Medical Plan

(For employees residing in Hawaii)

Summary Plan Description

January 1, 2025

This document is the Summary Plan Description ("SPD") for this benefit. This SPD is required by federal law called the Employee Retirement Income Security Act of 1974 ("ERISA"). This SPD reflects the terms of the benefit in effect as of January 1, 2025. Ecolab has the right to amend or terminate all or part of the Plan at any time.

ADMINISTRATIVE INFORMATION
TABLE OF CONTENTS

Plan Name and Description 1

Benefit Options Chart 1

Eligible Employees 3

Eligible Dependents 4

Enrollment Periods and Coverage Effective Dates 5

Mid-Year Election Change Events 6

Coverage and Benefits Information in Benefits Description 7

Benefit Payments 8

Impact of Leaves of Absence on Benefits 8

Benefit Claims and Appeals 10

Participation Claims and Appeals 11

Qualified Medical Child Support Orders 12

Post Retirement Benefits 12

COBRA Continuation Coverage 12

USERRA Continuation Coverage 17

Other Notices 18

Subrogation and Reimbursement 20

ERISA Plan Information 23

Statement of ERISA Rights 24

ECOLAB HEALTH AND WELFARE BENEFITS PLAN: MEDICAL, PRESCRIPTION DRUG, DENTAL, VISION, EAP AND FLEXIBLE BENEFIT OPTIONS

ADMINISTRATIVE INFORMATION SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2025

Plan Name and Description

The name of the Plan is the Ecolab Health and Welfare Benefits Plan ("Plan"). The Plan provides health and other welfare benefits to Eligible Employees of Ecolab Inc. and subsidiaries of Ecolab Inc. that have adopted the Plan ("Participating Employers" or "Employers") and their Eligible Dependents.

This Administrative Information Summary Plan Description ("Administrative Information SPD") describes the medical, prescription drug, dental, vision and EAP options under the Plan.

This Administrative Information SPD and the attached Vendor Benefit Description together make up the ERISA-required Summary Plan Description. The list of options covered under this Administrative Information SPD and the title of the Vendor Benefit Description for each option is below in the *Benefit Options Chart.* The SPD is part of the Plan Document.

Benefit Options Chart

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Health Savings Account Medical Plan Option (for Employees Residing in US Other than Alaska, Wyoming and Hawaii) Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Traditional Medical Plan Option (for Employees Residing in US Other Than Alaska, Wyoming and Hawaii) Benefit Description
Medical	Insured	HMSA PO Box 1958 Honolulu, HI 96805-1958 1-800-810-2583 www.hmsa.com	Hawaii Medical Plan Option Benefit Description

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Health Savings Account Medical Plan Option (for Employees Residing in Alaska and Wyoming) Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Traditional Medical Plan Option (for Employees Residing in Alaska and Wyoming) Benefit Description
Medical, Prescription Drug, Dental and Vision and EAP	Insured	Cigna Global PO Box 15050 Wilmington DE 19850-5050 1-800-441-2668 www.cignaenvoy.com	International Benefits Plan Option Benefit Description
Prescription Drug	Self-Insured	CVS/caremark PO Box 52136 Phoenix, AZ 85072-2136 1-866-490-0021 www.caremark.com (See Benefit Description for addresses for out-of-network claim reimbursement, appeals and mail order prescriptions.)	Health Savings Account Prescription Drug Plan Option Benefit Description
Prescription Drug	Self-Insured	CVS/caremark PO Box 52136 Phoenix, AZ 85072-2136 1-866-490-0021 www.caremark.com (See Benefit Description for addresses for out-of-network claim reimbursement, appeals and mail order prescriptions.)	Traditional Prescription Drug Plan Option Benefit Description
Dental	Insured	MetLife Dental Claims PO Box 981282 El Paso, TX 79998-1282 1-800-942-0854 www.mybenefits.metlife.com	Premier Dental Plan Option Benefit Description

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor Benefit Description
Dental	Insured	MetLife Dental Claims PO Box 981282 El Paso, TX 79998-1282 1-800-942-0854 www.mybenefits.metlife.com	Standard Dental Plan Option Benefit Description
Vision	Insured	EyeMed Fidelity Security Life Insurance Company 3130 Broadway Kansas City, MO 64111-2406 1-833-918-1259 member.eyemedvisioncare.com/ecolab/en	Vision Plan Option Group Vision Insurance Certificate / Benefit Description
EAP	Insured	Cigna Behavioral Health 11095 Viking Drive Suite 350 Eden Prairie, MN 55344 Member Services at: 1-800-900-3791 www.mycigna.com	Employee Assistance Plan (EAP) Option Benefit Description
Flexible Benefit	Self-Insured	ThrivePass 1-866-855-2844 mybenefits.us.ecolab.com	Flexible Benefit Plan Option Benefit Description

Eligible Employees

You are eligible to participate in the Plan if you are an Eligible Employee. If you and your family member are both employed by Ecolab or another Participating Employer ("Employer"), you cannot be enrolled as both an employee and a dependent (you and your family member will both be enrolled as employees, provided you are Eligible Employees). To enroll for coverage under an Insurance Policy, you must also satisfy the eligibility requirements for coverage as set forth in the Policy.

Eligible Employee. You are an Eligible Employee if you are:

1. employed by the Employer;
2. in a budgeted position;
3. regularly scheduled to work at least 20 hours per week; and
4. not excluded from the definition of Eligible Employee.

Not Eligible Employee (Excluded). You are not an Eligible Employee (excluded from the definition of Eligible Employee) if you are:

1. classified by the Employer as a temporary employee, a leased employee, or independent contractor;
2. covered by a collective bargaining agreement or contract that does not provide for your participation; or

3. employed by an Ecolab subsidiary that has not adopted the Plan.

Foreign Service for Eligible Employees. If you are a U.S. citizen or resident alien who is transferred to a full-time position with Ecolab or an Ecolab subsidiary in a foreign country (outside of the United States) on a temporary basis for 6 months or more, you will be eligible for coverage under the Ecolab Expatriate option.

Union Employees. If you are covered by a collective bargaining agreement, you are eligible for coverage only if your union agreement provides for your Plan participation.

Reclassification as an Eligible Employee. If you are reclassified as an Eligible Employee by a court, an administrative body or the Employer on a retroactive basis, you will be eligible for coverage only during periods that follow the reclassification. No Plan coverage will be retroactive.

Eligible Dependents

Eligible Dependents are: (1) your Spouse or your Domestic Partner; and (2) your Dependent Child(ren).

You must enroll your Eligible Dependents within the period required by the Plan. Refer to the "Enrollment Periods and Coverage Effective Dates" section below. You must be enrolled in an option to enroll your Eligible Dependents in that option.

Proof of Dependent Status. You must provide documents supporting Eligible Dependent status when you first enroll your Spouse or Domestic Partner or your Dependent Child, such as a birth certificate, marriage certificate or domestic partner affidavit.

If you fail to provide the required documentation by the deadline imposed by the Plan Administrator, your dependent will not be enrolled and cannot enroll until the next Open Enrollment Period (unless you experience a qualifying election change event before then).

You may periodically be required to provide proof of Eligible Dependent status after initial enrollment as well.

Spouse. Spouse means your spouse through marriage recognized as valid under U.S. federal law.

Domestic Partner. To be a Domestic Partner, your partner must be:

1. of the same gender as you and the two of you must be in a civil union, in a registered domestic partnership or a similar arrangement that is legally recognized under the laws of a state in the United States or under the laws of a jurisdiction outside of the United States; or

2. of the same or opposite gender as you and the two of you must:

    a. be at least 18 years old and legally competent to enter into a contract;

    b. not be married to or the domestic partner of anyone else;

    c. be jointly responsible for each other's well-being and financial obligations;

    d. not be related to you by blood to a degree that would prohibit your marriage in your state of residence;

    e. have an ongoing and committed spouse-like relationship and intend to do so indefinitely;

    f. live together in the same principal residence and intend to do so indefinitely; and

g. be jointly responsible for the direction and financial management of your household and take joint financial responsibility for each other's financial obligations.

You must submit your certificate of civil union or registered domestic partnership, or a domestic partner affidavit signed by you and your Domestic Partner. Domestic Partner benefits are only available for an option if provided in the Vendor Benefit Description. Federal tax rules generally require your contribution for coverage for a Domestic Partner and his or her children to be paid on an after-tax basis and the value of employer-paid coverage for the Domestic Partner and his or her children to be imputed to you as income.

Dependent Child. Dependent Child means a child who:

1. has one of the following relationships to you or to your Spouse or Domestic Partner:
    a. biological child;
    b. legally adopted child;
    c. child placed for legal adoption;
    d. foster child; or
    e. legal ward (child for whom you or your Spouse or Domestic Partner are legal guardian); and
2. is either:
    a. under the Limiting Age; or
    b. is eligible for Extended Disabled Dependent Coverage.

Limiting Age. The Limiting Age is age 26, regardless of marital, support, or student status.

Extended Disabled Dependent Coverage. To be eligible for Extended Disabled Dependent Coverage, a child must: (1) provide proof of eligibility for Extended Disabled Dependent Coverage when requested; and (2) not be self-supporting due to physical, mental or intellectual disability.

Enrollment Periods and Coverage Effective Dates

You must enroll in the manner directed by Human Resources.

