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What You Should Know about this Guide to Benefits

The Trust Fund has contracted with us to administer a health benefits plan (Plan) as described in this Guide to Benefits.* The type of health care coverage provided by this Plan is called a Comprehensive Medical plan. If you enroll in our Comprehensive Medical plan this means you have medical benefits for your health care needs including office visits, inpatient facility services, outpatient facility services, and other provider services. This coverage offers you flexibility in the way you get medical benefits. Your opportunity to take an active role in your health care decisions makes this coverage special. In general, to get the lowest out-of-pocket costs possible, you should seek services from HMSA Participating Providers.

To keep pace with change, HMSA’s New Technology Assessment Committee uses scientific evidence to evaluate new developments in technology and new applications of existing technologies. The Committee’s recommendations are a critical factor in our decisions to cover new technologies and applications. HMSA’s Pharmacy and Therapeutics Advisory Committee, composed of practicing physicians and pharmacists from the community, meet quarterly to assess drugs, including new drugs, for inclusion in HMSA’s plans. Drugs that meet the Committee’s standards for safety, efficacy, ease of use, and value are included in various plan formularies. For more details on coverage under this plan, see Chapter 4: Description of Benefits and Chapter 6: Services Not Covered.

*EUTF Administrative Rules

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

Terminology

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

The term Provider means an approved physician or other practitioner who provides you with health care services. Your provider may also be the place where you get services, such as a hospital or extended care facility. Also, your provider may be a supplier of health care products, such as a home or durable medical equipment supplier.
## Definitions
Throughout this Guide, terms appear in **Bold Italics** the first time they are defined. Terms are also defined in Chapter 11: Glossary.

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

### Summary of Provider Categories
This chart shows how the various provider categories impact your benefits.

<table>
<thead>
<tr>
<th></th>
<th>Provider Category</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>HMSA Participating Provider</td>
</tr>
<tr>
<td>Does your provider contract with HMSA?</td>
<td>Yes</td>
</tr>
<tr>
<td>Does your provider always file claims for you?</td>
<td>Yes</td>
</tr>
<tr>
<td>Does your provider accept eligible charge as payment in full? If so, you do not pay for any difference between actual charge and eligible charge.</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you pay copayments to the provider? If so, we send benefit payment directly to the provider.</td>
<td>Yes</td>
</tr>
<tr>
<td>Does your provider get precertification approvals for you?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Chapter 1: Important Information

Care While You are Away from Home

Medical Care Outside of Hawaii (BlueCard® Program)

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Participating Medical Providers

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

When you receive covered medical services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered medical services is calculated based on the lower of:

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

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

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

Inter-Plan Programs: Federal/State Taxes/ Surcharges/Fees

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

Nonparticipating Providers Outside Hawaii

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

In certain situations, we may use other payment methods, such as billed covered charges, the payment we would make if the covered medical services had been obtained within our service area, or a special negotiated payment, to determine
Chapter 1: Important Information

the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered services as set forth in this paragraph.

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

Blue Cross Blue Shield Global Core

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

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

Finding BlueCard Participating Providers

The Host Blue in the area where you need services can provide you with information on participating providers in the area. You can also visit the BlueCard Doctor and Hospital Finder web site (www.BCBS.com) or call 1-800-810-BLUE (2583).

Carry Your Member Card

Always carry your HMSA Member Card. Your member card ensures that you get all the conveniences you’re used to when you get medical services at home in Hawaii. The card tells participating providers which independent Blue Plan you belong to. It also includes information the provider needs to file your claim for you.

Questions We Ask When You Receive Care

Is the Care Covered?

To get benefits, the care you get must be a covered treatment, service, or supply. See Chapter 4: Description of Benefits for a listing of covered treatments, services and supplies.
Chapter 1: Important Information

Does the Care Meet Payment Determination Criteria?

All care you get must meet all of the following Payment Determination Criteria:

- For the purpose of treating a medical condition.
- The most appropriate delivery or level of service, considering potential benefits and harms to the patient.
- Known to be effective in improving health outcomes; provided that:
  - Effectiveness is determined first by scientific evidence;
  - If no scientific evidence exists, then by professional standards of care; and
  - If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and
- Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

Services that are not known to be effective in improving health outcomes include, but are not limited to, services that are experimental or investigational.

The terms in bold italics above are defined in the glossary.

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

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

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

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

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

Is the Care Consistent with HMSA's Medical Policies?

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

From What Provider Category Did You Receive Care?

Your benefits may be different depending on the category of provider that you get care from. In general, you will get the maximum benefits possible when you get services from an HMSA participating provider.

When you see a nonparticipating provider you will owe any copayment that applies to the service plus the difference between HMSA's eligible charge and the provider's actual charge. Also, nonparticipating providers have not agreed to HMSA's payment policies and can bill you for services or other charges that HMSA does not cover. Participating providers have agreed not to charge you for these services. These amounts will be included in the nonparticipating provider's actual charge.

For more details on provider categories see the sections Summary of Provider Categories and Care While You are Away from Home earlier in this chapter.

Please note: Your participating provider may refer services to a nonparticipating provider and you may incur a greater out-of-pocket expense.
Chapter 1: Important Information

For example, your participating provider may send a blood sample to a nonparticipating lab to analyze. Or, your participating provider may send you to a nonparticipating specialist for added care.

You are encouraged to work with your provider to find suitable specialty care from a participating provider. If no option is available, you may request to have specialty care received from a nonparticipating provider covered at the participating provider benefit level but only in accord with Hawaii law and if all of the following criteria are met:

- You are diagnosed with a condition or disease requiring specialty care.
- A participating provider who can provide the health care services for your condition or disease is either:
  - not available or
  - access to a participating provider requires unreasonable travel or delay.
- Benefits are limited to services received within the State of Hawaii, unless specialty care is not available in the State.
- Services must be approved by HMSA prior to receiving the services. See Chapter 5: Precertification. Without prior approval, covered services will be subject to the nonparticipating provider benefit level.

If you need more details, call us at one of phone numbers listed on the back cover of this Guide.

<table>
<thead>
<tr>
<th>Is the Service or Supply Subject to a Benefit Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Maximum is the maximum benefit amount allowed for a covered service or supply. A coverage maximum may limit the duration or the number of visits. For details about benefit maximums, read Chapter 2: Payment Information and Chapter 4: Description of Benefits.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the Service or Supply Subject to Precertification?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certain services require our prior approval. HMSA participating providers get approval for you, but other providers may not. If you get services from a BlueCard or nonparticipating provider and approval for certain services is not obtained, benefits may be denied. In some cases, benefits are denied entirely. For services subject to approval, read Chapter 5: Precertification.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did You Receive Care from a Provider Recognized by Us?</th>
</tr>
</thead>
<tbody>
<tr>
<td>To determine if a provider is recognized, we look at many factors including licensure, professional history, and type of practice. All participating providers and some nonparticipating providers are recognized. To find out if your physician is a participating provider, refer to your HMSA Directory of Participating Providers. If you need a copy, call us and we will send one to you or visit <a href="http://www.hmsa.com">www.hmsa.com</a>. To find out if a nonparticipating provider is recognized, call us at one of the phone numbers on the back cover of this Guide.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did a Recognized Provider Order the Care?</th>
</tr>
</thead>
<tbody>
<tr>
<td>All covered treatment, services, and supplies must be ordered by a recognized provider practicing within the scope of his or her license.</td>
</tr>
</tbody>
</table>

What You Can Do to Maintain Good Health

Practice Good Health Habits

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

Be a Wise Consumer

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

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

You may get copies of your Report to Member online through My Account on hmsa.com or by mail upon request.
Chapter 1: Important Information

Interpreting this Guide

Our Rights to Interpret this Document

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

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

Our determinations and interpretations, and our decisions on these matters are subject to review by the Trust Fund. If you do not agree with our interpretation or determination, you may appeal to the Trust Fund after you have exhausted our appeal procedures. See Chapter 8: Dispute Resolution.

No oral statement of any person shall modify or otherwise affect the benefits, limits and exclusions of this Guide to Benefits, convey or void any coverage, or increase or reduce any benefits under this Plan.
Chapter 2: Payment Information

Eligible Charge

For most medical services, except for emergency and air ambulance services provided by nonparticipating providers, and certain services provided by nonparticipating providers in participating facilities, the Eligible Charge is the lower of either the provider's actual charge or the amount we establish as the maximum allowable fee. HMSA’s payment, and your copayment, are based on the eligible charge. Exceptions: For services from participating facilities, HMSA’s payment is based on the maximum allowable fee and your copayment is based on the lower of the actual charge or the maximum allowable fee. Some services may be rendered by providers who accept monthly payments from HMSA to manage the care of a certain population of their patients.

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

Participating providers agree to accept HMSA’s payment plus your copayment as payment in full for covered services. Nonparticipating providers generally do not. If you get services from a nonparticipating provider, you are responsible for a copayment plus any difference between the actual charge and the eligible charge.

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

Please note: Eligible charge does not include excise or other tax. You are responsible for all taxes related to the medical care you receive. If your provider accepts monthly payments to manage your care, you may owe tax on your copayment.

Copayment

A copayment applies to most covered services. It is either a fixed percentage of the eligible charge or a fixed dollar amount. Exception: For services provided at a participating facility, your copayment is based on the lower of the facility’s actual charge or the maximum allowable fee. You owe a copayment even if the facility’s actual charge is less than the maximum allowable fee.
Chapter 2: Payment Information

**Please note:** If you get services from a nonparticipating or noncontracting provider, you are responsible for the copayment plus any difference between the actual charge and the eligible charge.

**Amount**

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

**Examples**

Here are two examples of how the copayment works.

Let's say you have a sore throat and go to a participating physician to have it checked.

- The physician's bill or actual charge = $125.
- HMSA’s eligible charge = $60.
- Your copayment = $12 (20% of $60).

If you go to a nonparticipating physician, your out of pocket will be higher.

- The physician’s bill or actual charge = $125.
- HMSA’s eligible charge = $60.
- Your copayment = $12 (20% of $60).
- The difference between the actual charge and the eligible charge = $65.
- You owe $77 (your copayment plus the difference between the actual charge and the eligible charge).

### Annual Copayment Maximum

**Definition**

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

**Amount**

- $2,500 per person
- $5,000 (maximum) per family

**When You Pay More**

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

- Payments for services subject to a maximum once you reach the maximum. See Benefit Maximum later in this chapter.
- The difference between the actual charge and the eligible charge that you pay when you get services from a nonparticipating provider.
- Payments for noncovered services.
- Any amounts you owe in addition to your copayment for covered services.

### Maximum Allowable Fee

**Definition**

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

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

- For most services, supplies, or procedures, we consider:
  - Increases in the cost of medical and non-medical services in Hawaii over the last year.
  - The relative difficulty of the service compared to other services.
  - Changes in technology.
  - Payment for the service under federal, state, and other private insurance programs.
- For some facility-billed services, we use a per case, per treatment, or per day fee (per diem) rather than an itemized amount (fee for service). This does not include practitioner-billed facility services. For nonparticipating hospitals, our maximum allowable fee for all-inclusive daily rates established by the hospital will never exceed more than if the hospital had charged separately for services.
Chapter 2: Payment Information

• For services billed by BlueCard participating providers outside of Hawaii, we use the lower of the provider’s actual charge or the negotiated price passed on to us by the on-site Blue Cross and/or Blue Shield Plan. For more details on HMSA’s payment practices under the BlueCard Program, see Care While You are Away from Home in Chapter 1: Important Information.

<table>
<thead>
<tr>
<th>Benefit Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
</tr>
<tr>
<td>A <strong>Benefit Maximum</strong> is a limit that applies to a specified covered service or supply. A service or supply may be limited by duration or number of visits. The maximum may apply per service or calendar year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where to Look for Limitations</th>
</tr>
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<tbody>
<tr>
<td>See Chapter 4: Description of Benefits.</td>
</tr>
</tbody>
</table>
Chapter 3: Summary of Benefits and Your Payment Obligations

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Benefit and Payment Chart

About this Chart

This benefit and payment chart:
- Is a summary of covered services and supplies. It is not a complete description of benefits. For coverage criteria, other limitations of covered services, and excluded services, be sure to read Chapter 1: Important Information, Chapter 4: Description of Benefits, and Chapter 6: Services Not Covered.
- Gives you the page number where you can find more details about the service or supply.
- Tells you what the copayment percentage or fixed dollar amount is for covered services and supplies.

Please note: Special limits may apply to a service or supply listed in this benefit and payment chart. Please read the benefit details on the page referenced.

* = An asterisk next to a service or supply means either:
- A service dollar maximum may apply.
- You may owe amounts in addition to your copayment.

Please read the benefit details on the page referenced.
## Chapter 3: Summary of Benefits and Your Payment Obligations

* = see page 13

<table>
<thead>
<tr>
<th>Hospital and Facility Services</th>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgical Center (ASC)</td>
<td>22 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)</td>
<td>22 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Hospital Ancillary Services</td>
<td>22 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Hospital Room and Board</td>
<td>23 20%*</td>
<td>20%*</td>
</tr>
<tr>
<td>Intensive Care Unit/Coronary Care Unit</td>
<td>23 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Intermediate Care Unit</td>
<td>23 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Isolation Care Unit</td>
<td>23 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Operating Room</td>
<td>23 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>23 20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Services</th>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>24 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Emergency Services - All Other Services and Supplies</td>
<td>Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.</td>
<td>Same as participating copayment for the service or supply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Online Care</th>
<th>Participating</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Online Care</td>
<td>None</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telehealth</th>
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<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth</td>
<td>Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Physician Services</th>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>25 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Consultation Services</td>
<td>25 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Immunizations</td>
<td>25 None</td>
<td>None</td>
</tr>
<tr>
<td>Physician Visits – Emergency Room</td>
<td>25 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Physician Visits - Home, Office, and Extended Care Facility</td>
<td>26 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Physician Visits – Hospital</td>
<td>26 20%</td>
<td>20%</td>
</tr>
</tbody>
</table>
### Surgical Services

<table>
<thead>
<tr>
<th>Service</th>
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<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Surgeon Services</td>
<td>26%</td>
<td>20%</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>26%</td>
<td>20%</td>
</tr>
<tr>
<td>Colonoscopy (screening)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Cutting Surgery</td>
<td>26%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-cutting Surgery</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>27%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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

### Testing, Laboratory and Radiology

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Testing</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Allergy Treatment Materials</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Bone Density Screening</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Diagnostic Testing – Inpatient</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Diagnostic Testing – Outpatient</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Fecal Occult Blood Test (FOBT) (screening)</td>
<td>27%</td>
<td>None</td>
</tr>
<tr>
<td>Genetic Testing and Counseling</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Laboratory and Pathology – Inpatient</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Laboratory and Pathology – Outpatient</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Radiology – Inpatient</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Radiology – Outpatient</td>
<td>27%</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Chemotherapy and Radiation Therapy

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy – Infusion/Injections</td>
<td>28%</td>
<td>20%</td>
</tr>
<tr>
<td>Radiation Therapy – Inpatient</td>
<td>28%</td>
<td>20%</td>
</tr>
<tr>
<td>Radiation Therapy – Outpatient</td>
<td>28%</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Other Medical Services and Supplies

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning</td>
<td>28%</td>
<td>None</td>
</tr>
</tbody>
</table>

* = see page 13

more info.

