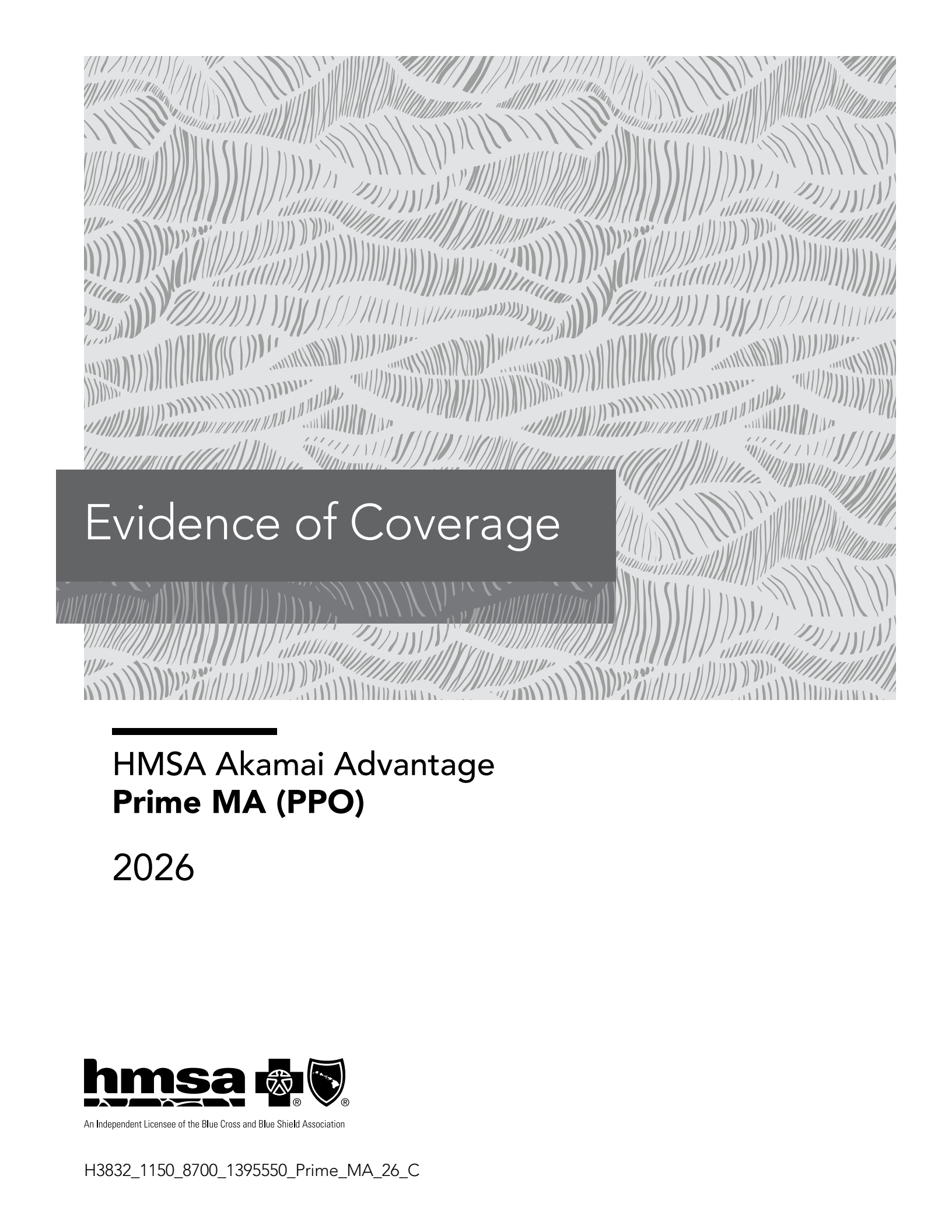




Evidence of Coverage

**HMSA Akamai Advantage
Prime MA (PPO)**

2026



An Independent Licensee of the Blue Cross and Blue Shield Association

H3832_1150_8700_1395550_Prime_MA_26_C

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services as a Member of *HMSA Akamai Advantage® Prime MA (PPO)*.

This document gives the details of your Medicare health 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 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 8:00 am - 8:00 pm, 7 days a week. This call is free.

This plan, *HMSA Akamai Advantage Prime MA*, 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 Prime MA*.)

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 copayment/coinsurance may change on January 1, 2027.

Our provider network can change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

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CHAPTER 1:

Get started as a member

SECTION 1 **You're a member of *HMSA Akamai Advantage Prime MA***

Section 1.1 **You're enrolled in *HMSA Akamai Advantage Prime MA*, which is a Medicare PPO**

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, *HMSA Akamai Advantage Prime MA*. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

HMSA Akamai Advantage Prime MA is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan doesn't include Part D 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 Prime MA* covers your care. Other parts of this contract include your enrollment form 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 Prime MA* 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 Prime MA* 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 Prime MA* each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer our plan and Medicare 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 conditions:

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be 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.

Section 2.2 Plan service area for *HMSA Akamai Advantage Prime MA*

HMSA Akamai Advantage Prime MA 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 all 50 states, the District of Columbia, and the territory of Puerto Rico.

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 2.3 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 Prime MA* if you're not eligible to stay a member of our plan on this basis. *HMSA Akamai Advantage Prime MA* 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. You should also show the provider your Medicaid card, if you have one. Sample membership card:

		Prime MA	
Subscriber Name KIMO M ALOHA	Group 18089	H3832 805	
Subscriber ID XLLA000012345678	Primary Care Provider DR MOKI HANA		
MEDICAL 698	VISION 0MD		
Generated 08-16-2022 			

	hmsa.com/advantage Customer Service: (808) 948-6000 or 1 (800) 660-4672 TTY 711 For care when traveling out of state call: Blue Card 1 (800) 810-BLUE
Do NOT bill Medicare. Claims for covered services must be filed with HMSA. Payment will be based on the member's eligibility at the time services are received. Medicare limiting charges may apply. Submit claims to: HMSA - CLAIMS P.O. Box 860 Honolulu, HI 96808-0860 Services rendered out-of-state, mail claims to: The local Blue Cross/Blue Shield of the service area.	Blue Cross Blue Shield of Hawai'i 818 Keeaumoku St. Honolulu, HI 96814-2365 An Independent Licensee of the Blue Cross and Blue Shield Association Business hours: 7 days a week 8 a.m. to 8 p.m.