Initial Enrollment. If you are a new Eligible Employee (a new hire or newly eligible for coverage), you must make your benefit elections within 31 days of your hire date or date of initial eligibility, and must be an Eligible Employee on the date of your enrollment. Your coverage will be retroactive to your hire date.

Annual Open Enrollment. All Eligible Employees can make new elections or changes for the next Plan Year during the Open Enrollment Period that occurs in the fall. Open enrollment elections are effective on January 1 following the Open Enrollment Period.

Mid-Year Special Enrollment. Mid-year special enrollment is provided for medical and prescription drug options pursuant to HIPAA for birth or adoption of a child, marriage, loss of other health plan coverage, losing a child's health insurance coverage through the state or becoming eligible for a premium subsidy from the state to obtain coverage for a child under this Plan. Additional details are provided in the medical Vendor Benefit Description.

Mid-Year Election Changes. Mid-year election changes can only be made if you have experienced a qualifying Mid-Year Election Change Event (see the list below) and make new elections within 31 days of the event. You must make the election in the manner directed by the Plan Administrator. You are required to provide documents supporting your qualifying Mid-Year Election Change Event when you submit your election change form (for example, birth certificate, marriage certificate, divorce decree).

The Plan Administrator will determine whether you have experienced a qualifying Mid-Year Election Change Event and whether the change you are requesting is consistent with that event in accordance with IRS regulations.

An election change will generally be effective on the date of the Mid-Year Election Change Event. Adjusted premium contributions will begin the first pay period after the effective date of your election change. Premium payments will be made for any period of retroactive coverage. Refunds or retroactive adjustments will be made to your premium contributions.

Mid-Year Election Change Events

The following are qualifying Mid-Year Election Change Events for purposes of the Plan:

1. Change in Status Events. The following are change in status events. An election change will be consistent with a change in status only if the change in status: affects eligibility for coverage under an employer plan, or some other plan such as for medical coverage, or coverage under this Plan; and the election change is on account of, and corresponds with, the change in status.

    a. Gain or loss of a Spouse or Domestic Partner;

    b. A change in the number of your Dependent Children, such as through birth or adoption;

    c. A change in your employment or the employment of your Spouse, Domestic Partner or Dependent Child, including:

        i. starting or losing a job;

        ii. a reduction or increase in the hours of employment (including going on and returning from unpaid leave),

        iii. gain or loss of eligibility for benefits under another employer's plan.

    d. Your child satisfying or ceasing to satisfy eligibility requirements for coverage, such as reaching the limiting age.

2. Change in Cost or Coverage Events. The change in cost or coverage events, and the election changes that are permitted as a result, are:

    a. An insignificant cost change in your contribution for Plan coverage will result in an automatic adjustment to your pre-tax contribution.

    b. A significant increase in the cost of a coverage option will permit you to switch to a similar coverage option or, if one is not available, to cancel coverage.

    c. A significant decrease in the cost of a coverage option will permit you to elect that coverage option, even if you are not currently a participant.

    d. The loss of a coverage option will permit you to change to a similar coverage option if any or, if one is not available, to cancel coverage.

e. The reduction of coverage within a coverage option will permit you to switch to a similar coverage option.

f. The addition or significant improvement of a coverage option will permit you to switch to the new or improved coverage option.

3. Election Lock Events. An election change made under another employer's plan, such as the plan of your Spouse's employer, will permit a corresponding change under this Plan if the other plan permits its participants to make an election change in accordance with the IRS cafeteria plan regulations or the other employer's plan and this Plan have different plan years.

4. QMCSO Events. You may change your election for Plan coverage in a manner that is consistent with a judgment, decree or order (including a Qualified Medical Child Support Order) resulting from a divorce, legal separation, annulment or change in legal custody ("Order") that requires health coverage to be provided for your child by you or another individual, such as your ex-Spouse. You may only elect to cancel coverage for your child under this Plan if the Order requires another individual to provide health coverage for your child and that coverage is actually provided.

> The Plan is not obligated to comply with any order requiring you to add your ex-spouse to coverage. The Plan does not cover ex-spouses other than under COBRA continuation coverage. You must notify the Plan of a divorce for your ex-spouse to be eligible for COBRA. See the *COBRA Continuation Coverage* section of this SPD for details. You may be in violation of a court order if you drop your Spouse from coverage prior to divorce or fail to notify the Plan of the divorce and elect COBRA Continuation Coverage for your ex-spouse. You should consult with your divorce attorney.

5. Gain or Loss of Other Health Coverage Events. You may change your election for Plan coverage in a manner that is consistent with the gain or loss by you or your Spouse, Domestic Partner or Dependent Child of entitlement to Medicare or Medicaid. If you or your Spouse, Domestic Partner or Dependent Child loses group health plan coverage under a state children's health insurance program under Title XXI of the Social Security Act (“SCHIPS”), a tribal plan, a state health benefits risk pool, or a foreign governmental plan, you may enroll the individual(s) losing the coverage in corresponding Plan coverage.

6. Mid-Year Special Enrollment Events. If you exercise HIPAA special enrollment rights for medical Plan coverage because you gained an Eligible Dependent through marriage, birth, adoption or placement for adoption or lost other health coverage, pre-tax contributions for premiums for the coverage will be changed automatically.

7. FMLA Events. You may change your elections for Plan coverage when going on or returning from FMLA leave in a manner that is consistent with FMLA requirements and Plan rules.

8. Other Approved Leaves of Absence. Refer to the section entitled “Impact of Leaves of Absence on Benefits.”

Coverage and Benefits Information in Benefits Description

The terms and conditions of coverage and benefits for an option are in the Benefit Description, including:

1. additional eligibility requirements for coverage (if any);

2. commencement and termination of coverage;

3. type and amount of benefits provided;

4. deductibles, co-insurance, co-payments, and benefit maximums;

5. restrictions, limitations and conditions of coverage and benefits;

6. procedure for filing a benefit claim, including the period within which claims must be filed, and the appeal procedure for a denied benefit claim; and

7. the Plan's reimbursement and subrogation rights (for a self-insured option, the *Subrogation and Reimbursement* section of this SPD below will apply to the extent that it is not inconsistent with the subrogation and reimbursement language in the Benefit Description).

Benefit Payments

Benefits do not vest under this Plan. Benefit payments are limited to the amount due under the Plan and late benefit payments will not include interest or penalties.

If a benefit overpayment is made, you are required to promptly repay it. If you do not, the overpayment may be offset from future benefit payments.

Impact of Leaves of Absence on Benefits

Your participation in the Plan during leave of absence depends on whether it is paid or unpaid and the type of leave (for example, FMLA).

Type of Leave	Going on Approved Leave	Returning from Approved Leave (before or at expiration of Approved Leave)
Paid/Partially Paid Leave	Your participation in Plan benefit options (at the active employee premium rates) will continue while you receive pay (health & safe time, vacation time, parental leave or short-term disability). Premiums will be deducted, in whole or in part, from the pay you receive during your leave. If your pay does not cover them in full, they will be deducted in the order determined by the Plan Administrator (e.g., medical premiums will be deducted first, then dental premiums, etc.) and any premiums that are not deducted will be deducted from future pay. If you experience a qualifying Mid-Year Election Change Event, refer to the Mid-Year Election Change Events section of this SPD.	Your Plan benefit options, and pre-tax premium contribution elections remain in place. You will not be able to make a benefit election change on your return from leave unless you experience a qualifying Mid-Year Election Change Event. Refer to the Mid-Year Election Change Events section of this SPD.
Unpaid Leave, FMLA	Your participation in Plan benefit options will continue at the active employee premium rates. Your premium contributions will be put in arrears and deducted from future pay. You may elect to discontinue your benefits options within 31 days from the start of your FMLA leave. Your coverage under the pre-tax benefit options will end as specified in the various	Your Plan benefit options and pre-tax contribution elections that were in place during your leave will continue, but you can change your elections within 31 days from the date of your return. You will be required to reimburse the Employer for unpaid premium contributions during your FMLA leave.