Copayment Is
(Percentage copayments are based on eligible charges)
## Chapter 3: Summary of Benefits and Your Payment Obligations

* = see page 13

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance (air)</td>
<td>28</td>
<td>20%</td>
</tr>
<tr>
<td>Ambulance (ground)</td>
<td>28</td>
<td>20%</td>
</tr>
<tr>
<td>Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us</td>
<td>29</td>
<td>20%</td>
</tr>
<tr>
<td>Blood and Blood Products</td>
<td>29</td>
<td>20%</td>
</tr>
<tr>
<td>Dentist, Services of</td>
<td>29</td>
<td>20%</td>
</tr>
<tr>
<td>Dialysis and Supplies</td>
<td>29</td>
<td>20%</td>
</tr>
<tr>
<td>Durable Medical Equipment and Supplies</td>
<td>29</td>
<td>20%</td>
</tr>
<tr>
<td>Evaluations for Hearing Aids</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Gender Identity Services</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Growth Hormone Therapy</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Implanted Internal Items/Implants - Outpatient</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Inhalation Therapy</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Injections – Other than Self-Administered</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Injections – Self-Administered</td>
<td>31</td>
<td>20%</td>
</tr>
<tr>
<td>Medical Foods</td>
<td>31</td>
<td>20%</td>
</tr>
<tr>
<td>Medical Nutrition Therapy</td>
<td>31</td>
<td>20%</td>
</tr>
<tr>
<td>Orthodontic Services to Treat Orofacial Anomalies</td>
<td>31</td>
<td>None*</td>
</tr>
<tr>
<td>Orthotics and External Prosthetics</td>
<td>31</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient IV Therapy</td>
<td>32</td>
<td>20%</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>51</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Vision and Hearing Appliances</td>
<td>32</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Copayment Is
(Percentage copayments are based on eligible charges)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance (air)</td>
<td>28</td>
<td>20%</td>
</tr>
<tr>
<td>Ambulance (ground)</td>
<td>28</td>
<td>20%</td>
</tr>
<tr>
<td>Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us</td>
<td>29</td>
<td>20%</td>
</tr>
<tr>
<td>Blood and Blood Products</td>
<td>29</td>
<td>20%</td>
</tr>
<tr>
<td>Dentist, Services of</td>
<td>29</td>
<td>20%</td>
</tr>
<tr>
<td>Dialysis and Supplies</td>
<td>29</td>
<td>20%</td>
</tr>
<tr>
<td>Durable Medical Equipment and Supplies</td>
<td>29</td>
<td>20%</td>
</tr>
<tr>
<td>Evaluations for Hearing Aids</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Gender Identity Services</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Growth Hormone Therapy</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Implanted Internal Items/Implants - Outpatient</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Inhalation Therapy</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Injections – Other than Self-Administered</td>
<td>30</td>
<td>20%</td>
</tr>
<tr>
<td>Injections – Self-Administered</td>
<td>31</td>
<td>20%</td>
</tr>
<tr>
<td>Medical Foods</td>
<td>31</td>
<td>20%</td>
</tr>
<tr>
<td>Medical Nutrition Therapy</td>
<td>31</td>
<td>20%</td>
</tr>
<tr>
<td>Orthodontic Services to Treat Orofacial Anomalies</td>
<td>31</td>
<td>None*</td>
</tr>
<tr>
<td>Orthotics and External Prosthetics</td>
<td>31</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient IV Therapy</td>
<td>32</td>
<td>20%</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>51</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Vision and Hearing Appliances</td>
<td>32</td>
<td>20%</td>
</tr>
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</table>

### Rehabilitation Therapy

<table>
<thead>
<tr>
<th>Service Description</th>
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<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Ornish’s Program for Reversing Heart Disease (TM)</td>
<td>32</td>
<td>20%</td>
</tr>
<tr>
<td>Physical and Occupational Therapy - Inpatient</td>
<td>33</td>
<td>20%</td>
</tr>
<tr>
<td>Physical and Occupational Therapy - Outpatient</td>
<td>33</td>
<td>20%</td>
</tr>
</tbody>
</table>
## Chapter 3: Summary of Benefits and Your Payment Obligations

### Special Benefits – Disease Management and Preventive Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Reduced (Percentage)</th>
<th>None</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia (screening)</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Diabetes Prevention Program</td>
<td>None when received from a provider that meets the requirements of the Diabetes Prevention Program as described in Chapter 4 under Special Benefits – Disease Management and Preventive Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease Management and Preventive Services Programs</td>
<td>None</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Gonorrhea (screening)</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Physical Examinations (routine annual checkup)</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Screening Services, Preventive Counseling, and Preventive Services</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Well-Being Services</td>
<td>Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Special Benefits for Children

<table>
<thead>
<tr>
<th>Service</th>
<th>Reduced (Percentage)</th>
<th>None</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Circumcision</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Care Immunizations</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Well-Child Care Laboratory Tests</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Well-Child Care Physician Office Visits</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

### Special Benefits for Men

<table>
<thead>
<tr>
<th>Service</th>
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<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erectile Dysfunction</td>
<td>Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) Test (screening)</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Special Benefits for Women

<table>
<thead>
<tr>
<th>Service</th>
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<th>None</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Pump</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Contraceptive IUD</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Contraceptive Implants</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
## Chapter 3: Summary of Benefits and Your Payment Obligations

* = see page 13

<table>
<thead>
<tr>
<th></th>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraceptive Injectables</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>In Vitro Fertilization</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Mammography (screening)</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Nurse Midwives</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Pap Smears (screening)</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Tubal Ligation</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Well Woman Exam</strong></td>
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</table>

### Special Benefits for Homebound, Terminal, or Long-Term Care

<table>
<thead>
<tr>
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<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Management Services</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Hospice Services</strong></td>
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<td>None</td>
</tr>
<tr>
<td><strong>Supportive Care</strong></td>
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### Behavioral Health – Mental Health and Substance Abuse

<table>
<thead>
<tr>
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</tr>
</thead>
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<tr>
<td><strong>Hospital and Facility Services – Inpatient</strong></td>
<td>20%*</td>
<td>20%*</td>
</tr>
<tr>
<td><strong>Hospital and Facility Services – Outpatient</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Physician Services – Inpatient</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Physician Services – Outpatient</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Psychological Testing – Inpatient</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Psychological Testing – Outpatient</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Organ and Tissue Transplants

<table>
<thead>
<tr>
<th></th>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corneal Transplant Surgery</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Kidney Transplant Surgery</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Organ Donor Services</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Transplant Evaluation</strong></td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

*Copayment is (Percentage copayments are based on eligible charges)*

Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.
### Chapter 3: Summary of Benefits and Your Payment Obligations

* = see page 13

<table>
<thead>
<tr>
<th>Other Organ and Tissue Transplants</th>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Transplants</td>
<td>41</td>
<td>None</td>
</tr>
<tr>
<td>Heart and Lung Transplants</td>
<td>41</td>
<td>None</td>
</tr>
<tr>
<td>Liver Transplants</td>
<td>41</td>
<td>None</td>
</tr>
<tr>
<td>Lung Transplants</td>
<td>41</td>
<td>None</td>
</tr>
<tr>
<td>Pancreas Transplants</td>
<td>41</td>
<td>None</td>
</tr>
<tr>
<td>Simultaneous Kidney/Pancreas</td>
<td>41</td>
<td>None</td>
</tr>
<tr>
<td>Transplants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small Bowel and Multivisceral</td>
<td>41</td>
<td>None</td>
</tr>
<tr>
<td>Transplants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stem-Cell Transplants (including</td>
<td>41</td>
<td>None</td>
</tr>
<tr>
<td>Bone Marrow Transplants</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Copayment Is (Percentage copayments are based on eligible charges)
Chapter 3: Summary of Benefits and Your Payment Obligations

Chiropractic Services

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

<table>
<thead>
<tr>
<th>Service</th>
<th>ASH In-Network Provider</th>
<th>ASH Out-of-Network Provider</th>
<th>Copayment Is (Copayments are based on the ASH Group eligible charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic – Supports and Supplies</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Office Visit (Follow-up)</td>
<td>No</td>
<td>Not Covered</td>
<td>$12</td>
</tr>
<tr>
<td>Patient Exam (New or Established)</td>
<td>No</td>
<td>Not Covered</td>
<td>$12</td>
</tr>
<tr>
<td>X-rays/Radiological Consultations</td>
<td>No</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

Annual Deductible Applies?

more info. on page: 41

ASH In-Network Provider

ASH Out-of-Network Provider

ASH In-Network Provider

ASH Out-of-Network Provider

Not Covered

Not Covered

Not Covered

Not Covered

No

Not Covered

Not Covered

None

Not Covered

None

Not Covered
Chapter 4: Description of Benefits

About this Chapter

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

Additional Coverage Mandated by Law

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

Non-Assignment of Benefits

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

Hospital and Facility Services

Review of Inpatient Hospital Care

When your condition requires you to be an inpatient, we may work with your
Chapter 4: Description of Benefits

provider to review your medical records to determine if payment determination criteria are met. Inpatient reviews take place after admission and at set intervals thereafter, until you are discharged from the facility. We also review discharge plans for after-hospital care.

If payment determination criteria are not met, our nurse reviewer will discuss your case with a physician consultant. If more details are needed, our nurse or physician consultant may contact your attending physician.

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

Ambulatory Surgical Center (ASC) Covered, including:
- operating rooms,
- surgical supplies,
- drugs,
- dressings,
- anesthesia services and supplies,
- oxygen,
- antibiotics,
- blood transfusion services,
- routine lab and
- x-ray related to surgery.

Ambulatory Surgical Center is an outpatient facility that provides surgical services without an overnight stay. This facility may be in a hospital or it may be a separate independent facility.

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

Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) Covered in accord with HMSA’s medical policies. Information on our policies can be found at www.hmsa.com.

Room and board is covered, but only for semi-private rooms when all of the following are true:
- You are admitted by your physician.
- Care is ordered and certified by your physician.
- Care is for skilled nursing care, sub-acute care, or long-term acute care rendered in an extended care facility.
- Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care.
- The confinement is not for custodial care.

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

Services and supplies are covered, including:
- routine surgical supplies,
- drugs,
- dressings,
- oxygen,
- antibiotics,
- blood transfusion services, and
- diagnostic and therapy services.

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

Hospital Ancillary Services Covered, including:
- surgical supplies,
- hospital anesthesia services and supplies,
- diagnostic and therapy services,
Chapter 4: Description of Benefits

- drugs,
- dressings,
- oxygen,
- antibiotics, and
- hospital blood transfusion services.

For hospital ancillary services associated with maternity-related services, see **Special Benefits for Women** in the section **Maternity Care**.

**Please note:** Anesthesia for dental services are covered in accord with HMSA’s medical policy on “Deep Sedation and General Anesthesia for Dental Services” which can be found at [www.hmsa.com](http://www.hmsa.com). The medical policy provides detailed coverage criteria for when services meet HMSA’s payment determination criteria.

### Hospital Room and Board

Covered, including:

- **Semi-Private Rooms.** If you are hospitalized at a participating facility, your copayment is based on the facility’s medical/surgical semi-private room rate. If you are hospitalized at a nonparticipating facility, your copayment is based on HMSA’s maximum allowable fee for semi-private rooms. Also, you owe the difference between the nonparticipating hospital’s room charge and HMSA’s maximum allowable fee for semi-private rooms.
- **Private Rooms.**
  - At Participating Hospitals:
    - If you are hospitalized in a participating facility with private rooms only, your copayment is based on HMSA’s maximum allowable fee for semi-private rooms.
    - If you are hospitalized in a participating facility with semi-private and private rooms or a BlueCard facility, your copayment is based on the facility’s medical/surgical semi-private room rate. Also, you owe the difference between the facility’s charges for private and semi-private rooms. **Exception:** If you are hospitalized for conditions identified by HMSA as conditions that require a private room, your copayment is based on the facility’s medical/surgical private room rate. You may call HMSA for a list of these conditions.
  - At Nonparticipating Hospitals:
    - If you are hospitalized in a nonparticipating facility, your copayment is based on HMSA’s maximum allowable fee for semi-private rooms. Also, you owe the difference between the facility’s private room charge and HMSA’s maximum allowable fee for semi-private rooms. **Exception:** If you are hospitalized for conditions identified by HMSA as conditions that require a private room, your copayment is based on HMSA’s maximum allowable fee for private rooms. You may call HMSA for a list of these conditions.

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

For hospital room and board services associated with maternity-related services, see **Special Benefits for Women** in the section **Maternity Care**.

### Intensive Care Unit/Coronary Care Unit

Covered.

### Intermediate Care Unit

Covered.

### Isolation Care Unit

Covered.

### Operating Room

Covered.

### Outpatient Facility

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

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

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

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

Examples of an emergency include:

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

Examples of non-emergencies are:

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

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

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

Online Care

Covered, when provided by HMSA Online Care at www.hmsa.com. You must be at least 18 years old. A member who is a dependent minor is covered when accompanied by an adult member. Initial base conversations as well as conversation extensions are covered for all provider types available on HMSA Online Care.

Please note: Sessions and eligibility are subject to the Online Care Consumer User Agreement.

Telehealth

Covered, in accord with Hawaii law and HMSA’s medical policy for “Telehealth Services” which can be found at www.hmsa.com. Telehealth is the use of telecommunications services to transmit medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis when the parties are separated by distance. Telecommunications services include:

- Store and forward technologies.
- Remote monitoring.
- Live consultation.
Chapter 4: Description of Benefits

• Mobile health.

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

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

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

<table>
<thead>
<tr>
<th>Physician Services</th>
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<tbody>
<tr>
<td><strong>Anesthesia</strong></td>
</tr>
<tr>
<td>Covered, as required by the attending provider and when appropriate for your condition. Services include:</td>
</tr>
<tr>
<td>• General anesthesia.</td>
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<tr>
<td>• Regional anesthesia.</td>
</tr>
<tr>
<td>• Monitored anesthesia when you meet HMSA’s high-risk criteria.</td>
</tr>
<tr>
<td><strong>Please note:</strong> Anesthesia for dental services are covered in accord with HMSA’s medical policy on “Deep Sedation and General Anesthesia for Dental Services” which can be found at <a href="http://www.hmsa.com">www.hmsa.com</a>. The medical policy provides detailed coverage criteria for when services meet HMSA’s payment determination criteria.</td>
</tr>
<tr>
<td><strong>Consultation Services</strong></td>
</tr>
<tr>
<td>Covered, as needed for surgical, obstetrical, pathological, radiological, or other medical conditions when all of these statements are true:</td>
</tr>
<tr>
<td>• The attending physician must require the consultation.</td>
</tr>
<tr>
<td>• If the consultation is for inpatient services, you must be confined as a registered bed patient.</td>
</tr>
<tr>
<td>• If the consultation is for inpatient services, the consultant's report must be acceptable to us. It must also be included as a part of the record kept by the hospital or extended care facility.</td>
</tr>
<tr>
<td>• The consultation must be for reasons other than to comply with requirements by the hospital or extended care facility.</td>
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<tr>
<td><strong>Immunizations</strong></td>
</tr>
<tr>
<td>Covered, but only vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).</td>
</tr>
<tr>
<td><strong>Please note:</strong> The list of ACIP recommended immunizations may change. If you would like information about the ACIP recommended immunizations, please visit our website at <a href="http://www.hmsa.com">www.hmsa.com</a> or call us at one of the phone numbers listed on the back cover of this Guide.</td>
</tr>
<tr>
<td><strong>Physician Visits - Emergency Room</strong></td>
</tr>
<tr>
<td>Covered, but only to stabilize a medical condition which is accompanied by acute symptoms of sufficient severity (including severe pain) that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:</td>
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<td>• Serious risk to the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child).</td>
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<td>• Serious impairment to bodily functions.</td>
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Chapter 4: Description of Benefits

- breathing problems,
- drug overdose,
- severe allergic reaction,
- severe burns, and
- broken bones.

Examples of non-emergencies are:
- colds,
- flu,
- earaches,
- sore throats, and
- using the emergency room for your convenience or during normal physician office hours for medical conditions that can be treated in a physician’s office.

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

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

**Physician Visits – Home, Office, and Extended Care Facility**

Covered, when you are an inpatient in an extended care facility or outpatient. A physician visit may be received in the physician's office, your home, an extended care facility or outpatient hospital setting. You are also covered for family planning counseling services.

**Please note:** Routine preventive care is described under the Special Benefits sections.

**Physician Visits – Hospital**

Covered, when you are an inpatient in a hospital.

---

**Surgical Services**

Participating Providers have agreed to comply with HMSA's payment policies and so will not bill you for services or added charges that HMSA does not cover. When you see a nonparticipating provider you will owe any copayment that applies to the service plus the difference between HMSA's eligible charge and the provider's actual charge. This may include services or added charges not covered by HMSA.

**Approval for Certain Surgical Procedures**

Certain surgical procedures must have precertification from HMSA. See Chapter 5: Precertification.