DON’T use your red, white, and blue Medicare card for covered medical services while you’re a member of this plan. If you use your Medicare card instead of your *HMSA Akamai Advantage Prime MA* 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 Directory

The *Provider Directory* (<https://hmsa.com/search/providers/assets/pdf/AA-Medical-Directory.pdf>) lists our current network providers and durable medical equipment suppliers. **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.

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. Go to Chapter 3 for more specific information.

Get the most recent list of providers and suppliers on our website at www.hmsa.com/advantage.

If you don’t have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Customer Relations at 1-800-660-4672 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

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.	Contact your employer group plan benefit administrator
Maximum out-of-pocket amount This is the <u>most</u> you’ll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1.2 for details).	From network providers: \$4,200 From in-network and out-of-network providers combined: \$6,300
Primary care office visits	In-Network \$0 copayment per visit
Specialist office visits	In-Network \$30 copayment per visit
Inpatient hospital stays	In-Network Day 1-5: \$350 copayment per day

Your costs in 2026**Days 6-30: \$50 copayment per day****Days 31-90: \$0 copayment per day**

\$0 copayment per Lifetime Reserve Day.

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium.

Your coverage is provided through a contract with your current employer or former employer or union. Contact the employer's or union's benefits administrator for information about our plan premium.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2026* handbook, in 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, **you must continue paying your Medicare premiums to stay a member of our plan.** This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay our monthly plan premium

Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your 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 can be found 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 premiums deducted from 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 plan premium.

If you decide to change how you pay your plan premium, it can take up to 3 months for your new payment method to take effect. While we process your request for a new payment method, you're still responsible for making sure your 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. TTY users should call 711.

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

If you have trouble paying your plan premium

Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.

Your plan premium is due in our office by the fifth day of the month. If we 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 plan premium within 30 days.

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

If we end your membership because you didn't pay your plan premium, you'll have health coverage under Original Medicare.

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.

Chapter 1 Get started as a member

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control that made you unable to pay your premiums within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 7 to learn how to make a complaint or call us at (808) 948-6174 or 1-800-782-4672, 8:00 am 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.

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, and other providers in our plan's network **use your membership record to know what services 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). Your coverage is provided through a contract with your current employer or former employer or union. You may need to contact the employer's or union's benefits administrator to update this information.

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 that 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, employer group health plans, and/or Medigap have paid.

CHAPTER 2:

Phone numbers and resources

SECTION 1 *HMSA Akamai Advantage Prime MA contacts*

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

Customer Relations – Contact Information	
Call	From Oahu: (808) 948-6000 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 8:00 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 8:00 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

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services. 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, go to Chapter 7.

Coverage Decisions and Appeals for Medical Care – Contact Information

Call	From Oahu: (808) 948-6000 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 8:00 am - 8:00 pm, 7 days a week.
TTY	711 Calls to this number are free. This number is available 8:00 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/

Appeals for Medical Care – 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: <i>HMSA Akamai Advantage Prime MA</i> 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

You can make a complaint about us or one of our network providers, 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 7.

Complaints about Medical Care – Contact Information	
Call	From Oahu: (808) 948-6000 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 8:00 am - 8:00 pm, 7 days a week.
TTY	711 Calls to this number are free. This number is available 8:00 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 <i>HMSA Akamai Advantage Prime MA</i> 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 for our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 5 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 7 for more information.

Payment Requests about Medical Care – Contact Information

Call	From Oahu: (808) 948-6000 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 8:00 am - 8:00 pm, 7 days a week.
TTY	711 Calls to this number are free. This number is available 8:00 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

Payment Requests about Routine Vision Items and Services – Contact Information

Call	From Oahu: (808) 948-6000 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 8:00 am - 8:00 pm, 7 days a week.
TTY	711 Calls to this number are free. This number is available 8:00 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#/.

Payment Requests about Routine Hearing Items and Services – Contact Information

Call	From Oahu: (808) 948-6000 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 8:00 am - 8:00 pm, 7 days a week.
TTY	711 Calls to this number are free. This number is available 8:00 am - 8:00 pm, 7 days a week.

Chapter 2 Phone numbers and resources

Write	HMSA Akamai Advantage Customer Relations P.O. Box 860 Honolulu, HI 96808-0860
Website	www.hmsa.com/advantage

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 <i>HMSA Akamai Advantage Prime MA</i>. 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.hawaiiiship.org

SECTION 4 Quality Improvement Organization (QIO)

A 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 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. 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

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** are:

- **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+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings Programs, 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 Calls to these numbers are free. 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

SECTION 7 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 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 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 8 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.

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 our 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 their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

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

As a Medicare health plan, *HMSA Akamai Advantage Prime MA* must cover all services covered by Original Medicare and follow Original Medicare’s coverage rules.

HMSA Akamai Advantage Prime MA 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 get your care from a provider who’s eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).
 - o The providers in our network are listed in the *Provider Directory* at <https://www.hmsa.com/advantage>.
 - o If you use an out-of-network provider, your share of the costs for your covered services may be higher.

- o 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 can't pay a provider who isn't eligible to participate in Medicare. If you go to a provider who is not 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.

SECTION 2 Use network and out-of-network providers to get medical care

Section 2.1 You may choose a Primary Care Provider (PCP) to provide and oversee your medical 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 Directory*. Download the “HMSA Akamai Advantage (PPO)” 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 9 (*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 a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 7).