	SPDs for those benefits, and expenses that you incur during your period of non-participation will not be eligible for reimbursement. If you continue coverage during your leave, but do not return to work at the end of your leave, you may be eligible to continue coverage through COBRA. Refer to the COBRA Continuation Coverage section of this SPD for details.	
Unpaid/Partially Paid Leave, Military	If your military leave is unpaid or partially paid, your Plan benefit options continue at the active employee premium rates through the end of the month following the month in which your military leave begins. If your military leave is partially paid, your premiums will be deducted, in whole or in part, from the pay you receive during your leave. If your pay does not cover them in full, they will be deducted in the order determined by the Plan Administrator (e.g., medical premiums, then dental premiums, etc.) and any premiums that are not deducted will be deducted from future pay. You may elect to continue your Plan benefit options under COBRA beyond the end of the month following the month in which your leave began to the extent required by USERRA. If you elect to continue your Plan benefits options, you will pay the active employee premium rates for the first 12 months of COBRA.	If you did not continue your coverage during the entire period of your leave, coverage (and pre-tax premiums for the coverage) will be offered upon your re-employment in accordance with Plan rules and to the extent required by USERRA. You will be required to reimburse the Employer for unpaid premium contributions during your Military leave.
Unpaid Leave, Special	Your participation in Plan benefit options will continue at the active employee premium rates. Your premium contributions will be put in arrears and deducted from future pay. You may elect to discontinue your benefit options within 31 days from the start of your special leave. Your coverage under the pre-tax benefit options will end as specified in the various SPDs for those benefits, and expenses that you incur during your period of non-participation will not be eligible for reimbursement. If you continue coverage during your leave, but do not return to work at the end of your leave, you may be eligible to continue coverage through COBRA. Refer to the COBRA Continuation Coverage section of this SPD for details.	Your Plan benefit options and pre-tax contribution elections that were in place during your leave will continue, but you can change your elections within 31 days from the date of your return. You will be required to reimburse the Employer for unpaid premium contributions during your Special leave.
Long-Term Disability Leave	When you transition to Long-Term Disability leave, your participation in Plan benefit options will continue at the active	Your Plan benefit options will continue, and the pre-tax premium contributions will resume the first of the month following your return to work

	employee premium rates. Your premium contributions will be paid on an after-tax basis to Ecolab's direct bill vendor. You may elect to discontinue your benefit options within 31 days from the start of your Long-Term Disability leave. Your coverage under the benefit options will end as specified in the various SPDs for those benefits, and expenses that you incur during your period of non-participation will not be eligible for reimbursement. If you continue coverage during your leave, but do not return to work at the end of your leave, you may be eligible to continue coverage through COBRA. Refer to the COBRA Continuation Coverage section of this SPD for details.	date. You can change your benefit elections within 31 days from the date of your return.

Benefit Claims and Appeals

Benefit claims must be filed with the Insurer or Claims Administrator in the period and in the manner provided in the Benefit Description.

The Insurer or Claims Administrator is the named fiduciary for benefit claims and appeals and has complete discretionary power and authority to make benefit determinations. A benefit is not payable unless the Insurer or Claims Administrator says that it is.

You are required to complete the claims and appeal procedure outlined in the Benefit Description before you can bring a claim in a court. After you have completed the claims and appeal procedure, you have a limited time to bring a claim in court. See the "Limitation of Legal Action" section below for more information.

Participation Claims and Appeals

If you believe that you have been improperly denied eligibility to participate in the Plan, enroll dependents, make election changes or correct premium contributions, you may file a Participation Claim with the Plan Administrator. Direct your Participation Claim to the attention of the Human Resources Benefits Department.

Definitions.

1. "Participation Claim" is a claim that relates to anything other than a claim for the payment of benefits that is made by a Claimant in accordance with the Plan's procedures for filing a Participation Claim. Participation Claim includes claims of eligibility to participate in the Plan, enroll dependents, make coverage changes, and to correct Employee contributions. A Participation Claim does not include an eligibility claim arising out of a request for a Plan benefit (such a claim is subject to the benefit claim and appeal procedures in the Vendor Benefit Description).

2. "Claimant" means an individual who, individually or through a Representative, has made a Participation Claim.

3. A “Representative” is an individual who can act on behalf of the Claimant. A parent or guardian will generally be considered the Representative of a child. In all other situations, the Claimant must notify the Plan in writing of a Representative.

Claim Submission.

1. A Participation Claim must be submitted to the Plan Administrator in writing and include the reason why the Claimant believes that the Participation Claim is valid. Completion and submission of enrollment, coverage change or other forms required by the Plan Administrator satisfies these requirements.

2. A Participation Claim must be made in the manner required by the Plan Administrator and within the period applicable to the type of Claim at issue:

    a. An Employee’s request to enroll himself or herself or a Spouse, Dependent, Domestic Partner or Domestic Partner's Child in Plan coverage must be made within the enrollment or coverage change period required by the Plan (for example, during open enrollment, within 31 days of an Employee’s hire or becoming eligible for coverage, within 31 days of the acquisition of a new Dependent or the date of loss of coverage for special enrollment or within 31 days of an event that permits a coverage change).

    b. A request to correct the amount of an Employee coverage contribution must be made within 60 days of the date of the improper contribution. A contribution is made on the date that it is deducted from the Employee’s pay.

Initial Review.

1. The Plan Administrator will provide its initial review determination to the Claimant within 90 days of receiving the Participation Claim. This period can be extended by up to 90 days in special circumstances, provided notice is given to the Claimant.

2. If a Participation Claim is denied in whole or part, the Plan will provide a written notice to the Claimant that includes:

    a. the reason(s) for the denial;

    b. a description of any additional material or information necessary for the Claimant to perfect the Participation Claim and an explanation as to why the information or material is necessary; and

    c. an explanation of the Plan’s appeal review procedure for the Participation Claim, including the applicable time limits.

Appeal Review.

1. The Claimant must appeal an initial Participation Claim denial within 30 days of his or her receipt of the denial. The appeal must be in writing and include the reason why the Claimant believes that the Participation Claim is valid.

2. The Claimant may submit written comments, documents, records, and other information to the Plan Administrator and the information will be considered on review regardless of whether it was submitted or considered in the initial review.

3. The Plan will provide to the Claimant reasonable access to documents, records, and other information which are, in the judgment of the Plan Administrator, relevant to the Participation Claim.

4. The Plan Administrator will provide its appeal review determination to the Claimant within 60 days of receiving the appeal of the denial of the Participation Claim. This period can be extended by up to 60 days in special circumstances, provided notice is given to the Claimant.

5. If the Participation Claim is denied on appeal review, the Plan will provide written notice to the Claimant that includes the reason(s) for the continued denial.

Qualified Medical Child Support Orders

The Plan Administrator will determine whether an order requiring the Plan to provide group health coverage to a child is a Qualified Medical Child Support Order. You can obtain a copy of the QMCSO procedures on request and free of charge from the Plan Administrator. If you are not enrolled, you will be required to enroll in order to enroll your child pursuant to a QMCSO. You must pay the premium required for your coverage and your child's coverage.

The Plan is not obligated to comply with any order requiring you to add your ex-spouse to coverage. The Plan does not cover ex-spouses other than under COBRA continuation coverage. You must notify the Plan of a divorce for your ex-spouse to be eligible for COBRA. See the COBRA Continuation Coverage section of this SPD for details. You may be in violation of a court order if you drop your Spouse from coverage prior to divorce or fail to notify the Plan of the divorce allowing your ex-spouse to elect COBRA Continuation Coverage. You should consult with your divorce attorney.

Post Retirement Benefits

The Ecolab Post Retirement Benefits Plan and certain other Ecolab plans currently provide eligible retirees with medical, dental and vision benefits, in addition to a small death benefit. For eligibility information, refer to the Ecolab Post Retirement Benefit Plan Summary Plan Description (SPD).

Under the terms of the plans applicable to Nalco Company retirees, you will lose eligibility for retiree medical and dental benefits if (i) you directly or indirectly in any manner or under any circumstances or conditions, engage in, as a partner, principal, agent, employee, stockholder, officer, director, trustee, consultant, or in any other capacity whatsoever, except as a nominal owner of stock of a public corporation, any business that in any way competes with the Company within any geographic area in which you had direct or indirect responsibility during the last two (2) years of your employment; or (ii) you, at any time, solicit any employee of the Company, or any person who served as an employee of the Company during the six (6) months immediately before your termination from employment, for employment or service or retain, hire or encourage any other person to solicit employees of the Company. You will forfeit eligibility under the retiree plans effective as of the last day of the month in which the Plan sponsor reasonably determines you are in competition with the Company, and you will not become eligible to participate in the retiree plans again.

COBRA Continuation Coverage

If you or your dependent loses coverage due to a COBRA qualifying event (reduction of hours, termination of employment, death, divorce or loss of dependent status), COBRA continuation coverage may be elected to temporarily continue your coverage as provided in this section. You must notify Ecolab Human Resources in writing within 60 days of a death, divorce or loss of Eligible Dependent status. If you do not notify Ecolab within 60 days, COBRA continuation coverage rights will be lost.

Any covered Eligible Employee or Eligible Dependent who loses Plan coverage as a result of a "qualifying event" will be eligible to elect to temporarily continue Plan coverage under a federal law called COBRA as described below.

For employees, the qualifying events are: (1) termination of employment for any reason other than gross misconduct; and (2) a reduction in hours.

For dependents, the qualifying events are: (1) the employee's termination of employment for any reason other than gross misconduct; (2) the employee's loss of eligibility for coverage due to a reduction in work hours; (3) the employee's death; (4) the employee's divorce, legal separation or termination of domestic partnership; or (5) loss of Eligible Dependent status under the Plan.

"You" or "your" refers to an Eligible Employee who is eligible for (and when required, has elected) COBRA continuation coverage. Your "dependent" means your Eligible Dependent who is eligible for (and when required, has elected) COBRA continuation coverage.

"Employer" means Ecolab Inc. or a Participating Employer.

Maximum COBRA Coverage Period

If your qualifying event was termination of employment or reduction of hours, your coverage and the coverage of your dependents can generally be continued for up to 18 months from the date of the employment termination or hours reduction. The coverage period can be extended to up to 29 months if you or your dependent is determined to be disabled for Social Security purposes at any time during the first 60 days of coverage continuation and you satisfy the notice requirement stated in "Disability Determination" below.