**Please note:** This list of procedures changes periodically. To ensure your surgical procedure is covered, call us and we will check if it requires approval before you get the surgery.

If you are under the care of a:
- Participating physician, the physician will get approval for you.
- Nonparticipating physician, the physician may not get approval for you. Getting approval is your responsibility. See Chapter 5: Precertification.

**Assistant Surgeon Services**

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

**Bariatric Surgery**

Covered, but only if you meet HMSA’s criteria.

**Colonoscopy (screening)**

Covered in accord with HMSA’s medical policies.

**Cutting Surgery**

Covered, including preoperative and postoperative care.
Please note: Nonparticipating providers may bill separately for preoperative care, the surgical procedure and postoperative care. In such cases, the total charge is often more than the eligible charge. You are responsible for any amount that exceeds the eligible charge.

**Non-cutting Surgery**
Covered. Examples of non-cutting surgical procedures include:
- diagnostic endoscopic procedures;
- diagnostic and therapeutic injections including catheters injections into joints, muscles, and tendons;
- orthopedic castings;
- destruction of localized lesions by chemotherapy (excluding silver nitrate), cryotherapy or electrosurgery, and
- acne treatment.

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

Complications of a non-covered cosmetic reconstructive surgery are not covered.

**Sigmoidoscopy (screening)**
Covered in accord with HMSA’s medical policies.

**Surgical Supplies**
Covered.

### Chapter 4: Description of Benefits

**Please note:** Nonparticipating providers may bill separately for preoperative care, the surgical procedure and postoperative care. In such cases, the total charge is often more than the eligible charge. You are responsible for any amount that exceeds the eligible charge.

**Non-cutting Surgery**
Covered. Examples of non-cutting surgical procedures include:
- diagnostic endoscopic procedures;
- diagnostic and therapeutic injections including catheters injections into joints, muscles, and tendons;
- orthopedic castings;
- destruction of localized lesions by chemotherapy (excluding silver nitrate), cryotherapy or electrosurgery, and
- acne treatment.

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

Complications of a non-covered cosmetic reconstructive surgery are not covered.

**Sigmoidoscopy (screening)**
Covered in accord with HMSA’s medical policies.

**Surgical Supplies**
Covered.

### Testing, Laboratory, and Radiology

**Allergy Testing**
Covered.

**Allergy Treatment Materials**
Covered.

**Bone Density Screening**
Covered.

**Diagnostic Testing**
Covered when related to an injury or illness. Examples of diagnostic tests include:
- Electroencephalograms (EEG).
- Electrocardiograms (EKG or ECG).
- Holter Monitoring.
- Stress Tests.

**Fecal Occult Blood Test (FOBT) (screening)**
Covered in accord with HMSA’s medical policies.

**Genetic Testing and Counseling**
Covered, but only if you meet HMSA’s criteria. Call us for more details. Our phone number is listed on the back cover of this Guide.

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

Other services identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations are described under Special Benefits – Disease Management, Screening Services, Preventive Counseling, and Preventive Services.

**Laboratory and Pathology**
Covered, when related to an illness or injury. For other routine and preventive lab services, see later in this chapter in the Special Benefits sections.

**Radiology**
Covered. Examples of radiology include:
- Computerized Tomography Scan (CT Scan).
- Diagnostic mammography.
- Nuclear Medicine.
**Chapter 4: Description of Benefits**

- Ultrasound.
- X-rays.

*Please note:* Some radiological procedures must have precertification. See *Chapter 5: Precertification.*

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

<table>
<thead>
<tr>
<th><strong>Ambulance (air)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered, for intra-island or inter-island air ambulance services to the nearest, adequate hospital to treat your illness or injury.</td>
</tr>
<tr>
<td>We will cover your ambulance transportation if the following apply:</td>
</tr>
<tr>
<td>• Services to treat your illness or injury are not available in the hospital or nursing facility where you are an inpatient.</td>
</tr>
<tr>
<td>• Transportation starts where an injury or illness took place or first needed emergency care.</td>
</tr>
<tr>
<td>• Transportation ends at the nearest facility equipped to furnish emergency care.</td>
</tr>
<tr>
<td>• Transportation is for the purpose of emergency treatment.</td>
</tr>
<tr>
<td>• Transportation takes you to the nearest facility equipped to furnish emergency treatment.</td>
</tr>
<tr>
<td><em>Please note:</em> Air ambulance is limited to transportation within the state of Hawaii except as described in the next section labeled “Ambulance (air) – to the Continental United States”.*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Ambulance (air) – to the Continental United States</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered in certain situations when treatment for critical care is not available in Hawaii and air ambulance transportation to the continental US with life supporting equipment and/or a medical support team is needed. Services are covered in accord with HMSA’s medical policy on air ambulance services which can be found at <a href="http://www.hmsa.com">www.hmsa.com</a>.</td>
</tr>
<tr>
<td><em>Please note:</em> Air ambulance services to the continental US must be precertified. See <em>Chapter 5: Precertification.</em></td>
</tr>
<tr>
<td><em>Please note:</em> Exclusions or limitations may apply. See <em>Chapter 6: Services Not Covered, Miscellaneous Exclusions.</em></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Ambulance (ground)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered, for ground ambulance services to the nearest, adequate hospital to treat your illness or injury.</td>
</tr>
</tbody>
</table>
| We will cover your ambulance transportation if the following apply:
Chapter 4: Description of Benefits

• Services to treat your illness or injury are not available in the hospital or nursing facility where you are an inpatient.
• Transportation starts where an injury or illness took place or first needed emergency care.
• Transportation ends at the nearest facility equipped to furnish emergency care.
• Transportation is for the purpose of emergency treatment.
• Transportation takes you to the nearest facility equipped to furnish emergency treatment.

Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us

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

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

Autism Spectrum Disorders – Diagnosis and Treatment

Covered, in accord with Hawaii law and HMSA’s medical policies, for the following services:
• Behavioral health treatment. Benefits for Applied Behavior Analysis rendered by a Recognized Behavior Analyst as described more fully in the section labeled “Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us”.
• Psychiatric care.
• Psychological care.
• Therapeutic care.

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

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

Blood and Blood Products

Covered, including blood costs, blood bank services, blood processing.

You are not covered for peripheral stem-cell transplants except as described in this chapter under Stem-Cell Transplants (including Bone Marrow Transplants).

Dentist, Services of

Covered, but only when the dentist performs emergency or surgical services that could also be performed by a physician.

Dialysis and Supplies

Covered.

Durable Medical Equipment and Supplies

Covered, but only when prescribed by your treating provider.

The equipment must meet all of the following criteria:
• FDA-approved for the purpose that it is being prescribed.
• Able to withstand repeated use.
• Primarily and customarily used to serve a medical purpose.
• Appropriate for use in the home. Home means the place where you live other than a hospital or skilled or intermediate nursing facility.
• Necessary and reasonable to treat an illness or injury, or to improve the functioning of a malformed body part. It should not be useful to a person in the absence of illness or injury.

Durable medical equipment (DME) can be rented or purchased; however, certain items are covered only as rentals.

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

Repair and replacement of durable medical equipment is covered subject to certain limitations and exclusions. Please call your nearest HMSA office listed on the back cover of this Guide for details.

Examples of durable medical equipment include:
• oxygen equipment,
• hospital beds,
• mobility assistive equipment (wheelchairs, walkers, power mobility devices), and
Chapter 4: Description of Benefits

- insulin pumps.

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

Evaluations for Hearing Aids

Covered, but only when you get the evaluation for the use of a hearing aid in the office of a physician or audiologist.

Gender Identity Services

Covered, in accord with HMSA’s medical policy for “Gender Identity Services” which can be found at [www.hmsa.com](http://www.hmsa.com).

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

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

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

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

Growth Hormone Therapy

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

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

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

Implanted Internal Items/Implants - Outpatient

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

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

Inhalation Therapy

Covered.

Injections – Other than Self-Administered

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

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

Injectable drugs must be FDA approved.

If you have a drug plan with a similar benefit, there shall be no duplication or coordination of benefits between this plan and your drug plan.
Chapter 4: Description of Benefits

*Please note*: Coverage includes at least one drug in each of the following drug categories and classes:

- Blood products/modifiers/volume expanders (coagulants)
- Immunological agents (immunizing agents, passive)

*Please note*: Selected specialty drugs may not be a benefit of this plan. For questions regarding your EUTF specialty drug coverage, please contact the EUTF pharmacy benefit manager.

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

**Injections – Self-Administered**

Covered, for FDA approved injectable drugs.

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

*Please note*: Self-administered specialty drugs may not be a benefit of this plan. For questions regarding your specialty drug coverage, please contact the EUTF pharmacy benefit manager.

*Please note*: Selected specialty drugs may not be a benefit of this plan. For questions regarding your EUTF specialty drug coverage, please contact the EUTF pharmacy benefit manager.

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

**Medical Foods**

Covered, to treat inborn errors of metabolism in accord with Hawaii law and HMSA guidelines.

**Medical Nutrition Therapy**

Covered to treat medical conditions, such as chronic kidney disease, in accord with Hawaii law and HMSA’s medical policy on “Medical Nutrition Therapy” which can be found at www.hmsa.com.

If you are diagnosed with an eating disorder by a qualified provider, medical nutrition therapy must be rendered by a recognized licensed dietitian.

Other counseling services identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations are described in other sections of this chapter. See *Special Benefits – Disease Management and Preventive Services, Screening Services, Preventive Counseling and Preventive Services*.

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

**Orthodontic Services to Treat Orofacial Anomalies**

Covered, to treat orofacial anomalies resulting from birth defects or birth defect syndromes, in accord with Hawaii law and HMSA’s medical policy.

**Benefit Limitation**: Benefits are limited to a maximum of $5,500 per treatment phase.

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

**Orthotics and External Prosthetics**

*Orthotics* are covered, when prescribed by your treating provider to provide therapeutic support or restore function.

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

Examples of orthotics include:

- braces,
- orthopedic footwear, and
- shoe inserts.

*Foot orthotics* are only covered for members with specific diabetic conditions as defined by Medicare guidelines; for partial foot amputations; if they are an integral part of a leg brace; or if they are being prescribed as part of post-surgical or post-traumatic casting care.
Chapter 4: Description of Benefits

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

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

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

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

Please note: Certain prosthetics and orthotics must have precertification. See Chapter 5: Precertification.

Outpatient IV Therapy

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

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

Routine Care Associated with Clinical Trials

Covered in accord with the Affordable Care Act. Coverage is limited to services and supplies provided when you are enrolled in a qualified clinical trial if such services would be paid for by HMSA as routine care.

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

Vision and Hearing Appliances

Vision appliances, which include eyeglasses and contact lenses, are covered for certain medical conditions and are subject to special limits. Please call your nearest HMSA office listed on the back cover of this Guide for details.

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

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

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

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

Rehabilitation Therapy

Dr. Ornish’s Program for Reversing Heart Disease™

Covered in accord with HMSA’s then current policy available at www.hmsa.com and when:

• You received one or more of the following medical procedures:
  – An acute myocardial infarction within the preceding 12 months;
  – A coronary artery bypass surgery;
  – Current stable angina pectoris;
  – Heart valve repair or replacement;
  – Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;
  – A heart or heart-lung transplant; or
• Stable, chronic heart failure.
• Program services are provided by practitioners who contract with HMSA to provide program services, and
Chapter 4: Description of Benefits

• Services are received in the State of Hawaii at an accredited Ornish Reversal Program.

**Dr. Ornish’s Program for Reversing Heart Disease™** is a comprehensive approach to cardiovascular disease management and overall well-being improvement that addresses modifiable risk factors under the supervision of a multidisciplinary team. It helps members with heart disease and related health issues to assess, track and manage their condition; and, improve key factors such as eating habits, stress management and physical activity. The program consists of eighteen 4 hour sessions which include:

• Supervised exercise
• Yoga and meditation
• Support group
• Experiential education session with group meal

**Please note:** Coverage is limited to one program per lifetime. If you get benefits for this program under an HMSA plan, you will not be eligible for benefits for the program under any other HMSA plan.

**Physical and Occupational Therapy**

Covered in accord with HMSA’s medical policy for physical and occupational therapy. Changes to the policy may occur at any time during your plan year. Current medical policies can be found at [www.hmsa.com](http://www.hmsa.com). According to HMSA’s current medical policies, therapy services are covered but only when all of the following are true:

• The diagnosis is established by a physician, physician’s assistant or advanced practice registered nurse and the medical records document the need for skilled physical and/or occupational therapy.
• The therapy is ordered by a physician, physician’s assistant or advanced practice registered nurse under an individual treatment plan.
• The therapy is from a qualified provider of physical or occupational therapy services. A qualified provider is one who is licensed appropriately, performs within the scope of his/her licensure and is recognized by HMSA.
• The therapy is necessary to achieve a specific diagnosis-related goal that will significantly improve neurological and/or musculoskeletal function due to a congenital anomaly, or to restore neurological and/or musculoskeletal function that was lost or impaired due to an illness, injury, or prior therapeutic intervention. (Significant is defined as a measurable and meaningful increase in the level of physical and functional abilities attained through short-term therapy as documented in the medical records).
• The therapy is short-term, generally not longer than 90 days, defined as the number of visits necessary to improve or restore neurological or musculoskeletal function required to perform normal activities of daily living, such as grooming, toileting, feeding, etc. Therapy beyond this is considered long-term and is not covered. Maintenance therapy, defined as activities that preserve present functional level and prevent regression, are not covered.
• The therapy does not duplicate services from another therapy or available through schools and/or government programs.
• The therapy is described as covered in HMSA’s medical policies on physical and occupational therapy. Information on our policies can be found at [www.hmsa.com](http://www.hmsa.com).

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

Group exercise programs and group physical and occupational therapy exercise programs are not covered.

**Pulmonary Rehabilitation**

Pulmonary rehabilitation is a multidisciplinary approach to reducing symptoms and improving quality of life in patients with compromised lung function.

Benefits are not provided for maintenance programs.

Participants must meet HMSA’s eligibility criteria and guidelines.

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

Covered in accord with HMSA’s medical policy for speech therapy. Changes to the policy may occur at any time during your plan year. Current medical policies can be found at www.hmsa.com. According to HMSA’s current medical policy, speech therapy is covered to treat communication impairments and swallowing disorders but only when all of the following statements are true:

- The diagnosis is established by a physician, physician’s assistant, or advanced practice registered nurse and the medical records document the need for skilled speech therapy services.
- The therapy is ordered by a physician, physician’s assistant, or advanced practice registered nurse.
- The therapy is necessary to treat function lost or impaired by disease, trauma, congenital anomaly (structural malformation) or prior therapeutic intervention.
- The therapy is rendered by and requires the judgment and skills of a speech language pathologist certified as clinically competent (SLP CCC) by the American Speech Language Hearing Association (ASHA).
- The therapy is provided on a one-to-one basis.
- The therapy is used to achieve significant, functional improvement through objective goals and measurements.
- The therapy and diagnosis are covered as described in HMSA’s medical policies for speech therapy services. Information on our policies can be found at www.hmsa.com.
- The therapy is not for developmental delay/developmental learning disabilities.
- The therapy does not duplicate service from another therapy or available through schools and/or government programs.

Speech therapy services include:

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

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

Special Benefits – Disease Management and Preventive Services

Chlamydia (screening)

Covered.

Diabetes Prevention Program

The Diabetes Prevention Program is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

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

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

For more information on the program and how to find a provider, please visit our Diabetes Prevention Program page at https://hmsa.com/well-being/diabetes-prevention/.

Please note: Coverage is limited to one program per lifetime. If you receive benefits for this program under an HMSA plan, you will not be eligible for benefits for the program under any other HMSA plan.

Disease Management and Preventive Services Programs

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

- asthma,
- diabetes,
- cardiovascular disease,
- chronic obstructive pulmonary disease (COPD), and
- behavioral health conditions (mental health and substance abuse).
Chapter 4: Description of Benefits

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

Covered, for programs available through HMSA’s Health and Well-Being services such as the prenatal care program that helps expectant couples through normal and at-risk pregnancies with information and support services.