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 are covered benefits and are 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 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 medically necessary (Go to Chapter 7, Section 4 for information about asking for coverage decisions). 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 got, you have the right to appeal our decision not to cover your care (go to Chapter 7 to learn how to make an appeal).
- 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 5).
- 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 2.4 How to get care if you live in a non-network area

HMSA Akamai Advantage plans have a network in the state of Hawaii. In addition, plan members have access to Blue Medicare Advantage PPO network coverage of all Part A, Part B, and supplemental benefits. These providers are located outside of Hawaii, see Chapter 4, Section 2.2 for a list of the areas in which this network is available. (For some of the states listed, MA PPO networks are only available in portions of the state.) When you see Blue Medicare Advantage PPO providers, you will pay the same cost-sharing level (in-network cost-sharing) you would pay if you received covered benefits from in-network providers. Please see the Medical Benefits Chart for cost-sharing information.

To locate a Blue Medicare Advantage PPO provider, you may call 1-800-810-BLUE or our Customer Relations department (phone numbers are on the back cover of this document). You may also visit www.hmsa.com/advantage or <https://provider.bcbs.com> to find a Blue Medicare Advantage PPO provider.

If you do not live in a county in which Blue Medicare Advantage PPO providers are available, you may select any Medicare-approved provider and you will pay the same cost-sharing level (in-network cost-sharing) you would pay if you received covered benefits from in-network providers.

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 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. You are covered for emergency medical services or urgently needed care (not scheduled or elective care) in a foreign country. For more information, see the Medical Benefits Chart in Chapter 4 of this document. When you receive emergency/urgent care outside the country, you will need to pay the bill and ask for an itemized bill for your services. When you return to the United States, send the itemized bill and proof of payment to us along with a note describing your emergency/urgent care. If you did not pay your bill in U.S. dollars, the plan will reimburse you in U.S. dollars at the current exchange rate. See Chapter 5, Section 2 for more information on how to submit a bill for reimbursement, and the Medical Benefits Chart in Chapter 4 for more information.

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 and submit a prior authorization request. Your follow-up care will be covered by our plan.

If you get your follow-up care from out-of-network providers, you'll pay the higher out-of-network cost sharing.

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, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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 covers worldwide emergency or urgent care services outside the United States. For more information, see the Medical Benefits Chart in Chapter 4 of this document.

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.

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 got 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 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

HMSA Akamai Advantage Prime MA 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.

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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's 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 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 Chapter 5 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say 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 then 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, which is the same amount you'd pay under our plan's benefits.

When you're in 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* 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 is **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 Prime MA, however 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 in order 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 you already made (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 Prime MA* 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 Prime MA* 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's 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 Prime MA*. 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:

- **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.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount (MOOP)** is \$4,200. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, and services from out-of-network providers don't count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay \$4,200 for covered Part A and Part B services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is \$6,300. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums don't count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. These

services are marked with an asterisk in the Medical Benefits Chart.) If you pay \$6,300 for covered services, you'll have 100% coverage and won't have 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 1.3 Providers aren't allowed to balance bill you

As a member of *HMSA Akamai Advantage Prime MA*, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, \$15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost-sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
 - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balance billed you, call Customer Relations at 1-800-660-4672 (TTY users call 711).

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 Prime MA* covers and what you pay out of pocket for each service. 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 can't require prior authorization for any active course of

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

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 as in-network services *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 to be covered as in-network services are marked by an endnote in the Medical Benefits Chart. In addition, 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.
 - You never need approval in advance for out-of-network services from out-of-network providers.
 - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
- 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:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:
 - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
 - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (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), 24 hours a day, 7 days a week. 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.



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 1.2 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 or copayment 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 (CNs) (as identified in 1861(aa)(5) of the Act), and auxilliary 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. \$30 copayment for each Medicare-covered acupuncture for chronic low back pain visit from a specialist. 20% 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. Out-of-network \$30 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. \$40 copayment for each Medicare-covered acupuncture for chronic low back pain visit from a specialist. 40% 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 and Out-of-network \$300 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)
Ambulatory infusion suite (AIS) drug administration and nursing services An Ambulatory Infusion Suite (AIS) is an alternative care site to a home, physician office, or hospital setting, where patients can receive infusion therapy in a safe, monitored environment, and care is managed and performed by skilled nurses and clinical pharmacists following physician orders. Covered services include, but are not limited to: - Professional services, including nursing services, furnished in accordance with the plan of care - Supplies (for example, tubing and catheters) - Administration of Medicare Part B prescription drugs	In-Network 20% of the cost for professional services, including nursing services, and supplies furnished in the ambulatory infusion suite. Out-of-network 40% of the cost for professional services, including nursing services, and supplies furnished in the ambulatory infusion suite. For cost-sharing for certain drugs and biologicals that you can't give yourself, see <i>Medicare Part B drugs</i>. (1)

Covered Service	What you pay
 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 or copayment for the annual wellness visit.
 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 or copayment 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 or copayment for covered screening mammograms.

Covered Service	What you pay
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 \$30 copayment for each Medicare-covered cardiac rehabilitation service ordered by your physician. \$30 copayment for each Medicare-covered intensive cardiac rehabilitation service ordered by your physician. Out-of-network 40% of the cost for each Medicare-covered cardiac rehabilitation service ordered by your physician. 40% 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 or copayment for the intensive behavioral therapy cardiovascular disease preventive benefit.
 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 or copayment 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 or copayment for Medicare-covered preventive Pap and pelvic exams. There is no coinsurance or copayment for a Medicare-covered preventive HPV test.

Covered Service	What you pay
Chiropractic services Covered services include: Our plan only covers manual manipulation of the spine to correct subluxation	In-Network \$15 copayment for each visit for Medicare-covered services. Out-of-network 40% 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 <i>Physician/Practitioner services, including doctor's office visit</i>. Cost sharing for this service will vary depending on individual services provided under the course of treatment.
 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 year 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.	In-Network and Out-of-network \$0 copayment for each 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 copayment for each Medicare-covered colorectal cancer screening exam for your doctors' services. In a hospital outpatient setting, you also pay the hospital \$0 copayment for each Medicare-covered colorectal cancer screening exam. The Part B deductible doesn't apply.