The continuation coverage period for your dependent can be extended to up to 36 months if, within the initial 18-month period (or 29-month extended period), coverage under the Plan would otherwise terminate because you die, your dependent ceases to meet the eligibility requirements of the Plan, you and your Spouse become legally separated or divorced, or you and your Domestic Partner end your domestic partnership. This is called a "second qualifying event."

If you enrolled in Medicare benefits before you lost coverage because of a reduction in hours or termination of employment, coverage for your dependents can be extended until up to 18 months after the reduction or termination or up to 36 months after the date of Medicare enrollment, whichever is later.

If the qualifying event was your death, legal separation, divorce, termination of domestic partnership or your dependent's ceasing to meet the eligibility requirements of the Plan, the continuation period would be up to 36 months from the date of the event.

The maximum COBRA coverage periods described above will not be extended even though coverage under the Plan is continued unintentionally, resulting in a delay in termination of coverage, or the Employer reduces or subsidizes, in whole or in part, the premium an individual is required to pay for COBRA coverage. The continuation coverage periods described above are maximum periods that will be reduced as described below.

You Must Provide Notice to the Plan Administrator of Certain Events

There are four instances in which you are required to notify the Plan Administrator or COBRA Administrator of an event. They are below. If you fail to provide the required notice within the period noted below, the right to elect to continue coverage will be lost. The notice must be in writing, must contain the information described below, and must be mailed by first class mail, postage prepaid.

1. *Divorce, Legal Separation, Termination of Domestic Partnership or Loss of Dependent Child Status.* You or your dependent must notify the COBRA Administrator of your divorce, legal separation, termination of domestic partnership or your child's ceasing to qualify as a dependent under the Plan within 60 days of the date of the qualifying event. If the COBRA Administrator is not given the required notice within 60 days, the right to continue coverage will be lost. The notice must contain the following information:

    a. The name, address and Social Security Number of the employee;

b. The name, address and Social Security Number of each dependent covered by the Plan;

c. A description of the qualifying event;

d. The date of the qualifying event; and

e. A list of the health plan options under which the affected individuals are covered.

2. *Disability Determination.* If you or any of your dependents were eligible for COBRA coverage as a result of your termination of employment or reduction in hours and elected COBRA coverage, and you or any dependent was determined to be disabled by the Social Security Administration at any time within the first 60 days of COBRA continuation coverage (whether or not the disabled person elected COBRA coverage), you and your dependents who elected COBRA coverage will be eligible for an additional 11 months of COBRA continuation coverage if you notify the COBRA Administrator of such determination within 60 days after the Social Security Administration determination and prior to the expiration of 18 months following the qualifying event. If the COBRA Administrator is not given the required notice within 60 days after the Social Security Administration determination and within the 18 month continuation period, the right to the disability extension will be lost. The notice must contain the following information:

a. The name, address and Social Security Number of the employee;

b. The name, address and Social Security Number of each dependent covered by the Plan; and

c. A copy of the Social Security Administration notice of determination.

3. *End of Disability.* If the Social Security Administration determines that the person has ceased to be disabled, you or your dependent must notify the COBRA Administrator within 30 days. The notice must contain the following information:

1. The name, address and Social Security Number of the employee;

2. The name, address and Social Security Number of each dependent covered by the Plan;

3. A copy of the Social Security Administration notice of determination; and

4. A list of the group health plan options under which the affected individuals are covered.

4. *Second Qualifying Event.* If during an 18-month or 29-month period of continuation coverage your dependent would otherwise lose coverage because of a second qualifying event which is the employee's divorce, legal separation, or termination of domestic partnership or the child's ceasing to qualify as a dependent under the Plan, you or your dependent must notify the COBRA Administrator within 60 days of the date of the second qualifying event. If the COBRA Administrator is not given the required notice within 60 days, the right to extend continuation coverage to a maximum of 36 months will be lost. The notice must contain the following information:

a. The name, address and Social Security Number of the employee;

b. The name, address and Social Security Number of each dependent covered by the Plan;

c. A description of the second qualifying event;

d. The date of the second qualifying event; and

e. A list of the group health plan options under which the affected individuals are covered.

Type of COBRA Coverage Available

An individual electing COBRA continuation coverage may elect to continue the Plan coverage in effect immediately before the qualifying event. If, however, the coverage provided to similarly situated employees is eliminated and the Employer continues to maintain other medical coverage, the individual will have the right to elect that coverage.

While the individual can only elect to continue health care coverage he or she had at the time of the qualifying event, as long as he or she continues the coverage, he or she will have the same coverage options that he or she would have had if the qualifying event had not occurred. For example, he or she may be able to change to a different option offered by the Employer during an open enrollment period or add coverage for newly acquired Eligible Dependents. (Dependents who are added during coverage continuation (after the qualifying event) will not have any independent continuation rights, except for children born to, placed for adoption with or adopted by the employee during the employee's continuation coverage period.)

Who May Elect COBRA Coverage

If you are eligible for COBRA coverage, you can make the election for yourself and for any one or more of your dependents who are eligible for COBRA coverage. If you do not make the election, your Spouse or Domestic Partner can make the election for himself or herself and any covered Dependent Child. Finally, if neither you nor your Spouse or Domestic Partner make the election for a covered Dependent Child, the dependent may make the election for himself or herself. (A child who is born to, or placed for adoption with, the employee while the employee is continuing coverage under COBRA and who becomes covered by the Plan will have independent COBRA election rights as if he or she were covered at the time of the qualifying event.)

Impact of COBRA on other Federal Law Rights

In considering whether to elect continuation coverage, you should take into account that a failure to continue group health plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of the continuation coverage period if you get continuation coverage for the maximum time available to you.

COBRA Election Period

After a qualifying event or receiving notice of a qualifying event (if notice is required), the COBRA Administrator will send a notice regarding COBRA election rights to individuals eligible for COBRA. The individuals will have 60 days from the date of such notice (or from the date coverage would otherwise terminate because of the qualifying event, if the coverage would stop after the notice is sent) in which to file a written election to continue your coverage. If the individual does not file the required election form within this 60-day period, he or she will lose the right to continue coverage under the Plan. The election form must be submitted to the address specified in the election form.

The Trade Act of 2004 created a tax credit for certain individuals who become eligible for trade adjustment assistance ("eligible individuals"). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. An eligible individual who did not elect COBRA coverage will have a second 60-day COBRA election period beginning on the first day of the month in which he or she is determined to be

an eligible individual, but only if the election is made within six months after the original termination of employment. Any COBRA coverage elected during the second election period will begin with the first day of the second election period, rather than on the date coverage terminated.

COBRA Premium

You (or your dependent) must pay the full premium (both the employee and employer contribution), plus a 2% administration fee, for any coverage you continue. (The charge will be higher for coverage extended on account of disability.) The premium will be the same premium that would be paid for a person in your situation with respect to whom no qualifying event had occurred (but will include any portion the Employer normally pays for active employees). The first premium payment, covering the period between the date coverage would otherwise stop and the date of the payment, must be made within 45 days after the date you file the election to continue coverage. Subsequent premiums are due monthly on the day of the month coverage would have stopped if COBRA continuation had not been elected, and coverage will end if your or your dependent fails to pay the premium for any month within 30 days after the due date.

Under its current practice, if you die while actively employed by Ecolab or its subsidiary, Ecolab will subsidize the first 6 months of COBRA premiums for your dependents enrolled in medical coverage at the time of your death. Each dependent can elect to continue coverage at the full COBRA premium cost for the remaining 30 months of the continuation period.

No COBRA Coverage Pending Election or Payment

You will not have COBRA coverage until you have elected the coverage and made the required premium payment. Once you make the election and pay the premium, coverage will be reinstated retroactively to the date you lost your coverage.

Termination of Coverage

The continuation coverage will terminate when the first of the following events occurs.

1. The 18-, 29- or 36-month maximum continuation period ends.

2. You fail or your dependent fails to pay the initial premium within 45 days after your election, in which case you will be treated as not having elected to continue your coverage.

3. You fail or your dependent fails to pay any other premium within 30 days after it is due, in which case your coverage will end as of the end of the last period for which you made a timely premium payment.

4. After electing continuation coverage, you become or your dependent enrolls in Medicare benefits or becomes covered by any other group health plan that does not limit or exclude coverage because of a preexisting condition. Coverage already in place at the time of the continuation coverage election will not cause termination of continuation coverage.

5. The Employer ceases to provide group health benefits to any of its employees.

6. For coverage that is continued beyond 18 months because of disability, the disabled person ceases to be disabled, in which case the coverage will terminate as of the first day of the month that begins at least 30 days after date of the Social Security Administration’s determination that the person is no longer disabled.

7. The continuation coverage is terminated for cause (for example, you commit fraud against the Plan).

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator (see contact information below) or the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan and COBRA Administrator Informed of Address Changes

To protect your family's COBRA continuation rights, you should keep the Plan and COBRA Administrator informed of any changes in the addresses of family members.

Keep Copies of Any Notices You Send to the Plan or COBRA Administrator

You should also keep a copy, for your records, of any notices you send to the Plan and COBRA Administrator.