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

**Preventive Services**

As described below, each calendar year you are eligible for one Physical Examination (routine annual checkup).

**Physical Examinations** (routine annual checkup)

Covered for ages 22 and above. Includes a routine vision and hearing tests, and the following recommended screening tests.

- Audiogram (optional).
- Urinalysis.
- Blood count.
- Chest X-ray - 2 views (not more than once every two years).

Also for ages 40 and above:

- Biochemistry Panel.
- Electrocardiogram (EKG 12 lead).

**Gonorrhea (screening)**

Covered.

**Screening Services, Preventive Counseling, and Preventive Services**

Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following:

- Preventive Counseling
- Preventive Services
- Screening Laboratory Services:
  - Screening for Lipid Disorders in Adults
  - Screening for Asymptomatic Bacteriuria in Adults
  - Screening for Hepatitis B Virus Infection
  - Screening for HIV
  - Screening for Syphilis Infection
  - Screening for Type 2 Diabetes Mellitus in Adults
  - Screening for Iron Deficiency Anemia
  - Screening for Rh (D) Incompatibility
  - Screening for Congenital Hypothyroidism
  - Screening for Phenylketonuria (PKU)
  - Screening for Sickle Cell Disease in Newborns
  - Screening for Tuberculosis
- Screening Radiology Services:
  - Screening for Abdominal Aortic Aneurysm
  - Screening for Osteoporosis in Postmenopausal Women

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

**Please note:** The list of U.S. Preventive Services Task Force (USPSTF) recommended screenings may change. If you need more details about the USPSTF recommended screenings, including a current list of recommendations please visit our website at www.hmsa.com or call us at one of the phone numbers listed on the back of this Guide.

**Please note:** Benefits for other U.S. Preventive Services Task Force (USPSTF) Grade A and B recommended screenings may be found in other sections of this chapter under Surgical Services, Testing, Laboratory, and Radiology, and Special Benefits for Women.

Covered for recommended preventive services for women developed by the Institute of Medicine (IOM) and supported by the Health Resources and Services Administration (HRSA), such as the following:

- Breastfeeding Support and Counseling – but only from a trained physician or midwife during pregnancy and/or in the postpartum period.
- Contraceptive Counseling.
- Gestational Diabetes Screening.
- Human Papillomavirus (HPV) DNA Testing.
Chapter 4: Description of Benefits

- Interpersonal and Domestic Violence Screening and Counseling.

*Please note:* Benefits for other IOM recommended preventive services for women may be found in this section and under other sections of this chapter under *Special Benefits for Women.*

### Well-Being Services

HMSA offers a variety of well-being tools, programs and services to take care of you and your family. Visit [hmsa.com/wellbeing](http://hmsa.com/wellbeing) to find the latest benefits available to our members.

### Special Benefits for Children

#### Newborn Circumcision

Covered.

#### Well-Child Care

Covered, from birth through age twenty-one including:
- office visits for history,
- physical exams,
- sensory screenings,
- developmental/behavioral assessments,
- anticipatory guidance,
- lab tests, and
- immunizations.

*Well-Child Care* means routine and preventive care for children through age twenty-one. If your child needs medical care as the result of an illness or injury, physician visit benefits apply (and not well-child care benefits). See *Physician Services* earlier in this chapter.

#### Well-Child Care Immunizations

Covered, in accord with Hawaii law and the guidelines set by the Advisory Committee on Immunization Practices (ACIP).

#### Well-Child Care Laboratory Tests

Covered, in conjunction with office visits, from birth through age twenty-one. Laboratory tests are covered during the well-child care period as identified on the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care, in addition to one urinalysis through age five.

#### Well-Child Care Physician Office Visits

Covered, including routine sensory screening, and developmental/behavioral assessments based on the American Academy of Pediatrics (AAP) Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care:
- Birth to one year: seven visits.
- Age one year: three visits.
- Age two years: two visits.
- Age three years: one visit.
- Age four years through twenty-one years: 18 visits with one visit for each year of age and a minimum of 9 months between visits.

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

### Special Benefits for Men

#### Erectile Dysfunction

Services, supplies, prosthetic devices, and injectables approved by us are covered to treat erectile dysfunction due to organic cause as defined by HMSA or as described in this chapter under *Other Medical Services and Supplies, Gender Identity Services.*

#### Prostate Specific Antigen (PSA) Test (screening)

Covered, for men age 50 or older. Benefits are limited to one prostate specific antigen screening test per calendar year. For diagnostic PSA tests, see earlier in this chapter under *Testing, Laboratory, and Radiology.*
### Chapter 4: Description of Benefits

#### Vasectomy
Covered, but only the initial surgery for a vasectomy. Benefits do not include the reversal of a vasectomy.

#### Special Benefits for Women

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Breast Pump</strong></td>
<td>Covered, for the purchase of one device including attachments per pregnancy.</td>
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<tr>
<td></td>
<td>Covered, for the rental of a hospital-grade breast pump in accord with HMSA’s medical policy on breast pumps which can be found at <a href="http://www.hmsa.com">www.hmsa.com</a>.</td>
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<tr>
<td></td>
<td>Please note: Hospital-grade rentals must be precertified. See Chapter 5: Precertification.</td>
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<tr>
<td><strong>Contraceptive IUD</strong></td>
<td>Covered.</td>
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<tr>
<td></td>
<td>Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.</td>
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<tr>
<td><strong>Contraceptive Implants</strong></td>
<td>Covered.</td>
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<tr>
<td></td>
<td>Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.</td>
</tr>
<tr>
<td><strong>Contraceptive Injectables</strong></td>
<td>Covered.</td>
</tr>
<tr>
<td></td>
<td>Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.</td>
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<tr>
<td><strong>In Vitro Fertilization</strong></td>
<td>Covered. Coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are an HMSA member. If you get benefits for in vitro fertilization services under an HMSA plan, you will not be eligible for in vitro fertilization benefits under any other HMSA plan. In vitro fertilization services are not covered when a surrogate is used. The in vitro procedures must be performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists’ guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine’s minimal standards for programs of in vitro fertilization.</td>
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<td>If you have a male partner, you must meet all of the following criteria:</td>
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<td></td>
<td>• You and your male partner have a five-year history of infertility or infertility is related to one or more of the following medical conditions:</td>
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<td>– Endometriosis;</td>
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<td>– Exposure in utero to diethylstilbestrol (DES);</td>
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<td>– Blockage or surgical removal of one or both fallopian tubes; or</td>
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<td>– Abnormal male factors contributing to the infertility.</td>
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<td></td>
<td>• You and your male partner have been unable to attain a successful pregnancy through other covered infertility treatments.</td>
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<td>If you do not have a male partner, you must meet the following criteria:</td>
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<td>• You are not known to be otherwise infertile, and</td>
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<td>• You have failed to achieve pregnancy following three cycles of physician directed, appropriately timed intrauterine insemination.</td>
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<td>Please note: These services must have precertification. See Chapter 5: Precertification.</td>
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<tr>
<td></td>
<td>Please note: Exclusions or limits that may relate to this benefit are described in Chapter 6: Services Not Covered in the section labeled Fertility and Infertility.</td>
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<tr>
<td><strong>Mammography (screening)</strong></td>
<td>Covered according to the following schedule:</td>
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<td>• Age 35 - 39 years of age, one baseline mammogram.</td>
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<td>• Age 40 years of age or older, one mammogram per calendar year.</td>
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<td>Please note: A woman of any age may receive the screening more often if she has a history of breast cancer or if her mother or sister has a history of breast cancer. For diagnostic mammography benefits, see earlier in this chapter under Testing, Laboratory, and Radiology.</td>
</tr>
</tbody>
</table>
Chapter 4: Description of Benefits

Maternity Care

Covered, for:

- **Maternity Care.** Covered, including prenatal, false labor, delivery, and postnatal services. HMSA pays physicians a global fee related to a bundle of maternity care. If benefit payments are made separately before delivery, payments will be considered an advance and we will deduct the amount from the global benefit payment for maternity care.
- Nursery care following birth.
- Pregnancy Termination.
- Complications of pregnancy, except physician visits.
- Hospital room and care and ancillary services associated with maternity-related services.

*Please note:* All plan limitations apply to services associated with maternity care. See *Chapter 4: Description of Benefits* for limitations on a specific service.

Physician visits for complications of pregnancy, newborn physician visits, emergency room, emergency room visits, outpatient radiology, and outpatient laboratory and pathology are not included in this Maternity Care benefit. See *Physician Visits-Hospital, Emergency Services, Radiology – Outpatient, and Laboratory and Pathology – Outpatient* for benefits.

Newborn care is covered for the baby's routine non-surgical physician services and nursery care following birth. Benefits for a sick newborn are available when you add the child to your coverage within 31 days of birth. See *Chapter 10: General Provisions* under Eligibility for Coverage.

Maternity and Newborn Length of Stay

Covered, for up to:

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

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

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

Nurse Midwives

Covered for maternity care.

*Please note:* See copayment amounts listed in *Chapter 3: Summary of Benefits and Your Payment Obligations* for services rendered by nurse midwives unrelated to maternity care.

Pap Smears (screening)

Covered, but only one screening Pap smear per calendar year.

Tubal Ligation

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

Well Woman Exam

Covered, for one gynecological exam per calendar year. The well woman exam includes a pelvic exam, the collection of a specimen for Pap smear screening and a clinical breast exam.

Special Benefits for Homebound, Terminal, or Long-Term Care

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

- Assessment of individual/family needs related to the understanding of health status and physician treatment plans, self-care and compliance capability and continuum of care.
- Education of individual/family on disease, treatment compliance and self-care techniques.
- Help with organization of care, including arranging for needed services and supplies.
Chapter 4: Description of Benefits

- Assistance in arranging for a primary care provider to deliver and coordinate the care and/or consultation with physician specialists; and
- Referrals to community resources.

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

**Home Health Care**

Covered, but only when all of these statements are true:

- Services are prescribed in writing by a physician to treat an illness or injury when you are homebound. *Homebound* means that due to an illness or injury, you are unable to leave home, or if you do leave home, doing so requires a considerable and taxing effort.
- Part-time skilled health services are needed.
- Services are not more costly than alternate services that would be effective to diagnose and treat your condition.
- Without home health care, you would need inpatient hospital or extended care facility services.
- If you need home health care services for more than 30 days, a physician must certify that there is further need for the services and provide an ongoing plan of treatment at the end of each 30-day period of care.
- Services do not exceed 150 visits per calendar year.

**Hospice Services**

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

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

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

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

**Supportive Care**

Covered in accord with HMSA’s then current Supportive Care policy available at [www.hmsa.com](http://www.hmsa.com).

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

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

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

**Please note:**

- We cover Supportive Care referral visits during which a patient is advised of Supportive Care options, regardless of whether the referred member is later admitted to Supportive Care.
- Coverage is limited to 90 calendar days of services in a 12 month period that begins the first day Supportive Care services are provided.

**Behavioral Health – Mental Health and Substance Abuse**

Covered, if:
Chapter 4: Description of Benefits

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

**Please note:** Epilepsy, senility, intellectual disabilities, or other developmental disabilities and addiction to or abuse of intoxicating substances, do not in and of themselves constitute a mental disorder.

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

**Please note:** Precertification is required for the admission and continued treatment at all residential treatment facilities. See Chapter 5: Precertification.

### Alcohol or Drug Dependence Treatment

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

### Organ and Tissue Transplants

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

Benefits are not available for:

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

#### Corneal Transplant Surgery

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

#### Kidney Transplant Surgery

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

#### Organ Donor Services

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

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

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

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

#### Transplant Evaluation

Covered, if we approve, for:

- heart,
- heart-lung,
- liver,
- lung,
- pancreas,
- simultaneous kidney/pancreas,
- small bowel and multivisceral, or
Chapter 4: Description of Benefits

• stem-cell transplants.

See Chapter 5: Precertification. **Transplant Evaluation** means those procedures, including:
  • lab and diagnostic tests,
  • consultations, and
  • psychological evaluations that a facility uses in evaluating a potential transplant candidate.

This coverage is limited to one evaluation per transplant request. For details about donor screening benefits, see in this chapter under **Organ Donor Services**.

<table>
<thead>
<tr>
<th><strong>Other Organ and Tissue Transplants</strong></th>
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<tbody>
<tr>
<td>Covered, but only as described in this section and <strong>Organ and Tissue Transplants</strong>. Also, all transplants must receive our approval. Without approval for the specified transplants, benefits are not available. See Chapter 5: Precertification.</td>
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</tbody>
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<tr>
<th><strong>Heart Transplants</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered, but only if you meet HMSA’s criteria and if we approve. See Chapter 5: Precertification.</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Heart and Lung Transplants</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered, but only if you meet HMSA’s criteria and if we approve. See Chapter 5: Precertification.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Liver Transplants</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered, but only if you meet HMSA’s criteria and if we approve. See Chapter 5: Precertification.</td>
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</tbody>
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<thead>
<tr>
<th><strong>Lung Transplants</strong></th>
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<tbody>
<tr>
<td>Covered, but only if you meet HMSA’s criteria and if we approve. See Chapter 5: Precertification.</td>
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</tbody>
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<thead>
<tr>
<th><strong>Pancreas Transplants</strong></th>
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<tbody>
<tr>
<td>Covered, but only if you meet HMSA’s criteria and if we approve. See Chapter 5: Precertification.</td>
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</tbody>
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<thead>
<tr>
<th><strong>Simultaneous Kidney/Pancreas Transplants</strong></th>
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<tbody>
<tr>
<td>Covered, but only if you meet HMSA’s criteria and if we approve. See Chapter 5: Precertification.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Small Bowel and Multivisceral Transplants</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered, for small bowel (small intestine) and the small bowel with liver or small bowel with multiple organs such as the liver, stomach and pancreas, but only if you meet HMSA’s criteria and if we approve. See Chapter 5: Precertification.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Stem-Cell Transplants (including Bone Marrow Transplants)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Allogeneic stem-cell transplants, reduced intensity conditioning for allogeneic stem-cell transplants and autologous stem-cell transplants are available only for treatment prescribed in accord with HMSA’s medical policies and with our approval. See Chapter 5: Precertification.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Chiropractic Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered, in accord with American Specialty Health Group, Inc. (“ASH”) which has been contracted by HMSA to administer the benefit through a Complementary Care Rider for the following services. All Definitions, provisions, limitations, exclusions, and conditions of the Complementary Care Rider shall apply to the chiropractic services benefits described in this Guide to Benefits.</td>
</tr>
</tbody>
</table>
  • Office Visit - New/Established patient exam
    • Follow-up office visits (include manipulation of the spine, joints, and/or musculoskeletal soft tissue, a reevaluation, and/or other services in various combinations).
    • Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies covered only when provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue. |
Chapter 4: Description of Benefits

- X-rays/radiological consultations when provided by or referred by an in-state or out-of-state ASH In-Network provider to another in-state or out-of-state ASH In-Network provider.

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

**Benefit Limitation and maximums**

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

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

The amounts you pay towards Complimentary Care Rider for chiropractic services do not apply toward meeting the medical copayment maximum. You are responsible for these amounts even after you have met the medical copayment maximum.
Chapter 5: Precertification

Definition

Precertification is a special approval process to make sure that certain medical treatments, procedures, or devices meet payment determination criteria before the service is rendered.

Services and Supplies Which Require Precertification

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

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

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

When to Request Precertification

If you are under the care of:

- An HMSA participating physician or contracting physician, he or she will:
  - Get approval for you; and
  - Accept any penalties for failure to get approval.

- A BlueCard participating or nonparticipating provider you are responsible for getting the approval. If you do not get approval and get any of the services described in this chapter, benefits may be denied.

How to Request Precertification

Ask for precertification by writing or faxing us at:

HMSA
P.O. Box 2001
Honolulu, HI 96805-2001
(808) 944-5611

If you would like to check on the status of the precertification, call your nearest HMSA office listed on the back cover of this Guide.
# Chapter 5: Precertification

## Our Response to Your Non-Urgent Precertification Request

If your request for precertification is not urgent, HMSA will respond to your request within a reasonable time that is appropriate to the medical circumstances of your case. We will respond within 15 days after we get your request. We may extend the time once for 15 days if we cannot respond to your request within the first 15 days and if it is due to circumstances beyond our control. If this happens, we will let you know before the end of the first 15 days. We will tell you why we are extending the time and the date we expect to have our decision. If we need more details from you or your provider, we will let you or your provider know and give you at least 45 days to provide it.