Covered Service	What you pay
Colorectal cancer screening (continued) • 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.	
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 general, preventive dental benefits (such as cleaning) are not covered by our plan.	In-Network \$30 copayment for each visit for Medicare-covered dental benefits. Out-of-network 40% of the cost for each visit for Medicare-covered dental benefits.
 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 or copayment for an annual depression screening visit.

Covered Service	What you pay
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these 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 or copayment 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 You can also ask your pharmacist to tell you which brands and manufacturers we cover.	In-Network \$0 copayment for Medicare-covered blood glucose monitors, and other diabetes monitoring supplies. 20% of the cost for Medicare-covered therapeutic shoes or inserts. Out-of-network 40% of the cost for Medicare-covered blood glucose monitors, and other diabetes monitoring supplies. 40% of the cost for Medicare-covered therapeutic shoes or inserts. In-Network and Out-of-network There is no coinsurance or copayment for members eligible for the diabetes self-management training preventive benefit.

Covered Service	What you pay
Diabetes self-management training, diabetic services and supplies (continued) 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 <i>HMSA Akamai Advantage Prime MA</i> 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 10 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. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can 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.	In-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 <i>HMSA Akamai Advantage Prime MA</i> you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued)	<i>HMSA Akamai Advantage Prime MA</i> is 20% of the cost. Authorization rules may apply. (1) Out-of-network 40% of the cost for Medicare-covered durable medical equipment and related supplies. Your cost sharing for Medicare oxygen equipment coverage is 40% of the cost, every rental payment. Your cost sharing won't change after you're enrolled for 36 months. If prior to enrolling in <i>HMSA Akamai Advantage Prime MA</i> you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in <i>HMSA Akamai Advantage Prime MA</i> is 40% of the cost. For cost-sharing for home infusion therapy services (if billed separately), see <i>Home infusion therapy</i>.
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. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.	In-Network and Out-of-network \$115 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. For cost-sharing for additional services received at the emergency room, see the following: • Inpatient care that began in an emergency room admission, see <i>Inpatient hospital care</i>. • Physician services (if billed separately), see

Covered Service	What you pay
Emergency care (continued) For emergency services in a foreign country (Worldwide coverage*): - Physician services - Outpatient services - Room, board and ancillaries - Emergency transportation	<i>Physician/Practitioner services, including doctor's office visits.</i> - Services in an outpatient clinic, including same-day surgery, see <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers.</i> (1) - Laboratory tests, X-rays and other radiology services, and medical supplies such as splints and casts, see <i>Outpatient diagnostic tests and therapeutic services and supplies.</i> (1) - Certain drugs and biologicals that you can't give yourself, see <i>Medicare Part B drugs.</i> (1) In-Network and Out-of-network Worldwide coverage* 100% for any amounts above the plan's eligible charges for physician services. (2) 100% for any amounts above the plan's eligible charges for outpatient services. (2) 10% of the cost of the plan's eligible charge for hospital room, board and ancillaries. (2) 10% of the cost for emergency transportation. (2)
Hearing services Medicare-covered services include: 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. Supplemental covered services include: One routine hearing exam per calendar year	In-Network \$0 copayment for each Medicare-covered diagnostic hearing and balance exam. Out-of-network 40% of the cost for each Medicare-covered diagnostic hearing and balance exam. In-Network \$0 copayment for one routine hearing exam per calendar year.*

Covered Service	What you pay
Hearing services (continued) - Up to two hearing aids from the TruHearing Catalog every year (limit 1 hearing aid per ear). To use your benefit, you must call TruHearing at 1-855-739-4111 to schedule an appointment (for TTY, dial 711). Hearing aid purchase includes: - First year of follow-up provider visits 60 day trial period 3-year extended warranty 80 batteries per aid for non-rechargeable models (See Section 3.1 of this chapter for a list of exclusions)	\$0 copayment for first year of follow-up provider visits.* \$195 copayment per aid for Basic Aids* \$595 copayment per aid for Standard Aids* \$995 copayment per aid for Advanced Aids* \$1,395 copayment per aid for Premium Aids* Out-of-Network 40% of the cost for one routine hearing exam per calendar year.* 40% of the cost for first year of follow-up provider visits.* 40% of the cost per aid up to the maximum allowable charge of \$1,850 per aid, plus the difference between the actual hearing aid cost and the maximum allowable charge, if any.* When using an out-of-network provider you are responsible for submitting a claim. For additional information, see Chapter 5. For a definition of “TruHearing Providers,” see Chapter 10.

Covered Service	What you pay
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 or copayment 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 or copayment for members eligible for Medicare-covered preventive HIV screening.
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 40% of the cost for Medicare-covered home health agency services.

Covered Service	What you pay
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 our 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 \$30 copayment for Medicare-covered home infusion therapy services furnished by a qualified home infusion therapy supplier if billed separately. Out-of-network 40% 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 <i>Durable medical equipment (DME) and related supplies</i>. For cost-sharing for Medicare Part B prescription drugs (if billed separately), see <i>Medicare Part B drugs</i>.
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 may 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.	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 <i>HMSA Akamai Advantage Prime MA</i>. For cost-sharing for hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit, see <i>Physician/Practitioner services, including doctor's office visits</i>.

Covered Service	What you pay
Hospice care (continued) 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 the cost-sharing under Original Medicare For services covered by <i>HMSA Akamai Advantage Prime MA</i> but are not covered by Medicare Part A or B: <i>HMSA Akamai Advantage Prime MA</i> 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. 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.	