Plan Administrator Contact Information

Ecolab Inc.
Attn: Benefits Department – EGH3
1 Ecolab Place
St. Paul, MN 55102
If you have questions, call: (800) 964-0265

COBRA Administrator Contact Information:

ThrivePass
PO Box 220
Minneapolis, MN 55440-0220
(866) 855-2844

USERRA Continuation Coverage

If you leave your job with a Participating Employer to go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may elect to continue your coverage as provided in this section.

You will have the right to elect to continue Plan coverage for yourself and your Eligible Dependents during a period of Uniformed Service for up to 24 months, or the date on which you fail to return to work following your period of Uniformed Service, whichever is earlier. USERRA Continuation Coverage will begin on the first day of your leave of absence due to Uniformed Service.

Definitions

1. "Uniformed Service" includes service by an Employee in the Armed Forces, Reserves, federally activated National Guard and volunteers in the National Disaster Medical System.

2. "Service" means the performance of duty on a voluntary or involuntary basis in the Uniformed Services, including active and inactive duty training or service, examination to determine fitness for duty, certain funeral honors duties, and certain service by intermittent disaster-response personnel of the National Disaster Medical System.

3. "USERRA Continuation Coverage" means continuation of Plan coverage pursuant to USERRA.

Election of USERRA Continuation Coverage

You will be required to elect USERRA coverage. COBRA election procedures as set forth in COBRA Continuation Coverage Rights section will apply, except that an election for USERRA Continuation Coverage is not required if advance notice of leave is excused under USERRA. If you elect COBRA, you will be considered to have elected USERRA continuation coverage as well.

Cost of USERRA Continuation Coverage

The COBRA rate will apply. You will only be required to pay the active employee rate, however, for a USERRA leave of less than 31 days if you notify the Plan that your Uniformed Service is scheduled to last less than 31 days.

Termination of USERRA Continuation Coverage

USERRA Continuation Coverage will end when the earliest of the following occurs:

1. The 24-month USERRA Continuation Coverage period ends;

2. You fail to report back to work or apply for reemployment within the period required under USERRA after completing Service;

3. The Employer ceases to offer any group health plan to any of its employees; or

4. You fail to pay the required premium contribution within 30 days of the due date.

Coordination of COBRA Coverage and USERRA Coverage

The maximum USERRA Continuation Coverage period is 24 months. The maximum COBRA continuation coverage period may be 18 months, 29 months or 36 months depending on the qualifying event. The USERRA Continuation Coverage period and the COBRA continuation coverage period will run concurrently.

Covered dependents do have independent election rights under COBRA but not under USERRA. You must elect continuation coverage for yourself in order for your Spouse or Domestic Partner or Dependent Child to be eligible for any USERRA Continuation Coverage period that extends beyond the COBRA continuation coverage period.

Reinstatement of Coverage on Return from Service

To the extent required by USERRA, Plan coverage will be reinstated after you return to work even if you do not elect USERRA Continuation Coverage or your USERRA Continuation Coverage terminates for failure to pay a premium. No waiting period will be imposed.

Other Notices

Conditions of Participation

Participation in the Plan by an Eligible Employee is voluntary. Participation in the Plan does not give any Employee the right to continued employment.

As a condition of participation, each Eligible Employee and Eligible Dependent agrees to:

1. be bound by all of the terms and conditions of the Plan and, for an insured option, the Insurance Policy;

2. make the contributions required; and

3. furnish such information and execute such instruments and forms as the Plan Administrator and Insurer or Claims Administrator may request.

Committing Fraud or Intentional Misrepresentation Against the Plan

If you commit fraud or intentional misrepresentation of a material fact against the Plan (which may include enrolling someone in coverage who you know or should know does not qualify as your Eligible Dependent, continuing enrollment of someone in coverage who you know or should know has lost eligibility or filing a false claim) the Plan (or your Participating Employer) may take action, which may include the following:

1. Termination of Plan Coverage. Your coverage may be terminated. Coverage for the person you enrolled may be terminated. If you have committed fraud or made an intentional misrepresentation of a material fact, coverage may be terminated retroactively.

2. Repayment of Plan Benefits. You may be responsible for all benefits paid for a person who was not eligible for coverage or as a result of a false claim.

3. Discipline. You may be subject to discipline, including termination of your employment.

4. Notification of Law Enforcement. Law enforcement may be notified that you have committed intentional misrepresentation or fraud against the Plan.

Limitation of Legal Action

For insured options, the limitation of actions provision contained in the Policy will apply.

For self-insured options (and insured options if the Policy does not contain a limitation of action provision), the following will apply:

No action with respect to eligibility to participate or for any benefit under this Plan may be brought more than six months following the final decision in the final appeal review brought pursuant to the claim and appeal procedure set forth in the Vendor Benefit Description, or for eligibility claims, the participation and claims procedure described in this SPD. In no event can any action with respect to eligibility to participate or with respect to any benefit under this Plan be brought more than three years after the date the event giving rise to the claim occurred.

No Guarantee of Tax Consequences

Although Ecolab intends to provide certain Plan benefits on a tax-free basis, Ecolab does not guarantee that the benefits are tax-free or the tax consequences to you. You are responsible to pay any local, state or federal taxes that you owe as a result of your Plan participation or receipt of Plan benefits.

Availability of the Plan's HIPAA Notice of Privacy Practices

You can obtain a copy of the Plan's HIPAA Notice of Privacy Practices, which describes your privacy rights under the Health Insurance Portability and Accountability Act of 1996, from the Plan Administrator or from the Insurer for an insured option.

The separate HIPAA Plan amendment is part of the Plan document.

Health Care Providers

You are responsible for choosing your own health care provider. You must decide if any provider treating you (including an in-network provider) is right for you. You must decide with your health care provider which care you will receive. Your health care provider, whether in- or out-of-network, is responsible for the care provided to you.

The Plan pays for certain health care expenses. It does not provide health care. Determinations that health care services or supplies are not Covered Expenses (including that they are not medically necessary) are for payment purposes only.

The Insurer or Claims Administrator pays network providers through various types of contractual arrangements, which may include financial incentives to promote the delivery of care in a cost- effective manner (for example, bonuses based on quality, member satisfaction and cost-effectiveness). The financial incentives are not intended to affect your access to health care. If you have questions about whether your network provider's contract includes any financial incentives, you should discuss them with your provider and the Insurer or Claims Administrator.

Wellness Program Incentives

The Insurer, Claims Administrator or Plan may offer incentives to encourage you to participate in wellness programs or disease management programs. The decision whether to participate is yours alone and will not impact your eligibility to participate in the Plan or your employment at Ecolab.

Subrogation and Reimbursement

Insured vs. Self-insured. Subrogation and reimbursement under a fully insured Option will be as provided in the Policy. This section applies to self-insured medical options to the extent not inconsistent with the Vendor Benefit Description. If it is inconsistent with the Vendor Benefit Description, the Vendor Benefit Description controls.

Subrogation and Reimbursement Rights. Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and benefits the Plan provided to Eligible Employees or Eligible Dependents ("Covered Persons"), from any or all the following listed below. In addition to any subrogation rights and in consideration of the coverage provided by this Summary Plan Description, the Plan shall also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and benefits the Plan provides to Covered Persons, from any or all of the following listed below.

1. Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.

2. Any person or entity who is or may be obligated to provide benefits or payments to a Covered Person, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.

3. Any person or entity who is liable for payment to a Covered Person on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

Responsibilities of Covered Persons. Covered Persons agree as follows:

1. The Covered Person will cooperate with the Plan in a timely manner in protecting the Plan's legal and equitable rights to subrogation and reimbursement, including, but not limited to:

    a. providing any relevant information requested by the Plan;

    b. signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;

    c. responding to requests for information about any accident or injuries;

    d. appearing at depositions and in court; and

    e. obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.

2. Failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a Covered Person.

3. The Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

4. No court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.

5. Regardless of whether a Covered Person has been fully compensated or made whole, the Plan may collect from Covered Persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to, any and all amounts earmarked as non-economic damage settlement or judgment.

6. Benefits paid by the Plan may also be considered to be benefits advanced.

7. Covered Persons agree that if they receive any payment from any potentially responsible party as a result of an Injury or Sickness, whether by settlement (either before or after any determination of liability), or judgment, the Covered Person will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the Covered Person's duties hereunder.

8. Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the institution of legal action against the Covered Person.

9. The Plan shall be entitled to recover reasonable attorney fees from Covered Persons incurred in collecting from the Covered Person any funds held by the Covered Person that he or she recovered from any Third Party.

10. The Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.

11. Covered Persons will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Covered Person do anything to prejudice the Plan's rights under this section.

12. Covered Persons will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the Plan provided, plus reasonable costs of collection.

13. The Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom Covered Persons are seeking recovery, to be paid before any other of the Covered Person's claims are paid.

14. The Plan' rights will not be reduced due to the Covered Person's own negligence.

15. The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Person's name, which does not obligate the Plan in any way to pay the Covered Person part of any recovery the Plan might obtain.

16. The Plan shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.

17. If the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.

18. If the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

<u>Refund of Overpayments.</u>

1. If the Plan pays benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

   a. all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person; or

   b. all or some of the payment we made exceeded the benefits under the Plan.

2. The refund equals the amount we paid in excess of the amount we should have paid under the Plan.

3. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

4. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

ERISA Plan Information

Plan Name and Type: Ecolab Health and Welfare Benefits Plan. The Plan provides health and other welfare benefits to Eligible Employees of Ecolab Inc. and other Participating Employers.