## Our Response to Your Urgent Precertification Request

Your precertification request is urgent if the time periods that apply to a non-urgent request:

- Could seriously risk your life or health or your ability to regain maximum function, or
- In the opinion of your treating physician, would subject you to severe pain that cannot be adequately managed without the care that is the subject of the request for precertification.

HMSA will respond to your urgent precertification request as soon as possible given the medical circumstances of your case. It will be no later than 72 hours after all information sufficient to make a determination is provided to us.

If you do not provide enough details for us to determine if or to what extent the care you request is covered, we will notify you within 24 hours after we get your request. We will let you know what details we need to respond to your request and give you a reasonable time to respond. You will have at least 48 hours to provide it.

## Appeal of Our Precertification Decision

If you do not agree with our precertification decision, you may appeal it. See *Chapter 8: Dispute Resolution.*
Chapter 6: Services Not Covered

About this Chapter

Your health care coverage does not provide benefits for certain procedures, services or supplies that are listed in this chapter or limited by this chapter or Chapter 4. We divided this chapter with category headings. These category headings will help you find what you are looking for. Actual exclusions are listed across from category headings.

Please note: Even if a service or supply is not specifically listed as an exclusion in this chapter, there are more exclusions as described by the limitations in Chapter 4. If that service or supply is not specifically listed as an exclusion in this chapter or as a limitation exclusion in Chapter 4, it will not be covered unless:

• it is described in Chapter 4: Description of Benefits, and meets all of the criteria, circumstances or conditions described, and
• it meets all of the criteria described in Chapter 1: Important Information under Questions We Ask When You Receive Care.

If a service or supply does not meet the criteria described in Chapter 4, then it should be considered an exclusion or service that is not covered. This chapter should be read in conjunction with Chapter 4 in order to identify all items that are excluded from coverage.

If you are unsure if a specific procedure, service or supply is covered or not covered, please call us, and we will help you. We list our phone numbers on the back cover of this Guide.

Counseling Services

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

Genetic Counseling
You are not covered for genetic counseling, except as described in Chapter 4: Description of Benefits under Testing, Laboratory, and Radiology and Special Benefits – Disease Management and Preventive Services or as identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations. If you need more details about USPSTF recommended counseling, including a current list of recommendations, please visit our website at www.hmsa.com or
Chapter 6: Services Not Covered

call us at one of the phone numbers listed on the back of this Guide.

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

Sexual Orientation Counseling
You are not covered for sexual orientation counseling.

Coverage Under Other Programs or Laws

Military
You are not covered for treatment of an illness or injury related to military service when you get care in a hospital operated by an agency of the U.S. government. You are not covered for services or supplies that are needed to treat an illness or injury received while you are on active status in the military service.

Payment Responsibility
You are not covered when someone else has the legal obligation to pay for your care, and when, in the absence of this coverage, you would not be charged.

Third Party Reimbursement
You are not covered for services or supplies for an injury or illness caused or alleged to be caused by a third party and/or you have or may have a right to get payment or recover damages in connection with the illness or injury. You are not covered for services or supplies for an illness or injury for which you may recover damages or get payment without regard to fault. For more details about third party reimbursement, see Chapter 9: Coordination of Benefits and Third Party Liability.

Dental, Drug, and Vision

Dental Care
You are not covered for dental care under this health coverage except for those services listed in Chapter 4: Description of Benefits. Included in this exclusion are dental services that are generally provided only by dentists and not by physicians. The following exclusions apply regardless of the symptoms or illnesses being treated:

- Orthodontics except as described in Chapter 4: Description of Benefits under Other Medical Services and Supplies, Orthodontic Services to Treat Orofacial Anomalies.
- Dental splints and other dental appliances.
- Dental prostheses.
- Maxillary and mandibular implants (osseointegration) and all related services.
- Removal of impacted teeth.
- Any other dental procedures involving the teeth, gums and structures supporting the teeth.
- Any services in connection with the treatment of TMJ (temporomandibular joint) problems or malocclusion of the teeth or jaws, except for limited medical services related to the initial diagnosis of TMJ or malocclusion.

Drugs
You are not covered for prescription drugs and supplies.

Eyeglasses and Contacts
Except as described in Chapter 4: Description of Benefits under Other Medical Services and Supplies, Vision and Hearing Appliances, you are not covered for:

- Exams for a fitting or prescription (including vision exercises).
- Frames including repair and replacement of frame parts and accessories.
- Lenses including:
  - Nonstandard items for lenses including tinting and blending.
  - Oversized lenses, and invisible bifocals or trifocals.
  - Telescopic lenses.
  - Low vision lenses.
  - Corrective low vision lenses.
- Nonprescription industrial safety goggles.
- Prescription inserts for diving masks or other protective eyewear.
- Sunglasses.
Chapter 6: Services Not Covered

Vision Services
You are not covered for:
- Refractive eye surgery to correct visual acuity problems.
- Replacement of lost, stolen or broken lenses, contact lenses or frames.
- Vision training.
- Aniseikonic studies and prescriptions.
- Reading problem studies or other procedures determined to be special or unusual.

Fertility and Infertility

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

Infertility Diagnosis
You are not covered for services or supplies related to the diagnosis of infertility.

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

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

Preventive and Routine

Health Appraisal
You are not covered for Health Appraisal services except as stated in Chapter 4: Description of Benefits.

Immunizations
You are not covered for immunizations except those described in Chapter 4: Description of Benefits.

Physical Exams (routine annual check-up)
Physical exams and any associated screening procedures in connection with third party requests or requirements, such as those for:
- employment,
- participation in employee programs,
- sports,
- camp,
- insurance,
- disability licensing, or
- on court order or for parole or probation are not covered.

Physical exams that are needed by a third party and are coincidentally performed as part of a routine annual physical exam are covered.

Routine Circumcision
You are not covered for routine circumcision except as stated in Chapter 4: Description of Benefits under the Special Benefits for Children section.

Routine Foot Care
You are not covered for services or supplies related to routine foot care.
## Chapter 6: Services Not Covered

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complementary and Alternative Medicine Provider</strong></td>
<td>You are not covered for complementary and alternative medicine services or supplies, including but not limited to:</td>
</tr>
<tr>
<td></td>
<td>• botanical medicine,</td>
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<td></td>
<td>• aromatherapy,</td>
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<td></td>
<td>• herbal/nutritional supplements,</td>
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<td></td>
<td>• medication techniques,</td>
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<td></td>
<td>• relaxation techniques,</td>
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<td></td>
<td>• movement therapies,</td>
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<td></td>
<td>• energy therapies, and</td>
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<tr>
<td></td>
<td>• massage therapy when not part of rehabilitative therapy.</td>
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<tr>
<td><strong>Dietitian</strong></td>
<td>You are not covered for nutritional counseling services except as described in Chapter 4: Description of Benefits.</td>
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<tr>
<td></td>
<td><strong>See Other Medical Services and Supplies, Medical Nutrition Therapy or Special Benefits – Disease Management and Preventive Services, Screening Services, Preventive Counseling, and Preventive Services.</strong></td>
</tr>
<tr>
<td><strong>Provider is an Immediate Family Member</strong></td>
<td>You are not covered for professional services or supplies when furnished to you by a provider who is within your immediate family. <em>Immediate Family</em> is a parent, child, spouse, domestic partner, or yourself.</td>
</tr>
<tr>
<td><strong>Provider Nondiscrimination</strong></td>
<td>To the extent an item or service is a Covered Service under this Plan, and consistent with reasonable medical management techniques specified under this Plan with respect to the frequency, method, treatment or setting for an item or service, HMSA shall not discriminate based on a provider’s license or certification, to the extent the provider is acting within the scope of the provider’s license or certification under Hawaii law. HMSA is not required to accept all types of providers into its network. And HMSA has discretion governing provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.</td>
</tr>
<tr>
<td><strong>Social Worker</strong></td>
<td>You are not covered for services and supplies from a social worker. This exclusion does not apply to covered mental health or substance abuse services or Covered Services within the scope of the social worker’s professional license issued in Hawaii.</td>
</tr>
<tr>
<td></td>
<td><strong>Please note:</strong> Social workers are not Participating Providers under this plan except as noted above. You will be responsible for your copayment, if any, plus the difference between HMSA’s eligible charge and the social worker’s billed charge.</td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td><strong>Living Donor Transport</strong> You are not covered for expenses of transporting a living donor.</td>
</tr>
<tr>
<td></td>
<td><strong>Living Organ Donor Services</strong> You are not covered for organ donor services if you are the organ donor.</td>
</tr>
<tr>
<td></td>
<td><strong>Mechanical or Non-Human Organs</strong> You are not covered for mechanical or non-human organs, except for artificial hearts when used as a bridge to a permanent heart transplant.</td>
</tr>
<tr>
<td></td>
<td><strong>Organ Purchase</strong> You are not covered for the purchase of any organ.</td>
</tr>
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<td></td>
<td><strong>Transplant Services or Supplies</strong> You are not covered for transplant services or supplies or related services or supplies other than those described in Chapter 4: Description of Benefits under Organ and Tissue Transplants and Other Organ and Tissue Transplants. Related Transplant Supplies are those that would not meet payment determination criteria but for your receipt of the transplant, including, and without limit, all forms of stem-cell transplants.</td>
</tr>
</tbody>
</table>
# Chapter 6: Services Not Covered

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transportation Related to Organ and Tissue Transplants</strong></td>
<td>You are not covered for transportation for organ or tissue transplant services or transportation of organs or tissues.</td>
</tr>
<tr>
<td><strong>Miscellaneous Exclusions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Act of War</strong></td>
<td>To the extent allowed by law, you are not covered for services needed to treat an injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists.</td>
</tr>
<tr>
<td><strong>Acupuncture</strong></td>
<td>You are not covered for services or supplies related to acupuncture.</td>
</tr>
<tr>
<td><strong>Airline Oxygen</strong></td>
<td>You are not covered for airline oxygen.</td>
</tr>
<tr>
<td><strong>Ambulance (air)</strong></td>
<td>You are not covered for air ambulance services except as described in <em>Chapter 4: Description of Benefits</em>. The following air ambulance services are not covered:</td>
</tr>
<tr>
<td></td>
<td>- Transportation from the continental US to Hawaii.</td>
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<td>- Transportation within the continental US.</td>
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<td>- Transportation for patients whose condition allows for transportation via commercial airline.</td>
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<tr>
<td></td>
<td>- Transportation on a commercial airline.</td>
</tr>
<tr>
<td><strong>Biofeedback</strong></td>
<td>You are not covered for biofeedback and any related tests.</td>
</tr>
<tr>
<td><strong>Blood</strong></td>
<td>You are not covered for blood except as described in <em>Chapter 4: Description of Benefits</em>.</td>
</tr>
<tr>
<td><strong>Carcinoembryonic Antigen (CEA)</strong></td>
<td>You are not covered for carcinoembryonic antigen when used as a screening test.</td>
</tr>
<tr>
<td><strong>Cardiac Rehabilitation</strong></td>
<td>You are not covered for cardiac rehabilitation services except as described in <em>Chapter 4: Description of Benefits</em> under Dr. Ornish’s Program for Reversing Heart Disease.</td>
</tr>
<tr>
<td><strong>Chemotherapy (High-Dose)</strong></td>
<td>You are not covered for high-dose chemotherapy except when provided in conjunction with stem-cell transplants described in <em>Chapter 4: Description of Benefits</em> under Stem-Cell Transplants (including Bone Marrow Transplants).</td>
</tr>
<tr>
<td><strong>Complementary and Alternative Medicine Services</strong></td>
<td>You are not covered for complementary and alternative medicine services or supplies including, but not limited to:</td>
</tr>
<tr>
<td></td>
<td>- botanical medicine,</td>
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<tr>
<td></td>
<td>- aromatherapy,</td>
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<td>- herbal/nutritional supplements,</td>
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<td>- energy therapies, and</td>
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<td>- massage therapy when not part of rehabilitative therapy.</td>
</tr>
<tr>
<td><strong>Complications of a Non-Covered Procedure</strong></td>
<td>You are not covered for complications of a non-covered procedure, including complications of recent or past cosmetic surgeries, services or supplies.</td>
</tr>
<tr>
<td><strong>Convenience Treatments, Services or Supplies</strong></td>
<td>You are not covered for treatments, services or supplies that are prescribed, ordered or recommended primarily for your comfort or convenience or the comfort or convenience of your provider or caregiver. Such items may include:</td>
</tr>
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<td>- ramps,</td>
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<td>- home remodeling,</td>
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<td>- hot tubs,</td>
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<td>- swimming pools,</td>
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<td>- deluxe/upgraded items, or</td>
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<td>- personal supplies such as surgical stockings.</td>
</tr>
<tr>
<td><strong>Cosmetic Services, Surgery or Supplies</strong></td>
<td>You are not covered for cosmetic services or supplies that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function. You are not covered for complications of recent or past cosmetic surgeries, services or supplies.</td>
</tr>
</tbody>
</table>
Chapter 6: Services Not Covered

Custodial Care

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

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

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

Developmental Delay

You are not covered for treatment of developmental delay or services related to developmental delay that are available through government programs or agencies.

Ductal Lavage

You are not covered for ductal lavage.

Duplicate Item

You are not covered for duplicate items that are intended to be used as a back-up device, for multiple residences or for traveling including:

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

Some examples of duplicate items are a second wheeled mobility device specifically for work or school use or a back-up manual wheelchair when a power wheelchair is the primary means of mobility.

Effective Date

You are not covered for services or supplies that you get before the effective date of this coverage.

Electron Beam Computed Tomography (EBCT or Ultrafast CT)

You are not covered for electron beam computed tomography for coronary artery calcifications.

Enzyme-potentiated Desensitization

You are not covered for enzyme-potentiated desensitization for asthma.

Erectile Dysfunction

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

Extracorporeal Shock Wave Therapy

You are not covered for extracorporeal shock wave therapy except to treat kidney stones.

False Statements

You are not covered for services and supplies if you are eligible for care only by reason of a fraudulent statement or other intentional misrepresentation that you or the Trust Fund made for membership or in any claims for benefits. If we pay benefits to you or your provider before learning of any false statement, you or the Trust Fund are responsible for reimbursing us.