Covered Service	What you pay
 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 (or vaccines) 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	In-Network and Out-of-network There is no coinsurance or copayment 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 <i>Medicare Part B drugs</i> . (1)
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. • The plan covers unlimited additional hospital 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 1-5: \$350 copayment per day Days 6-30: \$50 copayment per day Days 31-90: \$0 copayment per day \$0 copayment per Lifetime Reserve Day. \$0 copayment for additional hospital days.* (2) 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: Days 1-11: \$375 copayment per day Days 12-90: \$0 copayment per day \$0 copayment per Lifetime Reserve Day. \$0 copayment for additional hospital days.* (2) In-Network and Out-of-network No limit to the number of days covered by the plan for each Medicare-covered inpatient hospital stay. Per day copayments are applied per hospital 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 will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are 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 <i>HMSA Akamai Advantage Prime MA</i> provides transplant services at a location outside the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will 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 begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. - 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 are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called <i>Medicare Hospital Benefits</i>. This fact sheet is available on the Web at https://es.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. You can call these numbers for free, 24 hours a day, 7 days a week.	If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would 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 does not apply to mental health care services provided in a psychiatric unit of a general hospital.	In-Network For Medicare-covered hospital stays: Days 1-5: \$350 copayment per day Days 6-90: \$0 copayment per day \$0 copayment per Lifetime Reserve Day. Authorization rules may apply. (1) Out-of-network For Medicare-covered hospital stays: Days 1-11: \$375 copayment per day Days 12-90: \$0 copayment per day \$0 copayment per Lifetime Reserve Day. In-Network and Out-of-network After you exhaust your Medicare 190-day lifetime limit, for coverage of all other inpatient services, see <i>Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay</i>. Per day copayments are applied per hospital 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 • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations	For cost-sharing for physician services, see <i>Physician/Practitioner services, including doctor's office visits</i>. 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 <i>Outpatient diagnostic tests and therapeutic services and supplies</i>. (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

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay (continued) - 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	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 <i>Prosthetic devices and related supplies</i>. (1) For cost-sharing for physical therapy, speech therapy, and occupational therapy, see <i>Outpatient rehabilitation services</i>. (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 or copayment for members eligible for Medicare-covered medical nutrition therapy services.
 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 or copayment for the MDPP benefit.

Covered Service	What you pay
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 or) 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. • 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 • 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. • 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	In-Network Up to 20% of the cost 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 40% 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 <i>Home infusion therapy</i>. For cost-sharing for ambulatory infusion suite services (if billed separately), see <i>Ambulatory infusion suite (AIS) drug administration and nursing services</i>. You may pay a lower coinsurance for rebatable drugs. For a definition of "rebatable drugs," see Chapter 10 of this document.

Covered Service	What you pay
Medicare Part B drugs (continued) • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv, 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) The following 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 vaccines under our Part B drug benefit.	
 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 or copayment 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)

Covered Service	What you pay
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 \$30 copayment for Medicare-approved Opioid Treatment Program services. Out-of-network 40% 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: • 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 ○ Advanced Imaging tests. Advanced imaging studies include MRI, MRA, CT, PET and nuclear cardiology services ○ 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	In-Network \$30 copayment for Medicare-covered X-rays. \$100 copayment for Advanced Imaging tests. (1) 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays or Advanced Imaging). \$30 copayment for Medicare-covered radiation therapy services. (1) \$30 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. \$30 copayment for other Medicare-covered diagnostic tests, therapeutic services and supplies. (1) Authorization rules may apply. (1) Out-of-network 40% of the cost for Medicare-covered X-rays.

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued)	40% of the cost for Advanced Imaging tests. 40% of the cost for Medicare-covered diagnostic radiology services (not including X-rays or Advanced Imaging). 40% of the cost for Medicare-covered radiation therapy services. 40% of the cost for Medicare-covered surgical supplies such as dressings, and splints, casts and other devices used to reduce fractures and dislocations. 40% of the cost for Medicare-covered lab services. \$0 copayment for Medicare-covered blood. 40% of the cost for other Medicare-covered diagnostic tests, therapeutic services and supplies.
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 people 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 <i>Medicare Hospital Benefits</i>. 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 \$100 copayment for Medicare-covered observation care. Out-of-network 40% of the cost for Medicare-covered observation care.

Covered Service	What you pay
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 that 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 aren't sure if you're an outpatient, you should ask the hospital staff.	In-Network and Out-of-network For cost-sharing for services in an emergency department, see <i>Emergency care</i>. For cost-sharing for services in an outpatient clinic, including same-day surgery, see <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i>. (1) For cost-sharing for outpatient hospital observation services, see <i>Outpatient Hospital Observation</i>. For cost-sharing for laboratory tests, X-rays and other radiology services, and medical supplies such as splints and casts, see <i>Outpatient diagnostic tests and therapeutic services and supplies</i>. (1) For cost-sharing for mental health care, see <i>Outpatient mental health care</i>. For cost-sharing for partial hospitalization services, see <i>Partial hospitalization services and Intensive outpatient services</i>. 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 <i>Medicare Part B drugs</i>. (1)

Covered Service	What you pay
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 \$30 copayment for each Medicare-covered individual or group therapy visit. Out-of-network 40% 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 \$30 copayment for each Medicare-covered physical and/or speech and language therapy visit ordered by your physician. \$30 copayment for each Medicare-covered occupational therapy visit ordered by your physician. Authorization rules may apply. (1) Out-of-network 40% of the cost for each Medicare-covered physical and/or speech and language therapy visit ordered by your physician. 40% of the cost for each Medicare-covered occupational therapy visit ordered by your physician.
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 \$30 copayment for each Medicare-covered individual or group visit. Out-of-network 40% of the cost for each Medicare-covered individual or group visit.

Covered Service	What you pay
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 20% of the cost for each Medicare-covered visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic. Authorization rules may apply. (1) Out-of-network 40% 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 <i>Physician/Practitioner services, including doctor's office visits</i>. For cost-sharing for other outpatient hospital services (if billed separately), see <i>Outpatient hospital services</i>.
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 \$30 copayment for Medicare-covered partial hospitalization program services. \$30 copayment for Medicare-covered intensive outpatient program services. Out-of-network 40% of the cost for Medicare-covered partial hospitalization program services. 40% of the cost for Medicare-covered intensive outpatient program services.