Participating Employers: Ecolab Inc. and subsidiaries of Ecolab Inc. that have adopted the Plan. If you have questions about whether your employer is a Participating Employer, contact the Plan Administrator.

Plan Number: The Plan number is 501.

Plan Year: The Plan Year is the 12-month period beginning each January 1 and ending the following December 31.

Plan Sponsor Taxpayer Identification Number: Ecolab's Taxpayer Identification Number is 41-0231510.

Plan Sponsor and Plan Administrator: Ecolab Inc. is the Plan Sponsor and Plan Administrator of the Plan.

Ecolab Inc.
Attn: Benefits Department - EGH3
1 Ecolab Place
St. Paul, MN 55102
(800) 964-0265

Plan Administrator Discretionary Authority: The Plan Administrator's determinations regarding coverage, claims and all other aspects of the Plan are binding. The Plan Administrator has complete discretionary power and authority with respect to all Plan matters, including eligibility and benefits, factual determinations and Plan interpretation. A benefit is not payable unless the Plan Administrator determines that it is. The Plan Administrator may delegate its authority to Plan service providers, such as the Insurer or Claims Administrator.

Right to Amend or Terminate Plan: Ecolab reserves the right to amend or terminate all or part of this Plan and will do so by written instrument signed by an authorized Ecolab officer. Plan terms cannot be modified by oral statements made by anyone. Misinformation or a mistake does not create a right to eligibility or benefits.

Insurer or Claims Administrator: The name, address and contact information for the Insurer or Claims Administrator for each option is listed in the *Benefits Options Chart* at the front of this SPD.

Premium Contributions and Plan Funding: Premiums for the Plan benefits you elect are paid through your contributions and contributions by your Participating Employer, if any. The Plan Administrator will inform you what Premium amount you will be required to pay for your coverage. To the extent permitted by federal law, your Premium contributions will automatically be paid on a pre-tax basis. Benefits for insured options are paid by the Insurer. Ecolab has no responsibility to pay any benefits under this Plan for insured options. Benefits for self-insured options are paid from Ecolab's general corporate assets.

Legal Process: Legal process may be served on the Plan Administrator at the following address:

Ecolab Inc.
Attn: General Counsel's Office
1 Ecolab Place
St. Paul, MN 55102

Collective Bargaining Agreements:

A copy of any collective bargaining agreement that provides for participation in this Plan is available for examination.

Provider Lists: Provider lists are furnished automatically, without charge, upon request.

Statement of ERISA Rights

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest Form 5500 and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of group health plan coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review *COBRA Continuation Coverage and USERRA Continuation Coverage* on the rules governing your COBRA continuation coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit provided under this Plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

There are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. The court may require the Plan Administrator to provide the materials and pay you

up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



Guide to Benefits



CompMED Choice

January 2025

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

Table of Contents

Chapter 1: Important Information 1

What You Should Know about this Guide to Benefits 1
Summary of Provider Categories 2
Care While You are Away from Home 3
Questions We Ask When You Receive Care 4
What You Can do to Maintain Good Health 6
Interpreting this Guide 7

Chapter 2: Payment Information 9

Eligible Charge 9
Copayment 9
Annual Deductible 10
Annual Copayment Maximum 12
Maximum Allowable Fee 12
Benefit Maximum 12

Chapter 3: Summary of Benefits and Your Payment Obligations 13

Benefit and Payment Chart 13
Hospital and Facility Services 14
Emergency Services 14
Online Care 14
Telehealth 14
Physician Services 14
Surgical Services 14
Testing, Laboratory and Radiology 15
Chemotherapy and Radiation Therapy 15
Other Medical Services and Supplies 15
Rehabilitation Therapy 16
Special Benefits - Disease Management and Preventive Services 17
Special Benefits for Men 17
Special Benefits for Women 17
Special Benefits for Homebound, Terminal, or Long-Term Care 18
Behavioral Health - Mental Health and Substance Abuse 18
Organ and Tissue Transplants 18
Other Organ and Tissue Transplants 18
Drugs and Supplies 20
Autism Spectrum Disorders Drugs 20
Chemotherapy - Oral Drugs 20
Contraceptives 20
Diabetic Drugs, Supplies, and Insulin 21
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs 21

Chapter 4: Description of Benefits 23

About this Chapter 23
Hospital and Facility Services 24
Emergency Services 26
Online Care 26
Telehealth 27
Physician Services 27
Surgical Services 28
Testing, Laboratory, and Radiology 29
Chemotherapy and Radiation Therapy 30
Other Medical Services and Supplies 30
Rehabilitation Therapy 34
Special Benefits – Disease Management and Preventive Services 36
Special Benefits for Men 37
Special Benefits for Women 37
Special Benefits for Homebound, Terminal, or Long-Term Care 39
Behavioral Health – Mental Health and Substance Abuse 40
Organ and Tissue Transplants 41
Other Organ and Tissue Transplants 42
Drugs and Supplies 42

Chapter 5: Precertification 47

Definitions 47

Table of Contents

Chapter 6: Services Not Covered 49

About this Chapter 49
Counseling Services 49
Coverage Under Other Programs or Laws 50
Dental, Drug, and Vision 50
Fertility and Infertility 51
Preventive and Routine 51
Provider Type 52
Transplants 52
Miscellaneous Exclusions 53

Chapter 7: Filing Claims 57

When to File Claims 57
How to File Claims 57
What Information You Must File 57
Other Claim Filing Information 58

Chapter 8: Dispute Resolution 59

Your Request for an Appeal 59
If You Disagree with Our Appeal Decision and You are Enrolled in a Group Plan that is not Self Funded 60
If You Disagree with Our Appeal Decision and You are Enrolled in a Self Funded Group Plan 62

Chapter 9: Coordination of Benefits and Third Party Liability 65

What Coordination of Benefits Means 65
General Coordination Rules 66
Dependent Children Coordination Rules 66
If You Are Hospitalized When Coverage Begins 66
Motor Vehicle Insurance Rules 66
Medicare Coordination Rules 67
Third Party Liability Rules 68

Chapter 10: General Provisions 71

Eligibility for Coverage 71
When Coverage Begins 72
When Coverage Ends 72
Continuity of Care 73
Continued Coverage 74
Confidential Information 76
Dues and Terms of Coverage 77
ERISA Information 78

Chapter 11: Glossary 79

CHAPTER 1

This Chapter Covers

What You Should Know about this Guide to Benefits 1
Summary of Provider Categories 2
Care While You are Away from Home 3
Questions We Ask When You Receive Care 4
What You Can do to Maintain Good Health 6
Interpreting this Guide 7

What You Should Know about this Guide to Benefits

About Your Comprehensive Medical Plan

Your health care coverage is a 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 uses scientific evidence to evaluate new developments in technology and new applications of existing technologies. Thorough reviews 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*.

Terminology

The terms ***You*** and ***Your*** mean you and your family members enrolled in this plan and eligible for this coverage. ***We***, ***Us***, and ***Our*** refer to HMSA.

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.

	Provider Category			
	HMSA Participating Provider	**BlueCard Participating Provider**	**Contracting Provider**	**Nonparticipating Provider (in or out of state)**
Does your provider contract with HMSA?	Yes	No, contracts with the BlueCard Program.	Yes, contracts with HMSA for transplant services.	No, does not contract with HMSA or the BlueCard program.
Does your provider always file claims for you?	Yes	Yes	Yes	No, you may have to file your own claims.
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.	Yes	Yes	Yes	No, you pay any difference between the actual charge and the eligible charge. See *From What Provider Category Did You Receive Care?* in the section labeled *Questions We Ask When You Receive Care* later in this chapter.
Do you pay deductibles and copayments to the provider? If so, we send benefit payment directly to the provider.	Yes	Yes	Yes	No, you pay provider in full. We send benefit payments to you.
Does your provider get precertification approvals for you?	Yes	No, you are responsible for getting approval.	Yes	No, you are responsible for getting approval.

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 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.

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 exists 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.

Definitions of terms and more details on the application of this Payment Determination Criteria are contained in the Patient's Bill of Rights and Responsibilities, Hawaii Revised Statutes § 432E-1.4. The current language of this statutory provision will be provided upon request. Requests should be submitted to HMSA's Customer Service Department.

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.

Exception: For certain services that may be subject to the No Surprises Act of 2021, your cost-share may be different based on the requirements of the law. Please check hmsa.com for details.

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.

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.

Is the Service or Supply Subject to a Benefit Maximum?

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.*

Is the Service or Supply Subject to Precertification?

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.*

Did You Receive Care from a Provider Recognized by Us?

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 www.hmsa.com. To find out if a nonparticipating provider is recognized, call us at one of the phone numbers on the back cover of this Guide.

Did a Recognized Provider Order the Care?

All covered treatment, services, and supplies must be ordered by a recognized provider practicing within the scope of his or her license.

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.

Interpreting this Guide

Agreement

The Agreement between HMSA and you is made up of all of the following:

- This Guide to Benefits.
- Any riders and/or amendments.
- The enrollment form submitted to us.
- The agreement between us and your employer or group sponsor.