Foot Orthotics

You are not covered for foot orthotics except, under the following conditions:

- Foot orthotics for persons with specific diabetic conditions per Medicare guidelines;
- Foot orthotics for persons with partial foot amputations;
- Foot orthotics that are an integral part of a leg brace and are necessary for the proper functioning of the brace, and;
- Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.
### Chapter 6: Services Not Covered

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic Testing</td>
<td>You are not covered for genetic tests except as stated in <em>Chapter 4: Description of Benefits</em> under <em>Testing, Laboratory, and Radiology</em> and <em>Special Benefits – Disease Management and Preventive Services</em>.</td>
</tr>
<tr>
<td>Growth Hormone Therapy</td>
<td>You are not covered for growth hormone therapy except as stated in <em>Chapter 4: Description of Benefits</em> under <em>Other Medical Services and Supplies</em>.</td>
</tr>
<tr>
<td>Hair Loss</td>
<td>You are not covered for services or supplies related to the treatment of baldness or hair loss regardless of condition. This includes hair transplants and topical medications.</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>You are not covered for hypnotherapy.</td>
</tr>
<tr>
<td>Incontinence Supplies</td>
<td>You are not covered for incontinence supplies including but not limited to pads, diapers, protective underwear, underpads, gloves and wipes.</td>
</tr>
<tr>
<td>Intradiscal Electro Thermal Therapy (IDET)</td>
<td>You are not covered for intradiscal electro thermal therapy.</td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>Massage therapy is not covered unless rendered as part of an approved rehabilitative therapy treatment plan.</td>
</tr>
<tr>
<td>Microprocessor (Upper/Lower Prostheses and Orthoses)</td>
<td>You are not covered for microprocessor or computer controlled, or myoelectric parts of upper and lower limb prosthetic and orthotic devices.</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>This plan does not cover the cost to buy or rent motor vehicles such as cars and vans. You are also not covered for equipment and costs related to converting a motor vehicle to accommodate a disability.</td>
</tr>
<tr>
<td>Non-Medical Items</td>
<td>You are not covered for durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances that are not primarily medical in nature. Some examples of non-medical items that are not primarily medical in nature are:</td>
</tr>
<tr>
<td></td>
<td>• environmental control equipment or supplies (such as air conditioners, humidifiers, dehumidifiers, air purifiers or sterilizers, water purifiers, vacuum cleaners, or supplies such as filters, vacuum cleaner bags and dust mite covers);</td>
</tr>
<tr>
<td></td>
<td>• hygienic equipment;</td>
</tr>
<tr>
<td></td>
<td>• exercise equipment;</td>
</tr>
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<td></td>
<td>• items primarily for participation in sports or leisure activities, and</td>
</tr>
<tr>
<td></td>
<td>• educational equipment.</td>
</tr>
<tr>
<td>Non-Related Items Exclusion</td>
<td>You are not covered for any service, procedure, or supply that is directly or indirectly related to a non-covered service, procedure, or supply.</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>You are not covered for private duty nursing.</td>
</tr>
<tr>
<td>Prohibited by Law</td>
<td>You are not covered for services or supplies we are prohibited from covering under the law.</td>
</tr>
<tr>
<td>Radiation (High-dose)</td>
<td>You are not covered for high-dose radiotherapy except when provided in conjunction with stem-cell transplants described in <em>Chapter 4: Description of Benefits</em> under <em>Stem-Cell Transplants (including Bone Marrow Transplants)</em>.</td>
</tr>
<tr>
<td>Radiation (Nonionizing)</td>
<td>You are not covered for treatment with nonionizing radiation.</td>
</tr>
<tr>
<td>Repair/Replacement</td>
<td>You are not covered for the repair or replacement of any item covered under the manufacturer or supplier warranty, including:</td>
</tr>
<tr>
<td></td>
<td>• durable medical equipment and supplies,</td>
</tr>
<tr>
<td></td>
<td>• orthotics and external prosthetics, and</td>
</tr>
<tr>
<td></td>
<td>• vision and hearing appliances</td>
</tr>
<tr>
<td></td>
<td>Replacement items that meet the same medical need as the current item but in a more efficient manner or is more convenient, when there is no change in your medical condition are also not covered.</td>
</tr>
<tr>
<td>Reversal of Gender Reassignment Surgery</td>
<td>You are not covered for reversal of gender reassignment surgery, except in the case of a serious medical barrier to completing gender reassignment or the development of a serious medical condition requiring a reversal.</td>
</tr>
</tbody>
</table>
# Chapter 6: Services Not Covered

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Help or Self-Cure</strong></td>
<td>You are not covered for self-help and self-cure programs or equipment.</td>
</tr>
<tr>
<td><strong>Services Related to Employment</strong></td>
<td>You are not covered for services related to getting or maintaining employment.</td>
</tr>
<tr>
<td><strong>Stand-by Time</strong></td>
<td>You are not covered for a provider's waiting or stand-by time.</td>
</tr>
<tr>
<td><strong>Supplies</strong></td>
<td>You are not covered for take home supplies or supplies billed separately by your provider when the supplies are integral to services being performed by your provider.</td>
</tr>
<tr>
<td><strong>Thoracic Electric Bioimpedance (Outpatient/Office)</strong></td>
<td>You are not covered for outpatient thoracic electric bioimpedance in an outpatient setting which includes a physician’s office.</td>
</tr>
<tr>
<td><strong>Topical Hyperbaric Oxygen Therapy</strong></td>
<td>You are not covered for topical hyperbaric oxygen therapy.</td>
</tr>
<tr>
<td><strong>Travel or Lodging Cost</strong></td>
<td>You are not covered for the cost of travel or lodging.</td>
</tr>
<tr>
<td><strong>Vertebral Axial Decompression (VAX-D)</strong></td>
<td>You are not covered for vertebral axial decompression.</td>
</tr>
</tbody>
</table>
| **Vitamins, Minerals, Medical Foods and Food Supplements** | You are not covered for:  
  * vitamins,  
  * minerals,  
  * medical foods, or  
  * food supplements except as described in *Chapter 4: Description of Benefits* under *Other Medical Services and Supplies*. |
| **Weight Reduction Programs** | You are not covered for weight reduction programs and supplies, whether or not weight reduction is medically appropriate. This includes:  
  * dietary supplements,  
  * food,  
  * equipment,  
  * lab tests,  
  * exams, and  
  * drugs and supplies. |
| **Wigs** | You are not covered for wigs and artificial hairpieces. |
Chapter 7: Filing Claims

This Chapter Covers

- When to File Claims.................................................................53
- How to File Claims.................................................................53
- What Information You Must File..............................................53
- Other Claim Filing Information...............................................54

When to File Claims

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

How to File Claims

One Claim Per Person and Per Provider
File a separate claim for each covered family member and each provider. You should follow the same procedure for filing a claim for services received in- or out-of-state or out-of-country.

What Information You Must File

Subscriber Number
The subscriber number that appears on your member card.

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

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

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

Signature
Make sure you sign the claim.
Chapter 7: Filing Claims

Other Claim Filing Information

Where to Send Claim
Send your claim to the address listed on the back cover of this Guide.

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

Information given to us will not be returned to you.

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

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

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

Cash or Deposit any Benefit Payment in a Timely Manner
If a check is enclosed with your Report To Member, you must cash or deposit the check before the check's expiration date. If you ask us to reissue the expired check, there will be a service charge.
Your Request for an Appeal

If you wish to dispute a decision made by HMSA related to coverage, reimbursement, this Agreement, or any other decision or action by HMSA you must ask for an appeal. Your request must be in writing unless you are asking for an expedited appeal. We must get it within one year from the date of the action or decision you are contesting. In the case of coverage or reimbursement disputes, this is one year from the date we first informed you of the denial or limitation of your claim, or of the denial of coverage for any requested service or supply.

Send written requests to:
HMSA Member Advocacy and Appeals
P.O. Box 1958
Honolulu, HI 96805-1958

Or, send us a fax at (808) 952-7546 or (808) 948-8206

And, provide the information described in the section below labeled “What Your Request Must Include”. Requests that do not comply with the requirements of this chapter will not be recognized or treated as an appeal by us.

If you have any questions about appeals, you can call us at (808) 948-5090, or toll free at 1-800-462-2085.

Appeal of Our Precertification Decision
We will respond to your appeal as soon as possible given the medical circumstances of your case. It will be within 30 days after we get your appeal.

Appeal of Any Other Decision or Action
We will respond to your appeal within 60 calendar days after we get your appeal.

Expedited Appeal
You may ask for an expedited appeal if the time periods for appeals above may:
• Seriously risk your life or health,
• Seriously risk your ability to gain maximum functioning, or
• Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

You may request expedited external review of our initial decision if you have requested an expedited internal appeal and the adverse benefit determination involves a medical condition for which the completion of an expedited internal appeal would meet the requirements above. The process for requesting an expedited external review is discussed below.

You may ask for an expedited appeal by calling us at (808) 948-5090, or toll free at 1-800-462-2085.

We will respond to your request for expedited appeal as soon as possible taking into account your medical condition. It will be no later than 72 hours after all information sufficient to make a determination is provided to us.
Chapter 8: Dispute Resolution

Who Can Request an Appeal

Either you or your authorized representative may ask for an appeal. Authorized representatives include:

- Any person you authorize to act on your behalf as long as you follow our procedures. This includes filing a form with us. To get a form to authorize a person to act on your behalf, call us at (808) 948-5090, or toll free at 1-800-462-2085. (Requests for appeal from an authorized representative who is a physician or practitioner must be in writing unless you are asking for an expedited appeal.)
- A court appointed guardian or an agent under a health care proxy.
- A person authorized by law to provide substituted consent for you or to make health care decisions on your behalf.
- A family member or your treating health care professional if you are unable to provide consent.

What Your Request Must Include

To be recognized as an appeal, your request must include all of this information:

- The date of your request.
- Your name and phone number (so we may contact you).
- The date of the service we denied or date of the contested action or decision. For precertification for a service or supply, it is the date of our denial of coverage for the service or supply.
- The subscriber number from your member card.
- The provider name.
- A description of facts related to your request and why you believe our action or decision was in error.
- Any other details about your appeal. This may include written comments, documents, and records you would like us to review.

You should keep a copy of the request for your records. It will not be returned to you.

Information Available From Us

If your appeal relates to a claim for benefits or request for precertification, we will provide upon your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim as defined by the Employee Retirement Income Security Act.

If our appeal decision denies your request or any part of it, we will provide an explanation, including the specific reason for denial, reference to the health plan terms on which our decision is based, a statement of your external review rights, and other information on our denial.

If You Disagree with Our Appeal Decision

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

- Request review by an Independent Review Organization (IRO), selected by the Insurance Commissioner if you are appealing an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness; or a determination by HMSA that the service or treatment is experimental or investigational;
- For all other issues:
  - Request arbitration before a mutually selected arbitrator; or
  - File a lawsuit against HMSA under 29 USC 1132(a) unless your plan is one of the two bulleted types below in which case you must select arbitration:
    - A church plan as defined in 29 USC 2002(33) and no selection has been made in accord with 26 USC 410(d), or
    - A government plan as defined in 29 USC 1002(32).

Request Review by Independent Review Organization (IRO) Selected by the Insurance Commissioner

If you choose review by an IRO, you must submit your request to the Insurance Commissioner within 130 days of HMSA’s decision on appeal to deny or limit the service or supply.

Unless you qualify for expedited external review of our appeal decision, before requesting review, you must have exhausted HMSA’s internal appeals process or show that HMSA violated federal rules related to claims and appeals unless the violation was: 1) de minimis; 2) non-prejudicial; 3) attributable to good cause or matters beyond HMSA’s control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of non-compliance.
Chapter 8: Dispute Resolution

Your request must be in writing and include:
- A copy of HMSA’s final internal appeal decision.
- A completed and signed authorization form releasing your medical records relevant to the subject of the IRO review. Copies of the authorization form are available from HMSA by calling (808) 948-5090, or toll free at 1-800-462-2085 or on HMSA.com.
- A complete and signed conflict of interest form. Copies of the conflict of interest form are available from HMSA by calling (808) 948-5090, or toll free at 1-800-462-2085 or on HMSA.com.
- A check for $15.00 made out to the Insurance Commissioner. It will be refunded to you if the IRO overturns HMSA’s decision. You are not required to pay more than $60.00 in any calendar year.

You must send the request to the Insurance Commissioner at:

Hawaii Insurance Division
ATTN: Health Insurance Branch – External Appeals
335 Merchant Street, Room 213
Honolulu, HI 96813
Phone: (808) 586-2804

You will be informed by the Insurance Commissioner within 14 business days if your request is eligible for external review by an IRO.

You may submit more information to the IRO. It must be received by the IRO within 5 business days of your receipt of notice that your request is eligible. Information received after that date will be considered at the discretion of the IRO.

The IRO will issue a decision within 45 calendar days of the IRO’s receipt of your request for review.

The IRO decision is final and binding except to the extent HMSA or you have other remedies available under applicable federal or state law.

**Expedited IRO Review**

You may request expedited IRO review if:
- You have requested an expedited internal appeal at the same time and the timeframe for completion of an expedited internal appeal would seriously jeopardize your life, health, or ability to gain maximum functioning or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse determination;
- The timeframe for completion of a standard external review would seriously jeopardize your life, health, or ability to gain maximum functioning, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse determination; or
- If the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which you received emergency services; provided you have not been discharged from a facility for health care services related to the emergency services.

Expedited IRO review is not available if the treatment or supply has been provided.

The IRO will issue a decision as expeditiously as your condition requires but in no event more than 72 hours after the IRO’s receipt of your request for review.

**External Review of Decisions Regarding Experimental or Investigational Services**

You may request IRO review of an HMSA determination that the supply or service is experimental or investigational.

Your request may be oral if your treating physician certifies, in writing, that the treatment or supply would be significantly less effective if not promptly started.

Written requests for review must include, and oral requests must be promptly followed up with, the same documents described above for standard IRO review plus a certification from your physician that:
- Standard health care services or treatments have not been effective in improving your condition;
- Standard health care services or treatments are not medically appropriate for you; or
Chapter 8: Dispute Resolution

- There is no available standard health care service or treatment covered by your plan that is more beneficial than the health care service or treatment that is the subject of the adverse action.

Your treating physician must certify in writing that the service recommended is likely to be more beneficial to you, in the physician’s opinion, than any available standard health care service or treatment, or your licensed, board certified or board eligible physician must certify in writing that scientifically valid studies using accepted protocols demonstrate the service that is the subject of the external review is likely to be more beneficial to you than any available standard health care services or treatment.

The IRO will issue a decision as expeditiously as your condition requires but in no event more than 7 calendar days of the IRO’s receipt of your request for review.

Request Arbitration

If you choose arbitration, you must submit a written request for arbitration to HMSA, Legal Services, P.O. Box 860, Honolulu, Hawaii 96808-0860. Your request for arbitration will not affect your rights to any other benefits under this plan. You must have fully complied with HMSA’s appeals procedures described above and we must get your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the issue. No other parties may be joined in the arbitration. The arbitration is binding and the parties waive their right to a court trial and jury.

Before arbitration starts, both parties (you and we) must agree on the person to be the arbitrator. If we both cannot agree within 30 days of your request for arbitration, either party may ask the First Circuit Court of the State of Hawaii to appoint an arbitrator.

The arbitration hearing shall be in Hawaii. The rules of the arbitration shall be those of the Dispute Prevention and Resolution, Inc. to the extent not inconsistent with this Chapter 8: Dispute Resolution. The arbitration shall be conducted in accord with the Federal Arbitration Act, 9 U.S.C. §1 et seq., and such other arbitration rules as both parties agree upon.

The arbitrator will make a decision as quickly as possible and will give both parties a copy of this decision. The decision of the arbitrator is final and binding. No further appeal or court action can be taken except as provided under the Federal Arbitration Act.

HMSA will pay the arbitrator's fee. You must pay your attorney's or witness's fees, if you have any, and we must pay ours. The arbitrator will decide who will pay all other costs of the arbitration.

HMSA waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.
Chapter 9: Coordination of Benefits and Third Party Liability

This Chapter Covers

- What Coordination of Benefits Means ............................................................... 59
- General Coordination Rules ............................................................................... 60
- Dependent Children Coordination Rules ............................................................ 60
- If You Are Hospitalized When Coverage Begins .............................................. 60
- Motor Vehicle Insurance Rules .......................................................................... 60
- Medicare Coordination Rules ............................................................................. 61
- Third Party Liability Rules ................................................................................. 62

What Coordination of Benefits Means

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

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

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

What You Should Do

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

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

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

You will get a letter from us if we need more details. If you do not give us the details we need to coordinate your benefits, your claims may be delayed or denied.

To help us coordinate your benefits, you should:

- Inform your provider by giving him or her information about the other coverage at the time services are rendered, and
- Indicate that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form.
Chapter 9: Coordination of Benefits and Third Party Liability

What We Will Do

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

General Coordination Rules

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

No Coordination Rules

The coverage without coordination of benefits rules pays first.

Member Coverage

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

Active Employee Coverage

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

Earliest Effective Date

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

Dependent Children Coordination Rules

Birthday Rule

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

Court Decree Stipulates

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

Court Decree Does Not Stipulate

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

- Custodial parent.
- Spouse of custodial parent.
- Other parent.
- Spouse of other parent.