Covered Service	What you pay
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 - 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 - 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 locations 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: - You have an in-person visit within 6 months prior to your first telehealth visit - You have an in-person visit every 12 months while receiving these telehealth services - 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	(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. \$30 copayment for each specialist visit for Medicare-covered benefits. \$0 copayment for certain telehealth services from eligible network providers. For a list of primary care providers, please refer to the <i>Provider Directory</i>. Out-of-network \$30 copayment for each primary care provider visit for Medicare-covered benefits. \$30 copayment for each visit with an advanced practice registered nurse, nurse practitioner, or physician assistant for Medicare-covered benefits. \$40 copayment for each specialist visit for Medicare-covered benefits. In-Network and Out-of-network For cost-sharing for hearing and balance exams, see <i>Hearing services</i>. For cost-sharing for non-routine dental care covered by Medicare, see <i>Dental services</i>.

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits (continued) • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: ○ You're not a new patient and ○ The evaluation isn't related to an office visit in the past 7 days and ○ 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 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)	
 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. A one-time hepatitis B virus screening.	In-Network and Out-of-network There is no coinsurance or copayment for the PrEP benefit.

Covered Service	What you pay
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 \$30 copayment for each visit for Medicare-covered services. Out-of-network 40% of the cost for each visit for Medicare-covered services.
 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 and Out-of-network There is no coinsurance or copayment for an annual PSA test. \$0 copayment for an annual digital rectal exam.
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 aren't 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 <i>Vision Care</i> later in this table for more detail.	In-Network 20% of the cost for Medicare-covered prosthetic devices and related supplies. Authorization rules may apply. (1) Out-of-network 40% 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 \$15 copayment for each Medicare-covered pulmonary rehabilitation service ordered by your physician. Authorization rules may apply. (1) Out-of-network 40% 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 or copayment 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. <i>For LDCT lung cancer screenings after the initial LDCT screening:</i> 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 or copayment for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Covered Service	What you pay
 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. 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've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	In-Network and Out-of-network There is no coinsurance, copayment, deductible for the Medicaid-covered screening for the Hepatitis C Virus.
 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 individual 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 or copayment 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)	In-Network and Out-of-network 20% of the cost 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.

Covered Service	What you pay
Services to treat kidney disease (continued) • 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 • 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.	\$0 copayment for Medicare-covered inpatient dialysis. For cost-sharing for physician services (if billed separately), see <i>Physician/Practitioner services, including doctor's office visits</i>.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 10. 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 1-20: \$10 copayment per day Days 21-40: \$210 copayment per day Days 41-100: \$0 copayment per day Authorization rules may apply. (1) Out-of-network For Medicare-covered SNF stays: Days 1-30: \$210 copayment per day Days 31-100: \$0 copayment per day In-Network and Out-of-network After you exhaust your Medicare SNF benefit, for coverage of other inpatient services, see <i>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</i>. 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 definition of a <i>Benefit Period</i> in Chapter 10.

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	
 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 this 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 or copayment for the Medicare-covered smoking and tobacco use cessation preventive benefits.
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 • 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	In-Network \$20 copayment for each Medicare-covered SET for PAD service ordered by your physician. Out-of-network 40% 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) 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 <i>Hospice care</i>.)	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.	In-Network and Out-of-network \$30 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 <i>In-Network Physician/Practitioner services, including doctor's office visits</i>.

Covered Service	What you pay
Urgently needed services (continued) For emergency services or urgently needed care (not scheduled or elective care) in a foreign country (Worldwide coverage*): • Physician services • Outpatient services • Room, board, and ancillaries • Emergency transportation	Worldwide coverage* 100% for amounts above the plan's eligible charges for physician services. (2) 100% for any amounts above the plan's eligible charges for outpatient services. (2) 10% of the cost of the plan's eligible charge for hospital room, board and ancillaries. (2) 10% of the cost for emergency transportation. (2)
 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 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 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. Out-of-network 40% of the cost for Medicare-covered eye exams to diagnose and treat diseases and injuries of the eye. In-Network and Out-of-network \$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. See Chapter 10 for a definition of <i>Medicare-approved provider</i>. If you receive consultation, diagnosis, or treatment by a specialist, see <i>Physician/Practitioner services, including doctor's office visits</i> for cost-sharing.

Covered Service	What you pay
Vision care (continued) 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* • International travel solution: We cover the following services when you travel abroad*: ○ Receive a temporary pair of glasses in case of an emergency  Vision care ○ Get help to find an eye doctor (Out-of-network benefits apply) (See Section 3.1 of this chapter for a list of exclusions)	In-Network \$0 copayment for one routine eye exam every calendar year.* \$0 copayment for one refraction eye exam every calendar year.* Out-of-network 40% of the cost for one routine eye exam every calendar year.* 40% 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 <i>Welcome to Medicare</i> 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 <i>Welcome to Medicare</i> 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 <i>Welcome to Medicare</i> preventive visit.	In-Network and Out-of-network There is no coinsurance or copayment for the <i>Welcome to Medicare</i> preventive visit or EKG service performed as a screening as part of the <i>Welcome to Medicare</i> 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. 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 2.2 Get care using our plan’s optional visitor/traveler benefit

If you don’t permanently move, but are continuously away from our plan’s service area for more than 6 months, we usually must disenroll you from our plan. However, we offer a visitor/traveler program, that will allow you to stay enrolled when you’re outside of our service area for less than 12 months. Under our visitor/traveler program you can get all plan covered services at in-network cost sharing. Contact our plan for help locating a provider when using the visitor/traveler benefit.

If you are in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you don’t return to our plan’s service area within 12 months, you’ll be disenrolled from our plan.

The visitor/traveler program includes Blue Medicare Advantage PPO network coverage of all Part A, Part B and supplemental benefits offered by your plan outside your service area in 47 states, the District of Columbia, and 1 territory: Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, West Virginia, and Wyoming. For some of the states listed, MA PPO networks are only available in portions of the state.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

(This list is current as of August 2025 and may change. For an updated list of states and to learn more, visit www.hmsa.com/health-plans/medicare/travel-program/.)