Our Rights to Interpret this Document

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

- To determine if you meet our written eligibility requirements.
- To determine the amount and type of benefits payable to you or your dependents according to the terms of this Agreement.
- To interpret the provisions of this Agreement as needed to determine benefits, including decisions on medical necessity.

Our determinations and interpretations, and our decisions on these matters are subject to *de novo* review by an impartial reviewer as provided in this Guide to Benefits or as allowed by law. If you do not agree with our interpretation or determination, you may appeal. 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 Agreement.

CHAPTER 2

This Chapter Covers

Eligible Charge 9
Copayment 9
Annual Deductible 10
Annual Copayment Maximum 12
Maximum Allowable Fee 12
Benefit Maximum 12

Eligible Charge

Definition

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 different 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

Definition

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*.

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 = $100.
- Your copayment = $12.

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 = $100.
- Your copayment = $12.
- The difference between the actual charge and the eligible charge = $25.
- You owe $37 (your copayment plus the difference between the actual charge and the eligible charge).

Annual Deductible

Definition

Annual Deductible is the fixed dollar amount you must pay each calendar year before benefits subject to the annual deductible become available. You cannot pay the annual deductible amount to us in advance. You must meet the deductible on a claim by claim basis.

The following amounts you pay do not apply toward meeting the annual deductible:

- Copayments for services that are not subject to the annual deductible.
- 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.

***Please note*:** For services subject to the annual deductible see *Chapter 3: Summary of Benefits and Your Payment Obligations*.

Amount

$200 per person or

$600 (maximum) per family

How it Works

If you have single coverage, your annual deductible is $200. Each calendar year, you must pay the first $200 of the eligible charges for covered health care services that are subject to the annual deductible.

If you have family coverage, you and each covered family member pays toward their own $200 per person annual deductible, and that amount is also credited toward the family deductible. When the $600 family deductible is met, you and your family will not pay any additional deductible amounts for the remainder of the calendar year.

After the annual deductible is met, you owe the copayment amounts listed in *Chapter 3: Summary of Benefits and Your Payment Obligations* for the service or supply you receive.

Example

Here are examples of how the $200 per person or $600 maximum per family annual deductible works. Let's say the services you receive are:

- from a participating provider,
- subject to the annual deductible, and
- your copayment is 20% after the annual deductible. ***Please note****:* Your actual copayment amounts vary depending on the type of service or supply. See the copayment amounts listed in *Chapter 3: Summary of Benefits and Your Payment Obligations* for the service or supply you receive.

Calculation of $200 Per Person Annual Deductible Example		Individual's Annual Services			
		Service 1	Service 2	Service 3	Service 4
a	Eligible Charge	$100.00	$80.00	$140.00	$120.00
b	Amount Applied to Annual Deductible	$100.00	$80.00	$20.00	$0.00
c	Remaining Eligible Charge After Annual Deductible[1]	$0.00	$0.00	$120.00	$120.00
d	Copayment Amount for Remaining Eligible Charge[2]	$0.00	$0.00	$24.00	$24.00
e	Annual Deductible and Copayment Amount You Owe[3]	$100.00	$80.00	$44.00	$24.00
f	Cumulative Total of Per Person Annual Deductible[4]	$100.00	$180.00	$200.00	$200.00
g	Individual Annual Deductible Met?[5]	No	No	Yes	Yes

Calculations for the per person annual deductible:
1. a – b = c
2. c * 20% = d
3. b + d = e
4. cumulative total of b
5. f = $200

Calculation of $600 Maximum per Family Annual Deductible Example		Family's Annual Services			
		Family Member 1	Family Member 2	Family Member 3	Family Member 4
a	Eligible Charge	$300.00	$240.00	$420.00	$360.00
b	Amount Applied to Annual Deductible	$200.00	$200.00	$200.00	$0.00
c	Remaining Eligible Charge After Annual Deductible[1]	$100.00	$40.00	$220.00	$360.00
d	Copayment Amount for Remaining Eligible Charge[2]	$20.00	$8.00	$44.00	$72.00
e	Annual Deductible and Copayment Amount You Owe[3]	$220.00	$208.00	$244.00	$72.00
f	Cumulative Total of Per Family Annual Deductible[4]	$200.00	$400.00	$600.00	$600.00
g	Individual Annual Deductible Met?[5]	Yes	Yes	Yes	No
h	Family Annual Deductible Met?[6]	No	No	Yes	Yes

Calculations for the family annual deductible:
1. a – b = c
2. c * 20% = d
3. b + d = e
4. cumulative total of b
5. b = $200
6. f = $600

Chapter 2: Payment Information

Annual Copayment Maximum

Definition

The ***Annual Copayment Maximum*** is 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.

Amount

$2,200 per person or

$6,600 (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.
- 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.*
- For *drugs and supplies*, we use nationally recognized pricing sources and other relevant information. The allowable fee includes a dispensing fee. Any discounts or rebates that we get will not reduce the charges that your copayments are based on. We apply discounts and rebates to reduce drugs and supplies coverage rates.

Benefit Maximum

Definition

A ***Benefit Maximum*** 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.

Where to Look for Limitations

See *Chapter 4: Description of Benefits.*

CHAPTER 3

This Chapter Covers

Hospital and Facility Services 14
Emergency Services 14
Online Care 14
Telehealth 14
Physician Services 14
Surgical Services 14
Testing, Laboratory and Radiology 15
Chemotherapy and Radiation Therapy 15
Other Medical Services and Supplies 15
Rehabilitation Therapy 16
Special Benefits - Disease Management and Preventive Services 17
Special Benefits for Men 17
Special Benefits for Women 17
Special Benefits for Homebound, Terminal, or Long-Term Care 18
Behavioral Health - Mental Health and Substance Abuse 18
Organ and Tissue Transplants 18
Other Organ and Tissue Transplants 18
Drugs and Supplies 20
Autism Spectrum Disorders Drugs 20
Chemotherapy - Oral Drugs 20
Contraceptives 20
Diabetic Drugs, Supplies, and Insulin 21
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs 21

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 if the annual deductible applies and 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	more info. on page:	Annual Deductible Applies?	Copayment Is (Percentage copayments are based on eligible charges)	
			Participating	**Nonparticipating**
Hospital and Facility Services				
Ambulatory Surgical Center (ASC)	24	Yes	20%	20%
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	24	Yes	20%	20%
Hospital Ancillary Services	25	Yes	20%	20%
* Hospital Room and Board	25	Yes	20%*	20%*
Intensive Care Unit/Coronary Care Unit	26	Yes	20%	20%
Intermediate Care Unit	26	Yes	20%	20%
Isolation Care Unit	26	Yes	20%	20%
Operating Room	26	Yes	20%	20%
Outpatient Facility	26	Yes	20%	20%
Emergency Services				
Emergency Room	26	Yes	20%	20%
Emergency Services - All Other Services and Supplies	**26**	Your deductible and copayment amounts vary depending on the type of service or supply. See deductible and copayment amounts listed in this chart for the service or supply you receive.		Same as participating copayment for the service or supply
Online Care				
Online Care	26	No	None	Not Covered
Telehealth				
Telehealth	**27**	Your deductible and copayment amounts vary depending on the type of service or supply. See deductible and copayment amounts listed in this chart for the service or supply you receive.		
Physician Services				
Anesthesia	27	Yes	20%	20%
Consultation Services	27	No	$12	$12
Physician Visits - Emergency Room	27	No	$12	$12
Physician Visits - Home, Office, and Extended Care Facility	28	No	$12	$12
Physician Visits - Hospital	28	No	$12	$12
Surgical Services				
Assistant Surgeon Services	28	Yes	20%	20%

* = see page 13	more info. on page:	Annual Deductible Applies?	Copayment Is (Percentage copayments are based on eligible charges)	
			Participating	**Nonparticipating**
Bariatric Surgery	28	Yes	20%	20%
Cutting Surgery	28	Yes	20%	20%
Newborn Circumcision	29	No	None	None
Non-cutting Surgery	29	Yes	20%	20%
Oral Surgery	29	Yes	20%	20%
Reconstructive Surgery	**29**	Your deductible and copayment amounts vary depending on the type of service or supply. See deductible and copayment amounts listed in this chart for the service or supply you receive.		
Surgical Supplies	29	Yes	20%	20%
Testing, Laboratory and Radiology				
Allergy Testing	29	No	$12	$12
Allergy Treatment Materials	29	No	$12	$12
Diagnostic Testing - Inpatient	29	Yes	20%	20%
Diagnostic Testing - Outpatient	29	No	20%	20%
Genetic Testing and Counseling	29	No	20%	20%
Laboratory and Pathology - Inpatient	29	Yes	20%	20%
Laboratory and Pathology - Outpatient	29	No	None	None
Radiology - Inpatient	30	Yes	20%	20%
Radiology - Outpatient	30	Yes	20%	20%
Chemotherapy and Radiation Therapy				
Chemotherapy - Infusion/Injections	30	Yes	20%	20%
Radiation Therapy - Inpatient	30	Yes	20%	20%
Radiation Therapy - Outpatient	30	Yes	20%	20%
Other Medical Services and Supplies				
Advance Care Planning	30	No	None	None
Ambulance (air)	30	Yes	20%	20%
Ambulance (ground)	31	Yes	20%	20%