Earliest Effective Date

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

If You Are Hospitalized When Coverage Begins

If You are Hospitalized on the Effective Date of Coverage

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

Motor Vehicle Insurance Rules

Automobile Coverage

If your injuries or illness are due to a motor vehicle accident or other event for which we believe motor vehicle insurance coverage reasonably appears available under Hawaii Revised Statutes Chapter 431, Article 10C, then that motor vehicle coverage will pay before this coverage. You are responsible for any cost sharing.
Chapter 9: Coordination of Benefits and Third Party Liability

payments required under such motor vehicle insurance coverage. We do not
cover such cost sharing payments. Before we pay benefits under this coverage
for an injury covered by motor vehicle insurance, you must give us a list
of medical expenses paid by the motor vehicle insurance. The list must show the
date expenses were incurred, the provider of service, and the amount paid by the
motor vehicle insurance. We will review the list of expenses to verify that the
motor vehicle insurance coverage available under Hawaii Revised Statutes
Chapter 431, Article 10C is exhausted. After it is verified, you are eligible for
covered services in accord with this Guide to Benefits.

Please note that you are also subject to the Third Party Liability Rules at the end
of this chapter if:

• your injury or illness is caused or alleged to have been caused by someone
  else and you have or may have a right to recover damages or receive
  payment in connection with the illness or injury, or
• you have or may have a right to recover damages or receive payment
  without regard to fault (other than personal injury protection coverage
  available under Hawaii Revised Statutes Chapter 431, Article 10C-103.5).

Any benefits paid by us in accord with this section or the Third Party Liability
Rules, are subject to the provisions described later in this chapter under Third
Party Liability Rules.

<table>
<thead>
<tr>
<th>Medicare Coordination Rules</th>
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<td><strong>Medicare as Secondary Payer</strong></td>
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<td><strong>If You are Age 65 or Older</strong></td>
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<td><strong>If You are Under Age 65 with Disability</strong></td>
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<tr>
<td><strong>If You are Under Age 65 with End-Stage Renal Disease (ESRD)</strong></td>
</tr>
<tr>
<td><strong>Dual Medicare Eligibility</strong></td>
</tr>
<tr>
<td><strong>This Plan Secondary Payer to Medicare</strong></td>
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</tbody>
</table>
If you get inpatient services and have coverage under Medicare Part B only or have exhausted your Medicare Part A benefits, we will pay inpatient benefits based on our eligible charge less any payments made by Medicare for Part B benefits (i.e., for inpatient lab, diagnostic and x-ray services).

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

Facilities or Providers Not Eligible or Entitled to Medicare Payment

When you get services at a facility or by a provider that is not eligible or entitled to reimbursement from Medicare, and Medicare is allowed by law to be the primary payer, we will limit payment to an amount that supplements the benefits that would have been payable by Medicare had the facility or provider been eligible or entitled to such payments, regardless of whether or not Medicare benefits are paid.

Third Party Liability Rules

If You have Coverage Under Worker's Compensation or Motor Vehicle Insurance

If you have or may have coverage under worker's compensation or motor vehicle insurance for the illness or injury, please note:

• **Worker's Compensation Insurance.** If you have or may have coverage under worker's compensation insurance, such coverage will apply instead of the coverage under this Guide to Benefits. Medical expenses from injuries or illness covered under worker's compensation insurance are excluded from coverage under this Guide to Benefits.

• **Motor Vehicle Insurance.** If you are or may be entitled to medical benefits from your automobile coverage, you must exhaust those benefits first, before receiving benefits from us. Please refer to the section in this Chapter entitled "Motor Vehicle Insurance Rules" for a detailed explanation of the rules that apply to your automobile coverage.

What Third Party Liability Means

Third party liability is when you are injured or become ill and:

• The illness or injury is caused or alleged to have been caused by someone else and you have or may have a right to recover damages or get payment in connection with the illness or injury; or

• You have or may have a right to recover damages or get payment without regard to fault.

In such cases, any payment made by us on your behalf in connection with such injury or illness will only be in accord with the following rules.

What You Need to Do

Your cooperation is required for us to determine our liability for coverage and to protect our rights to recover our payments. We will provide benefits in connection with the injury or illness in accord with the terms of this Guide to Benefits only if you cooperate with us by doing the following:

• **Give Us Timely Notice.** You must give us timely notice in writing of each of the following:

  - your knowledge of any potential claim against any third party or other source of recovery in connection with the injury or illness;
  - any written claim or demand (including legal proceeding) against any third party or against other source of recovery in connection with the injury or illness; and
  - any recovery of damages (including any settlement, judgment, award, insurance proceeds, or other payment) against any third party or other source of recovery in connection with the injury or illness.

To give timely notice, your notice must be no later than 30 calendar days after the occurrence of each of the events stated above;

• **Sign Requested Documents.** You must promptly sign and deliver to us all liens, assignments, and other documents we deem necessary to secure our rights to recover payments. You hereby authorize and direct any person or entity making or receiving any payment on account of such injury or illness to pay to us so much of such payment as needed to discharge your reimbursement obligations described above;

• **Provide Us Information.** You must promptly provide us any and all information reasonably related to our investigation of our liability for coverage and our determination of our rights to recover payments. We may ask you to complete an Injury/Illness report form, and provide us medical records and other relevant information;
Chapter 9: Coordination of Benefits and Third Party Liability

- **Do Not Release Claims Without Our Consent.** You must not release, extinguish, or otherwise impair our rights to recover our payments, without our express written consent; and
- **Cooperate With Us.** You must cooperate to help protect our rights under these rules. This includes giving notice of our lien as part of any written claim or demand made against any third party or other source of recovery in connection with the illness or injury.

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

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

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

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

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

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

- Do not expressly include medical expenses;
- Are stated to be for general damages only;
- Are for less than the actual loss or alleged loss suffered by you due to the injury or illness;
- Are obtained on your behalf by any person or entity, including your estate, legal representative, parent, or attorney;
- Are without any admission of liability, fault, or causation by the third party or payor.

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

Our lien will attach to and follow such recovery proceeds even if you distribute or allow the proceeds to be distributed to another person or entity. Our lien may be filed with the court, any third party or other source of recovery money, or any entity or person receiving payment regarding the illness or injury.

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

For any payment made by us under these rules, you are still responsible for your copayments, deductibles, timeliness in submission of claims, and other obligations under this Guide to Benefits.
Chapter 9: Coordination of Benefits and Third Party Liability

Nothing in these Third Party Liability Rules shall limit our ability to coordinate benefits as described in this Chapter.
Chapter 10: General Provisions

This Chapter Covers
- When Coverage Ends .......................................................... 65
- Continued Coverage ............................................................ 65
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When Coverage Ends

Notifying Us When Your Child's Eligibility Ends
You must inform the Trust Fund, in writing, if a child no longer meets the eligibility requirements. You must notify the Trust Fund on or before the first day of the month following the month the child no longer meets the requirements. For example, let's say that your child turns 26 on June 1. You would need to notify the Trust Fund by July 1.

If you fail to inform the Trust Fund that your child is no longer eligible, and we make payments for services on his or her behalf, you must reimburse us for the amount we paid.

Notifying Us When Other Events Cause Coverage To End
You must inform the Trust Fund, in writing, if other events occur that end coverage, such as divorce or the dissolution of a domestic partnership.

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

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

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

Continued Coverage

Other Continuation Coverage
If you are not eligible for COBRA coverage, you may be eligible for one of HMSA's individual payment plans. Please call us for more information.

Continued Coverage if Member Dies
Upon the death of a member, his or her spouse or domestic partner, if not eligible for group coverage, may become covered under an individual payment plan. In this case, all dependent children of such deceased member may continue to be enrolled as though they were dependents of such new member.
Chapter 10: General Provisions

Continued Coverage if You have Medicare

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

Confidential Information

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

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

Terms of Coverage

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

Authority to Terminate, Amend, or Modify Coverage

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

Governing Law

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

Payment in Error

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

Notice Address

You may send any notice required by this chapter to:

HMSA
P.O. Box 860
Honolulu, Hawaii 96808-0860

Any notice from us will be acceptable when addressed to you at your address as it appears in our records.
Accidental Injury  
An injury, separate from a disease or bodily infirmity of any other cause, that happens by chance and needs medical care right away.

Actual Charge  
The amount a provider bills for a covered service or supply.

Acute Care  
Inpatient 24-hour hospital care that needs physician and nursing care on a minute-to-minute, hour-to-hour basis.

Admission  
The formal acceptance of a patient into a facility for medical, surgical, or obstetric care.

Advance Care Planning  
Advance care planning (ACP) prepares members in the event they become very sick. Members discuss with their doctor what matters most to them and document the desired care. ACP becomes important when a member cannot communicate decisions.

Alcohol Dependence  
Any use of alcohol that produces a pattern of pathological use that causes impairment in social or occupational functions or produces physiological dependence evidenced by physical tolerance or withdrawal.

Allogeneic Transplant  
Transplant in which the tissue or organ for a transplant is obtained from someone other than the person receiving the transplant.

Ambulance Service  
Air or ground emergency transport to a hospital.

Ambulatory Surgical Center  
A facility that provides surgical services on an outpatient basis for patients who do not need an inpatient, acute care hospital bed.

Ancillary Services  
Facility charges other than room or board. For example, charges for inpatient drugs and biologicals, dressings, or medical supplies.

Anesthesia  
The use of anesthetics to produce loss of feeling or consciousness, usually with medical treatment such as surgery.

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

Applied Behavior Analysis  
The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of:
  • direct observation,
  • measurement, and
  • functional analysis of the relations between environment and behavior.

Arbitration  
When one person (an arbitrator) reviews the positions of two parties who have a dispute and makes a decision to end the dispute.
Chapter 11: Glossary

Assisting Surgeon: A physician who actively assists the physician in charge during a surgical procedure.

Autologous Transplant: Transplant in which the tissue or organ for a transplant is obtained from the person receiving the transplant.

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

Benefits: Services and supplies that are medically necessary and qualify for payment under this coverage.

Bereavement Services: Services that focus on healing from emotional loss.

Biofeedback: A technique in which a person uses information about a normally unconscious bodily function, such as blood pressure, to gain conscious control over that function. The condition to be treated must be a normally unconscious physiological function. A device or feedback monitoring equipment (i.e., external feedback loop) must be used to treat the condition. The purpose of treatment is to exert control over that physiological function.

Biological Therapeutics and Biopharmaceuticals: Any biology-based therapeutics that structurally mimic compounds found in the body. This includes:
- recombinant proteins,
- monoclonal and polyclonal antibodies,
- peptides,
- antisense oligonucleotides,
- therapeutic genes, and
- certain therapeutic vaccines.

Birthing Center: A facility that provides services for normal childbirth. This facility may be in a hospital or it may be a separate, independent facility.

Blood Transfusion: Transferring blood products such as blood, blood plasma, and saline solutions into a blood vessel, usually a vein.

BlueCard Participating Provider: A provider that participates with the BlueCard Program. BlueCard participating providers file claims for you and accept the eligible charge as payment in full.

BlueCard Program: The Blue Cross and Blue Shield Association program that gives HMSA members access to participating providers throughout the U.S.

Breast Prostheses (External): Artificial breast forms intended to simulate breasts for women who have uneven- or unequal-sized breasts who decide not to, or are waiting to, undergo surgical breast reconstruction after a covered mastectomy or lumpectomy. They include:
- mastectomy bras (surgical bras),
- forms,
- garments and
- sleeves.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985 that offers you and your eligible dependents continuation of this coverage if you lose coverage due to a qualifying event.

Calendar Year: The period starting January 1 and ending December 31 of any year. The first calendar year for anyone covered by this plan begins on that person's effective date and ends on December 31 of that same year.
| **Chemotherapy** | Treatment of infections or malignant diseases by drugs that act selectively on the cause of the disorder, but which may have substantial effects on normal tissue. Chemotherapy drugs must be FDA approved. |
| **Child** | Means any of the following: your son, daughter, stepson or stepdaughter, your legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian or your eligible foster child (defined as an individual who is placed with you by an authorized placement agency or by judgment, decree or other court order). |
| **Chiropractor** | A health care professional who practices the system of healing through spinal manipulation and specific adjustment of body structures. |
| **Claim** | A written request for payment of benefits for services covered by this coverage. |
| **Consultation Services** | A formal discussion between physicians on a case or its treatment. |
| **Contact Lenses** | Ophthalmic corrective lenses ground as prescribed by a physician or optometrist who fit the lenses directly to your eyes. |
| **Contraceptive Services** | Services that facilitate the use of contraceptives to prevent pregnancy. |
| **Contraceptives** | Any prescription contraceptive supplies or devices, including:  
  - oral medicine,  
  - implants,  
  - injectables,  
  - IUDs or  
  - other appropriate methods intended to prevent pregnancy. |
| **Coordination of Benefits (COB)** | Applies when you are covered by more than one insurance policy providing benefits for like services. |
| **Copayment** | A copayment applies to most covered services. It is either a fixed percentage of the eligible charge or a fixed dollar amount. Exception: For services provided at a participating facility, your copayment is based on the lower of the facility’s actual charge or the maximum allowable fee. You owe a copayment even if the facility’s actual charge is less than the maximum allowable fee. |
| **Cosmetic Services** | Services that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function, or are prescribed for psychological or psychiatric reasons. |
| **Cost-Effective** | A health intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the health intervention; provided that the characteristics of the individual patient shall be determinative when applying this criterion to an individual case. |
| **Covered Services** | Services or supplies that meet payment determination criteria and are either:  
  - Listed in this Guide in Chapter 4: Description of Benefits, or  
  - Not listed in this Guide in Chapter 6: Services Not Covered. |
| **Custodial Care** | Care that helps you meet your daily living activities. This type of care does not need the ongoing attention and help from licensed medical or trained paramedical personnel. |
Chapter 11: Glossary

Custom-Fabricated

Items that are individually made for a specific patient (no other patient would be able to use it) starting with basic materials including, but not limited to:

- plastic,
- metal,
- leather, or
- cloth in the form of sheets, bars, etc.

It involves substantial work such as:

- vacuum forming,
- cutting,
- bending,
- molding,
- sewing, etc.

It may involve the incorporation of some prefabricated components but it involves more than:

- trimming,
- bending, or
- making other modifications to a substantially prefabricated item.

Deluxe/Upgraded Items

Items that have certain convenience or luxury features that enhance standard or basic equipment. Standard equipment is equipment that meets the medical needs of a patient to perform activities of daily living primarily in the home and is not designed or customized for a specific individual’s use.

Dependent

The member's spouse or domestic partner and/or eligible child(ren) who are eligible to enroll in the Plan under Chapter 87A, Hawaii Revised Statutes, and the Trust Fund’s administrative rules, which may be amended from time to time.

Detoxification Services

A process of detoxifying a person who is dependent on alcohol and/or drugs. The process involves helping a person through the period of time needed to get rid of, by metabolic or other means, the intoxicating alcohol or drug dependency factors.

Diagnosis

The medical description of the disease or condition.

Diagnostic Testing

A measure used to help identify the disease process and signs and symptoms.

Dr. Ornish's Program for Reversing Heart Disease™

A comprehensive approach to cardiovascular disease management and overall well-being improvement that addresses modifiable risk factors under the supervision of a multidisciplinary team.

Drug

Any chemical compound that may be used on or given to help diagnose, treat, or prevent disease or other abnormal condition, to relieve pain or suffering, or to control or improve any physiologic or pathogenic condition.

Drug Dependence

Any pattern of pathological use of drugs that cause impairment in social or occupational function and produces psychological or physiological dependence or both, as evidenced by physical tolerance or withdrawal.

Dues

The monthly premium amount for HMSA membership.

Durable Medical Equipment

An item that meets these criteria:

- FDA-approved for the purpose that it is being prescribed.
- Able to withstand repeated use.
- Primarily and customarily used to serve a medical purpose.
- Appropriate for use in the home. **Home** means the place where you live other than a hospital or skilled or intermediate nursing facility.
- Necessary and reasonable to treat an illness or injury, or to improve the functioning of a malformed body part. It should not be useful to a person in the absence of illness or injury.
Examples of durable medical equipment include oxygen equipment, hospital beds, mobility assistive equipment (wheelchairs, walkers, power mobility devices), and insulin pumps.

**Effective**

A health intervention that may reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

**Effective Date**

The date on which you are first eligible for benefits under this coverage.

**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. HMSA’s payment, and your copayment, are based on the eligible charge. **Exceptions:** For services from participating facilities, HMSA’s payment is based on the maximum allowable fee and your copayment is based on the lower of the actual charge or the maximum allowable fee. Some services may be rendered by providers who accept monthly payments from HMSA to manage the care of a certain population of their patients.