To locate a Blue Medicare Advantage PPO provider, you may call 1-800-810-BLUE or our Customer Relations department (phone numbers are on the back cover of this document). You may also visit www.hmsa.com/advantage or <https://provider.bcbs.com> to find a Blue Medicare Advantage PPO provider.

When you see Blue Medicare Advantage PPO providers in any geographic area where the visitor/traveler program is offered, you will pay the same cost sharing level (in-network cost sharing) you would pay if you received covered benefits from in-network providers in their service area. Please see the Medicare Benefits Chart for cost sharing information.

Your Liability Calculation

When you receive Covered Services outside of our service area from a Medicare Advantage PPO network provider, the cost of the service, on which your liability (copayment/coinsurance) is based, will be either:

- The Medicare allowable amount for covered services, or
- The amount the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

Nonparticipating Healthcare Providers Outside Our Service Area

When Covered Services are provided outside of our service area by nonparticipating healthcare providers, the amount(s) you pay for such services will be based on either Medicare's limiting charge where applicable or the provider's billed charge. Payments for out-of-network emergency services will be governed by applicable federal and state law.

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

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 won't 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 7, Section 5.3)

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

Services not covered by Medicare	Covered only under specific conditions
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
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	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
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 <i>Vision care</i> 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 safety goggles; 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)
Routine hearing exams, hearing aids, or exams to fit hearing aids	Routine hearing exam and hearing aids are covered as a supplemental benefit. See <i>Hearing services</i> for more information about the services we cover. In-Network providers shall be limited to TruHearing Providers. For a definition of “TruHearing Providers,” see Chapter 10 of this document. No payment will be made for hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), over-the-counter (OTC) hearing aids, ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:

Asking us to pay our share of a bill for covered medical services

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

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can 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 covered by our plan. There may be deadlines that you must meet to get paid back. Go to see Section 2 of this chapter.

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 medical care from a provider who's not in our plan's network

When you get care from a provider who isn't part of our network, you're only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill our plan for our share of the cost.

- Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
 - If the provider is owed anything, we'll pay the provider directly.
 - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
- 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 can't pay a provider who isn't eligible to participate in Medicare. If the provider isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get.

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

Network providers should always bill our plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, 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 and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

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 after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

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 our share of the cost for the service. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or 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 have made. It's a good idea to make a copy of your bill and receipts for your records.

For Part C medical claims, routine hearing items and services, (not including routine vision items and services), 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)

Chapter 5 Asking us to pay our share of a bill for covered medical services

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 got 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 visit www.hmsa.com, select My Account, then select Claims, to submit a claim form. You can also call Customer Relations and ask for the claim form for routine vision.

Mail your request for payment together with any bills or paid 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 got 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 is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be 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 already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. 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 that we won't pay for all or part of the medical care, 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 7.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are 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 7 of this document.

CHAPTER 6:

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, 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 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's 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 our 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 can 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.

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

You have the right to choose a provider in our plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 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 have 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're 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're required to give Medicare your health information. 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 by 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, please call Customer Relations at 1-800-660-4672 (TTY users call 711).

For more information about our plan's privacy practices, go to Chapter 9.

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 Prime MA*, you have the right to get several kinds of information from us.

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 our plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers 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.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service drug isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know 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.
- **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. If you refuse treatment, 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 have 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 didn't 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) 5874272 Hawaii (Hilo): (808) 9338846 Hawaii (Kona): (808) 3279590 Kauai: (808) 2413300 Maui: (808) 2435808

Method	Advance Directive Complaints about Doctors – Contact Information
	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) 6927420 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) 6927447
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 have made**

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 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 users call 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 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** 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: <https://www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf>.)
 - 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.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, 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 your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**

Chapter 6 Your rights and responsibilities

- 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 Part B premiums to stay a member of our plan.
 - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **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 stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:

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 2 types of processes for handling problems and concerns:

- 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 complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to 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 is not 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).

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

Medicare

You can also contact Medicare for help. To Contact Medicare:

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

SECTION 3 Which process to use for your problem

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 they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 9. How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 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 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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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 that's 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 5.4** of this chapter for more information about Level 2 appeals for medical care.

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 4.1 Get help when 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 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 or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

- **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/forms/medicare-appoint-representative/.) This form gives that person permission to act on your behalf. It must be signed by you and by 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 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 4.2 Rules and deadlines for your different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each one of these situations in this chapter:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 7:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Customer Relations at 1-800-660-4672 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 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 ask 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 you're in any of the 5 following situations:

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1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
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 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7. Special rules apply to these types of care.

Section 5.2 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 an **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, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only* ask for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- 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 regain 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.

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- o 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 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*. 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 9 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 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*. (Go to Section 9 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.

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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 5.2 of this chapter.

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 copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We're allowed to charge a fee for copying and sending this information to you.

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

- When our plan is 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 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 if your request is for a Part B drug.
 - If we don't 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 5.4 explains the Level 2 appeal process.

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- **If our answer is yes to part or all of what you 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. (Go to Section 9 of this chapter for more information about complaints.)
 - 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 5.4 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 if your request is for a medical item or service, 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**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

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Legal Terms:

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's not 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: 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 copy of your case file**. We're 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.
- Reviewers at the independent review organization will take a careful look at all of the information about 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 get your appeal.
- However, 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 says 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

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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 this organization says no to part or all of your appeal**, it means they agree with us 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.

Step 3: 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 to a Level 3 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 8 tells more about Level 3, 4, and 5 of the appeals process.

Section 5.5 If you're asking us to pay you for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

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 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 you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't 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 in Section 5.3. For appeals concerning reimbursement, note:

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- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast 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 to the provider within 60 calendar days.

SECTION 6 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 6.1 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 quality of your hospital care.
- Your right to **request 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.

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- 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 notice online at <https://www.cms.gov/Medicare/forms-notice/beneficiary-notice-initiative/ffs-ma-im>.

