5990 ຫຼື ປຶກສາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.ສະມາຊິກແຜນ ປະກັນ Medicare Advantage ແລະ ຊັ້ນທຸລະກິດ, ໂທ 1 (800) 776-4672 ຫຼື TDD/TTY 1 (877) 447-5990.

(continued on next page)

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

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

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

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

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

ไทย
โปรดให้ความสนใจ: หากท่านไม่พูดภาษาอังกฤษ เรามีบริการให้ความช่วยเหลือทางภาษาแก่ท่านโดยไม่มีค่าใช้จ่าย และยังมีความช่วยเหลือและบริการเสริมเพื่อให้ข้อมูลแก่ท่านในรูปแบบที่เข้าถึงได้โดยไม่มีค่าใช้จ่าย สำหรับสมาชิก QUEST โปรดโทรไปที่หมายเลขโทรฟรีที่หมายเลข 1 (800) 440-0640, TTY 1 (877) 447-5990 หรือพูดคุยกับผู้ให้บริการของคุณ สำหรับสมาชิก Medicare Advantage และแผนเชิงพาณิชย์ โปรดโทรไปที่หมายเลข 1 (800) 776-4672 หรือ TDD/TTY 1 (877) 447-5990

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

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

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

HMSA Medicare Advantage Customer Relations

CALL	(808) 948-6000 or 1 (800) 660-4672, option 6, toll-free daily, 7:45 a.m.–8 p.m. Oct. 1-March 31: Seven days a week. April 1-Sept. 30: Monday-Friday. Calls to these numbers are free. Customer Relations also has free language interpreter services available for non-English speakers.
TTY	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	(808) 948-6433
WRITE	HMSA Medicare Advantage Customer Relations P.O. Box 860 Honolulu, HI 96808-0860
WEBSITE	hmsa.com/advantage
VISIT	Hours of operation may change. Please go to hmsa.com/contact before your visit. HMSA Centers with extended evening and weekend hours **Honolulu, Oahu** | 818 Keeaumoku St. Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m. **Pearl City, Oahu** | Pearl City Gateway, 1132 Kuala St., Suite 400 Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m. **Hilo, Hawaii Island** | Waiakea Center, 303A E. Makaala St. Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m. **Kahului, Maui** | Puunene Shopping Center, 70 Hookele St. Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–1 p.m. **Lihue, Kauai** | Kuhio Medical Center, 3-3295 Kuhio Highway, Suite 202 Monday–Friday, 8 a.m.–4 p.m.

Hawaii SHIP

Hawaii SHIP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

CALL	(808) 586-7299 or 1 (888) 875-9229 toll-free Monday–Sunday. This is a prerecorded helpline. Calls will be returned within five business days.
TTY	1 (866) 810-4379. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Hawaii SHIP Executive Office on Aging Hawaii State Department of Health No. 1 Capitol District 250 S. Hotel St., Suite 406 Honolulu, HI 96813-2831
WEBSITE	hawaiiship.org

8700-1397954 8.25