**Emergency**

A medical condition accompanied by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:
- serious risk to the health of the person (or, with respect to a pregnant woman, the health of the woman and her unborn child);
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ part.

**Employee**

An Active employee who is eligible to enroll in this Plan under Chapter 87A, Hawaii Revised Statutes, and the Trust Fund’s administrative rules, which may be amended from time to time.

**Extended Care Facility**

A facility that provides ongoing skilled nursing care, sub-acute care, or long-term acute care as ordered and certified by your attending Provider.

**Facility**

Examples include hospitals, extended care facilities, birthing centers, and ambulatory surgical facilities.

**False Statement**

Any fraudulent or intentional misrepresentation you or the Trust Fund made for membership or in any claims for benefits.

**Family Member**

The member's spouse or domestic partner and/or children who are eligible and enrolled in the Plan.

**Foot Orthotics**

Devices that are placed into shoes to assist in restoring or maintaining normal alignment of the foot, relieve stress from strained or injured soft tissues, bony prominences, deformed bones and joints and inflamed or chronic bursae.

**Frame**

A standard plastic eyeglass frame or similar frame into which two lenses are fitted.

**Gender Dysphoria**

The distress experienced when a person’s gender assigned at birth does not match their gender identity.

**Gender Identity**

A person's internal sense of being male, female, a gender different from the gender assigned at birth, a transgender person, or neither male nor female.

**Gender Transition**

The process of a person changing the person's outward appearance, including sex characteristics, to accord with the person's gender identity.
Chapter 11: Glossary

**Group**
Those members who share a common relationship such as employment or membership.

**Guide to Benefits**
This document, along with any riders or amendments that provide a written description of your health care coverage.

**HMSA**
Hawai‘i Medical Service Association, an independent licensee of the Blue Cross and Blue Shield Association.

**HMSA Directory of Participating Providers**
A complete list of HMSA participating providers.

**HMSA Participating Provider**
A provider that contracts with HMSA, files claims for you, accepts the eligible charge as payment in full, and handles precertification for you.

**Health Intervention**
An item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. New interventions for which clinical trials have not been conducted and effectiveness has not been scientifically established shall be evaluated on the basis of professional standards of care or expert opinion. For existing interventions, scientific evidence shall be considered first and to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Giving priority to scientific evidence shall not mean that coverage of existing interventions shall be denied in the absence of conclusive scientific evidence. Existing interventions may meet the definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or in the absence of such standards, convincing expert opinion.

**Health Outcomes**
Outcomes that affect health status as measured by the length or quality of a patient's life, primarily as perceived by the patient.

**High-Dose Chemotherapy**
A form of chemotherapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a stem-cell transplant is needed.

**High-Dose Radiotherapy**
A form of radiation therapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a stem-cell transplant is needed.

**Homebound**
Due to an illness or injury, you are unable to leave home, or leaving your home requires a large and taxing effort.

**Home Health Agency (HHA)**
An approved agency that provides skilled nursing care in your home.

**Home Infusion Therapy**
Treatment in the home that involves giving nutrients, antibiotics and other drugs and fluids intravenously or through a feeding tube. Drugs must be FDA approved.

**Hospice Program**
A program that provides care in a comfortable setting for patients who are terminally ill and have a life expectancy of six months or less. Care is normally provided in the patient’s home.

**Hospital**
An institution that provides diagnostic and therapeutic services for surgical and medical diagnosis, treatment and care of injured or sick persons.
Illness or Injury
Any bodily disorder, injury, disease or condition, including pregnancy and its complications.

Immediate Family Member
Your child, spouse, domestic partner, parent, or yourself.

Immunization
An injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

Implanted Internal Items/Implants (Surgical/Orthopedic)
Internal prosthetic devices used during surgery that are necessary for anatomical repair or reconstructive purposes. These devices remain in the body and replace a missing biological structure or support or enhance a damaged biological structure.

Examples include, but are not limited to:
- cardiac pacemakers,
- defibrillators,
- heart valves and stents,
- breast implants for post-mastectomy reconstruction,
- hip and knee replacements,
- hardware necessary to anchor fractured bones,
- implanted cataract lenses,
- cochlear implants,
- adjustable gastric bands for bariatric surgery, and
- human tissue.

The device must be FDA-approved for the purpose it is being used.

Incidental Procedure
A procedure that is an integral part of another procedure. Such procedures are not reimbursed separately.

Inhalation Therapy
Therapy to treat conditions of the cardiopulmonary system.

Injection
The introduction of a drug, biological therapeutic, biopharmaceutical, or vaccine into the body by using a syringe and needle. Injectable drugs must be FDA approved.

Inpatient Admission
A stay in an inpatient facility, usually involving overnight care.

Intravenous Injection
An injection made into the vein.

In Vitro Fertilization
A method used to treat infertility in women.

Laboratory Services
Services used to help diagnose, prevent, or treat disease.

Lenses
Ophthalmic corrective lenses ground as prescribed by a physician or optometrist for fitting into a frame.

Limited Services
Those covered services that are limited per service, per episode, per calendar year or per lifetime.

Long-Term Acute Care
A level of care for patients who:
- no longer require care in an acute hospital,
- are chronically and severely ill,
- are felt to have the potential for improvement, and
- require an intensity and specialization of care that is beyond that provided in any other level of post-acute care.

Examples include:
- skilled nursing facility,
- home healthcare,
- inpatient rehabilitation facility, and
Chapter 11: Glossary

- for a limited period until the condition is stabilized or a predetermined treatment course is completed.

**Mammogram**
An x-ray exam of the breast using equipment dedicated specifically for mammography.

**Mammography (screening)**
An x-ray film that screens for breast abnormalities.

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

**Medicaid**
A form of public assistance sponsored jointly by the federal and state governments providing medical assistance for eligible persons whose income falls below a certain level. The Hawaii Department of Human Services pursuant to Title XIX of the federal Social Security Act administers this program.

**Medical Condition**
A disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

**Medication**
The treatment of disease without surgery.

**Medicine**
To diagnose and treat disease and to maintain health.

**Member**
The employee who meets the Trust Fund’s eligibility requirements.

**Member Card**
Your member card issued to you by us. You must present this card to your provider at the time you get services.

**Mental Health Outpatient Facility**
A mental health clinic, institution, center, or community mental health center that provides for the diagnosis, treatment, care or rehabilitation of people who are mentally ill.

**Mental Illness/Disorder**
A syndrome of clinically significant psychological, biological, or behavioral abnormalities that result in personal distress or suffering, impairment of capacity to function, or both. Mental illness and disorder are used interchangeably in this Guide and as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or in the International Classification of Disease.

**Microprocessor-Controlled Prosthetic Device**
Prosthetic devices that use feedback from sensors to adjust joint movement on a real-time as-needed basis.

**Myoelectric Prosthetic Device**
Prosthetic devices powered by electric motors with an external power source. For example, the movement of an upper limb prosthesis (e.g., hand, wrist, and/or elbow) is driven by micro-chip-processed electrical activity in the muscles of the remaining limb stump.

**Newborn**
A recently born infant.

**Newborn Care**
All routine non-surgical physician services and nursery care provided to a newborn during the mother’s initial hospital stay.

**Non-Assignment**
When benefits for covered services and supplies cannot be transferred or assigned to anyone for use.

**Nonparticipating Providers**
Providers that are not under contract with HMSA or any other Blue Cross and/or Blue Shield Plan.
Chapter 11: Glossary

Nurse Midwife
A health care professional who provides services such as pre and post natal care, normal delivery services, routine gynecological services, and any other services within the scope of his or her certification.

Occupational Therapy
A form of therapy involving the treatment of neurological and musculoskeletal dysfunction through the use of specific tasks or goal-directed activities designed to improve the functional performance of an individual.

Online Care
Care provided by video conferencing, phone or web if obtained from HMSA Online.

Ophthalmologist
A physician specializing in the diagnosis and treatment of diseases and defects of the eye.

Optician
One who fits, adjusts and dispenses glasses and other optical devices, on the written prescription of a licensed physician or optometrist.

Optometrist
One who specializes in the examination, diagnosis, treatment and management of diseases and disorders of the visual system, the eye and related structures.

Oral Surgeon
A dentist licensed as a doctor of dentistry (D.M.D.) or dental surgery (D.D.S.) to diagnose and treat oral conditions that need surgery.

Organ Donor Services
Services related to the donation of an organ.

Orofacial Anomalies
Cleft lip or cleft palate and other birth defects of the mouth and face affecting functions such as eating, chewing, speech, and respiration.

Orthodontic Services to Treat Orofacial Anomalies
Direct or consultative services from a licensed dentist with a certification in orthodontics by the American Board of Orthodontics.

Orthotics/Orthotic Devices/Orthoses
Rigid or semi-rigid devices that are used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a diseased or injured part of the body. They must provide support and counterforce (i.e., a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace. An orthotic can be either prefabricated or custom-fabricated.

Osteopathy
Medicine that specializes in diseases of the bone.

Osteoporosis
The loss of minerals from the bone.

Other Providers
Health care providers other than facilities and practitioners. Examples include hospice agencies, ambulance services, retail pharmacies, home medical equipment suppliers, and independent labs.

Our
Reference to HMSA (Hawai‘i Medical Service Association).

Outpatient
Care received in a practitioner's office, the home, an ambulatory infusion suite, the outpatient department of a hospital or ambulatory surgery center.

Participating Provider
A provider that participates with us or a Blue Cross and/or Blue Shield Plan.

Physical Therapy
A form of therapy involving treatment of disease, injury, congenital anomaly or prior therapeutic intervention through the use of therapeutic modalities and other interventions that focus on a person’s ability to go through the functional activities of daily living and on alleviating pain.
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Psychologist
An approved provider who specializes in the treatment of mental health conditions.

Radiology
The use of radiant energy to diagnose and treat disease.

Registered Bed Patient
A person who is registered by a hospital or extended care facility as an inpatient for an illness or injury covered by this Guide.

Report to Member
The report you get from us that notes how we applied benefits to a claim. You may get copies of your report online through My Account on hmsa.com or by mail upon request.

Scientific Evidence
Controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and the health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. Scientific evidence may be found in the following and similar sources:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National [Institutes] of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);
- Medical journals recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the Social Security Act, as amended
- Standard reference compendia including the American Hospital Formulary Service-Drug Information, American Medical Association Drug Evaluation, American Dental Association Accepted Dental Therapeutics, and United States Pharmacopoeia-Drug Information;

- Findings, studies, or research conducted by or under the auspices of federal agencies and nationally recognized federal research institutes including but not limited to the Federal Agency for Health Care Policy and Research, National Institutes [of] Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- Peer-reviewed abstracts accepted for presentation at major medical association meetings.

Sexual Identification Counseling
Psychotherapy for a person with gender dysphoria.

Sexual Orientation Counseling
Treatment of an enduring pattern of emotional, romantic and/or sexual attractions to men, women or both sexes. Sexual orientation also refers to a person's sense of identity based on those attractions, related behaviors and membership in a community of others who share those attractions.

Single Coverage
Coverage for the member only.

Skilled Nursing Care
A level of care for patients who require skilled nursing and/or rehabilitation care, i.e., services that must be performed by or under the supervision of professional or technical personnel, on a daily basis.
# Chapter 11: Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>A facility that provides ongoing skilled nursing services as ordered and certified by your attending Provider.</td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td>A provider who is specifically trained in a certain branch of medicine related to a service or procedure, body area or function, or disease.</td>
</tr>
<tr>
<td><strong>Speech Therapy Services</strong></td>
<td>Services for the diagnosis, assessment and treatment of communication impairments and swallowing disorders.</td>
</tr>
<tr>
<td><strong>Spouse</strong></td>
<td>Your husband or wife as the result of a marriage who is legally recognized in the State of Hawaii. For purposes of this Guide to Benefits, “spouse” also includes an Employee’s domestic partner who is eligible to enroll in the Plan under the Trust Fund’s administrative rules.</td>
</tr>
<tr>
<td><strong>Stand by Time</strong></td>
<td>Any period of time that is used for waiting, or is idle.</td>
</tr>
<tr>
<td><strong>Sub-Acute Care</strong></td>
<td>A level of care for patients who no longer require care in an acute hospital and require more intensive skilled care that is beyond that traditionally provided in a skilled nursing facility, e.g., require frequent and recurrent patient assessment and review of clinical course and treatment plan.</td>
</tr>
<tr>
<td><strong>Subcutaneous Implant</strong></td>
<td>A medication that is surgically placed beneath the skin to release the drug in the bloodstream. An example is the Norplant contraceptive.</td>
</tr>
<tr>
<td><strong>Subscriber Number</strong></td>
<td>The number that appears on your HMSA member card.</td>
</tr>
<tr>
<td><strong>Substance Abuse Services</strong></td>
<td>Providing medical, psychological, nursing, counseling, or therapeutic services as part of a treatment plan for alcohol or drug dependence or both. Services may include aftercare and individual, group and family counseling services.</td>
</tr>
<tr>
<td><strong>Supportive Care</strong></td>
<td>A comprehensive approach to care for members with a serious or advanced illness including Stage 3 or 4 cancer, advanced Congestive Heart Failure (CHF), advanced Chronic Obstructive Pulmonary Disease (COPD), or any advanced illness that meets the requirements of the Supportive Care policy. Members get comfort-directed care, along with curative treatment from an interdisciplinary team of practitioners.</td>
</tr>
<tr>
<td><strong>Surgical Services</strong></td>
<td>Cutting, suturing, diagnostic, and therapeutic endoscopic procedures; debridement of wounds, including burns; surgical management or reduction of fractures and dislocations; orthopedic casting manipulation of joints under general anesthesia or destruction of localized surface lesions by chemotherapy cryotherapy, or electrosurgery.</td>
</tr>
<tr>
<td><strong>Third Party Liability</strong></td>
<td>Our rights to reimbursement when you or your family members get benefits under this coverage for an illness or injury and you have a lawful claim against another party or parties for compensation, damages, or other payment.</td>
</tr>
<tr>
<td><strong>Transgender Person</strong></td>
<td>A person who has gender identity disorder or gender dysphoria, received health care services related to gender transition, adopts the appearance or behavior of the opposite sex, or otherwise identifies as a gender different from the gender assigned to that person at birth.</td>
</tr>
<tr>
<td><strong>Transplant</strong></td>
<td>The transfer of an organ or tissue for grafting into another area of the same body or into another person.</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Management and care of the patient to combat a disease or disorder.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>Trust Fund</td>
<td>Hawaii Employer-Union Health Benefits Trust Fund (EUTF). The trust fund has executed an Agreement with us to administer a health benefits plan covering eligible members.</td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>A sterilization procedure for women.</td>
</tr>
<tr>
<td>Us</td>
<td>HMSA (Hawai‘i Medical Service Association).</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>A sterilization procedure for men.</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Services that test eyes for visual acuity and identify and correct visual acuity problems with lenses and other equipment.</td>
</tr>
<tr>
<td>We</td>
<td>HMSA (Hawai‘i Medical Service Association).</td>
</tr>
<tr>
<td>Well-Being Services</td>
<td>A variety of well-being tools, programs and services to take care of you and your family. Visit hmsa.com/wellbeing to find the latest benefits available to our members.</td>
</tr>
<tr>
<td>You and Your Family</td>
<td>You and your family members eligible for coverage under this Guide.</td>
</tr>
</tbody>
</table>
Serving you
Meet with knowledgeable, experienced health plan advisers. We’ll answer questions about your health plan, give you general health and well-being information, and more. Hours of operation may change. Go to hmsa.com/contact before you visit.

**HMSA Center @ Honolulu**
818 Keeaumoku St.
Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m.

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

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

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

Customer Relations representatives are also available in person at our Kauai office, Monday through Friday, 8 a.m. to 4 p.m.: 

**Lihue, Kauai**
4366 Kukui Grove St., Suite 103

**Contact HMSA. We’re here with you.**
Call (808) 948-6499 or 1 (800) 776-4672.

hmsa.com/EUTF  myhmsa  @askHMSA  askhmsa