Section 6.2 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 at any time, please call Customer Relations at 1-800-660-4672 (TTY users call 711). Or call your State Health Insurance Assistance Program, (SHIP) for personalized help. Hawai'i 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 experts 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.

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- o **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 contacted, we'll 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.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the 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 6.3 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 the information about 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 it's 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.

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- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 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's time to stop covering any of these 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 7.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal**. Asking for 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 7.2 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

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(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 wish to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Terms

Detailed Explanation of Non-Coverage. Notice that provides 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.
- 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 tell 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.

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Step 3: Within one full day after they have all the information they need, the reviewers will tell you their 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's 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 7.3 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 could 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 about 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.

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- 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 we 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, you'll 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 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 8 talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Levels 3, 4, and 5

Section 8.1 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 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 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 days after we get the 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.

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- o 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.
 - o 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.
 - o 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.**
 - o If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - o 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 Court** 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.

Making complaints

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 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.

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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, or other health professionals? Or by our Customer Relations or other staff at our plan? - Examples include waiting too long on the phone, in the waiting or exam room.
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 related to the <i>timeliness</i> 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 <i>fast coverage decision</i> or a <i>fast appeal</i>, 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 9.2**How to make a complaint****Legal Terms:**

- A **complaint** is also called a **grievance**.
- Making a complaint** is also called **filing a grievance**.
- Using the process for complaints** is called **using the process for filing a grievance**.
- A fast complaint is also called an expedited grievance.

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll 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.

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

- **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 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.**
 - o 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 9.4 You can also tell Medicare about your complaint

You can submit a complaint about *HMSA Akamai Advantage Prime MA* directly to Medicare. To submit a complaint to Medicare, go to <https://www.medicare.gov/my/medicare-complaint>. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8: Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in *HMSA Akamai Advantage Prime MA* may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're 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 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 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,
 - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 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 Enrollment 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 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 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of *HMSA Akamai Advantage Prime MA* may be eligible to end their 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 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.

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.
- Original Medicare *without* a separate Medicare drug plan.

Your membership will usually end on the first day of the month after we get your request to change our plan.

Section 2.4 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 <i>HMSA Akamai Advantage Prime MA</i> when your new plan's coverage starts.
• Original Medicare <i>with</i> a separate Medicare drug plan.	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from <i>HMSA Akamai Advantage Prime MA</i> when your new drug plan's coverage starts.
• Original Medicare <i>without</i> a separate Medicare drug plan.	• Send us a written request to disenroll. Contact Customer Relations at 1-800-660-4672 (TTY users call 711) if you need more information on how to do this. • You can 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 <i>HMSA Akamai Advantage Prime MA</i> when your coverage in Original Medicare starts.

Note: If you also have creditable drug coverage (e.g., a separate Medicare drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical items, and services through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services and through our plan.

- **Continue to use our network providers to get medical care.**
- **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 Prime MA* must end your plan membership in certain situations

HMSA Akamai Advantage Prime MA must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- 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 intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't 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 can't 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 plan premiums for two calendar months
 - We must notify you in writing that you have two calendar months to pay our 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 Prime MA 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 9: 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, age, 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 us at Customer Relations at 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 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 www.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 Prime MA*, 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 10: 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 payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of *HMSA Akamai Advantage Prime MA*, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost-sharing our plan says you must pay.

Benefit Period – The way that 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 gotten 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.

Billed Charge – This is the dollar amount that a provider charged for a service as shown on each service line of your Explanation of Benefits.

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.

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. Go to Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount.

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. 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 are gotten. (This is in addition to our plan’s monthly premium.) Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any fixed copayment amount that a plan requires when a specific service is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service that a plan requires when a specific service is gotten.

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 is 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.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

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 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 is 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 is 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.

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.

Grievance – A type of complaint you make about our plan, or providers, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

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've 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.

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.

In-Network Maximum Out-of-Pocket Amount – The most you'll pay for covered Part A and Part B services gotten from network (preferred) providers. After you have reached this limit, you won't have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

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.

Low Income Subsidy (LIS) – Go to Extra Help.

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 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 their 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 Allowable Amount (Medicare Approved Amount) – In Original Medicare, this is the amount a doctor or supplier who accepts Medicare assignment can be paid. It may be less than the actual amount a doctor or supplier charges.

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 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 Limiting Charge – In the Original Medicare plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15 percent over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Medicare Prescription 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.

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 is not 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 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.

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.

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 such as 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 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 gotten is also referred to as the member's out-of-pocket cost requirement.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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 gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-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 based on specific criteria. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but aren't 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.

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.

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.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

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 Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you're getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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.

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.

TruHearing Providers – Providers who are within TruHearing's network of providers. TruHearing providers may be contacted via TruHearing's call center at 1-855-739-4111. (For TTY, dial 711.)

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)



An Independent Licensee of the Blue Cross and Blue Shield Association

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 kanimong 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信息，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

ເລິ່ນຊາບ: ຖ້າທ່ານບໍ່ເວົ້າພາສາອັງກິດແມ່ນມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍພ້ອມໃຫ້ທ່ານ. ນອກຈາກນັ້ນກໍ່ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມເພື່ອໃຫ້ຂໍ້ມູນແກ່ທ່ານໃນຮູບແບບທີ່ເຂົາເຈົ້າໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ສະມາຊິກ QUEST ແມ່ນໂທບໍລິການໄດ້ທີ 1 (800) 440-0640, TTY 1 (877) 447-5990 ຫຼື ປຶກສາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. ສະມາຊິກແຜນປະກັນ Medicare Advantage ແລະ ຊັ້ນທຸລະກິດ, ໂທ 1 (800) 776-4672 ຫຼື TDD/TTY 1 (877) 447-5990.

Kajin Majōl

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-lgilisi, 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 inisiaua 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 โปรดโทรไปที่หมายเลขโทรศัพท์ที่หมายเลข 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 daily, 8 a.m.–8 p.m. 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 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	hawaiiiship.org

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