* = **see page** 13	more info. on page:	Annual Deductible Applies?	Copayment Is (Percentage copayments are based on eligible charges)	
			Participating	**Nonparticipating**
Blood and Blood Products	31	Yes	20%	20%
Dialysis and Supplies	31	Yes	20%	20%
Durable Medical Equipment and Supplies	31	Yes	20%	20%
Evaluations for Hearing Aids	**31**	Your deductible and copayment amounts vary depending on the type of service or supply. See deductible and copayment amounts listed in this chart for the service or supply you receive.		
Gender Identity Services	**31**	Your deductible and copayment amounts vary depending on the type of service or supply. See deductible and copayment amounts listed in this chart for the service or supply you receive.		
Growth Hormone Therapy	32	Yes	20%	20%
Implanted Internal Items/Implants - Outpatient	32	Yes	None	None
Inhalation Therapy	32	Yes	20%	20%
Injections - Other than Self-Administered	32	Yes	20%	20%
Injections - Self-Administered	32	Yes	20%	20%
Medical Foods	32	No	20%	20%
Medical Nutrition Therapy	33	No	None	None
* Orthodontic Services to Treat Orofacial Anomalies	33	No	None*	None*
Orthotics and External Prosthetics	33	Yes	20%	20%
Outpatient IV Therapy	33	Yes	20%	20%
Private Duty Nursing	55	Not Covered	Not Covered	Not Covered
Vision and Hearing Appliances	34	Yes	20%	20%
Rehabilitation Therapy				
Cardiac Rehabilitation	34	No	$12	$12
Dr. Ornish's Program for Reversing Heart Disease (TM)	34	No	$20 when received from a provider that meets the requirements of the Dr. Ornish Program described in *Chapter 4* under *Rehabilitation Therapy*	
Physical and Occupational Therapy - Inpatient	34	No	$12	$12
Physical and Occupational Therapy - Outpatient	34	No	$12	$12
Pulmonary Rehabilitation - Outpatient	35	No	$12	$12
Speech Therapy Services - Inpatient	35	No	$12	$12

* = **see page** 13	more info. on page:	Annual Deductible Applies?	Copayment Is (Percentage copayments are based on eligible charges)	
			Participating	**Nonparticipating**
Speech Therapy Services - Outpatient	35	No	$12	$12
Special Benefits - Disease Management and Preventive Services				
Annual Preventive Health Evaluation (preventive visit)	36	No	None	None
Diabetes Prevention Program	36	No	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*	
Disease Management and Preventive Services Programs	36	No	None	Not Covered
Preventive Health Services	36	No	None	None
Prostate Specific Antigen (PSA) Test (screening)	37	No	None	None
Well-Being Services	**37**	Your deductible and copayment amounts vary depending on the type of service or supply. See deductible and copayment amounts listed in this chart for the service or supply you receive.		
Well-Child Care Immunizations	37	No	None	None
Well-Child Care Laboratory Tests	37	No	None	None
Well-Child Care Physician Office Visits	37	No	None	None
Special Benefits for Men				
Erectile Dysfunction	**37**	Your deductible and copayment amounts vary depending on the type of service or supply. See deductible and copayment amounts listed in this chart for the service or supply you receive.		
Vasectomy	37	Yes	20%	20%
Special Benefits for Women				
Artificial Insemination	37	Yes	20%	20%
Breast Pump	37	No	None	None
Contraceptive IUD	38	No	None	None
Contraceptive Implants	38	No	None	None
Contraceptive Injectables	38	No	None	None
In Vitro Fertilization	**38**	Your deductible and copayment amounts vary depending on the type of service or supply. See deductible and copayment amounts listed in this chart for the service or supply you receive.		
Maternity Care - Routine Prenatal Visits, Delivery, and One Postpartum Visit	38	No	None	None

* = see page 13	more info. on page:	Annual Deductible Applies?	Copayment Is (Percentage copayments are based on eligible charges)	
			Participating	**Nonparticipating**
Pregnancy Termination	39	Yes	20%	20%
Tubal Ligation	39	No	None	None
Special Benefits for Homebound, Terminal, or Long-Term Care				
Case Management Services	**39**	Your deductible and copayment amounts vary depending on the type of service. See deductible and copayment amounts listed in this chart for the service you receive.		
Home Health Care	39	Yes	20%	20%
Hospice Services	39	No	None	None
Supportive Care	40	No	None	Not Covered
Behavioral Health - Mental Health and Substance Abuse				
Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us	40	No	None	None
* Hospital and Facility Services - Inpatient	40	Yes	20%*	20%*
Hospital and Facility Services - Outpatient	40	No	None	None
Physician Services - Inpatient	40	No	20%	20%
Physician Services - Outpatient	40	No	$12	$12
Psychological Testing - Inpatient	40	Yes	20%	20%
Psychological Testing - Outpatient	40	No	None	None
Organ and Tissue Transplants				
Corneal Transplant Surgery	41	No	None	None
Kidney Transplant Surgery	41	No	None	None
Organ Donor Services	41	Yes	20%	20%
Transplant Evaluation	41	No	None	None
Other Organ and Tissue Transplants				
Heart Transplants	42	No	None	None
Heart and Lung Transplants	42	No	None	None
Liver Transplants	42	No	None	None

* = **see page** 13	more info. on page:	Annual Deductible Applies?	Copayment Is (Percentage copayments are based on eligible charges)	
			Participating	**Nonparticipating**
Lung Transplants	42	No	None	None
Pancreas Transplants	42	No	None	None
Simultaneous Kidney/Pancreas Transplants	42	No	None	None
Small Bowel and Multivisceral Transplants	42	No	None	None
Stem-Cell Transplants (including Bone Marrow Transplants)	42	No	None	None

Chapter 3: Summary of Benefits and Your Payment Obligations

Drugs and Supplies

Copayments for ***Drugs and Supplies*** are listed below. This plan covers drugs and supplies only when approved by the FDA, prescribed by your Provider, and if you do not have an HMSA drug plan or your drug plan does not cover the drugs listed in the chart below. See *Chapter 4: Description of Benefits* for more details.

* = **see page** 13	more info. on page:	Annual Deductible Applies?	Copayment Is (Percentage copayments are based on eligible charges)	
			Participating	**Nonparticipating**
Autism Spectrum Disorders Drugs	***If you have an HMSA drug plan with benefits for drugs to treat autism spectrum disorders, the HMSA drug plan benefits will apply and not the benefits of this plan.***			
Generic Drugs	42	No	None	None
Mail Order Generic Drugs	42	No	None	Not Covered
Mail Order Non-Preferred Formulary Drugs	42	No	None	Not Covered
Mail Order Preferred Formulary Drugs	42	No	None	Not Covered
Non-Preferred Formulary Drugs	42	No	None	None
Preferred Formulary Drugs	42	No	None	None
Chemotherapy - Oral Drugs	***If you have an HMSA drug plan with benefits for oral chemotherapy drugs, the HMSA drug plan benefits will apply and not the benefits of this plan.***			
Chemotherapy - Oral	42	No	None	None
Mail Order Chemotherapy - Oral	42	No	None	Not Covered
Contraceptives	***If you have an HMSA drug plan with benefits for contraceptives, the HMSA drug plan benefits will apply and not the benefits of this plan.***			
Contraceptive - Diaphragms/Cervical Caps	42	No	None	None
Contraceptive - Oral (Generic Drugs)	42	No	None	None
Contraceptive - Oral (Non-Preferred Formulary Drugs)	42	No	30%	30%
Contraceptive - Oral (Preferred Formulary Drugs)	42	No	20%	20%
Contraceptive - Other Methods (Generic Drugs)	42	No	None	None
Contraceptive - Other Methods (Non-Preferred Formulary Drugs)	42	No	30%	30%
Contraceptive - Other Methods (Preferred Formulary Drugs)	42	No	20%	20%
Contraceptive - Over-the-counter (OTC)	42	No	None	None
Mail Order Contraceptive - Diaphragms/Cervical Caps	42	No	None	Not Covered
Mail Order Contraceptive - Oral (Generic Drugs)	42	No	None	Not Covered
Mail Order Contraceptive - Oral (Non-Preferred Formulary Drugs)	42	No	30%	Not Covered

* = see page 13	more info. on page:	Annual Deductible Applies?	Copayment Is (Percentage copayments are based on eligible charges)	
			Participating	**Nonparticipating**
Mail Order Contraceptive - Oral (Preferred Formulary Drugs)	42	No	20%	Not Covered
Mail Order Contraceptive - Other Contraceptive Methods (Generic Drugs)	42	No	None	Not Covered
Mail Order Contraceptive - Other Contraceptive Methods (Non-Preferred Formulary Drugs)	42	No	30%	Not Covered
Mail Order Contraceptive - Other Contraceptive Methods (Preferred Formulary Drugs)	42	No	20%	Not Covered
Mail Order Contraceptive - Over-the-counter (OTC)	42	No	None	Not Covered
Diabetic Drugs, Supplies, and Insulin	***If you have an HMSA drug plan with benefits for diabetic drugs, supplies, and insulin, the HMSA drug plan benefits will apply and not the benefits of this plan.***			
Diabetic Drugs - Generic Drugs	42	No	20%	20%
Diabetic Drugs - Non-Preferred Formulary Drugs	42	No	30%	30%
Diabetic Drugs - Preferred Formulary Drugs	42	No	20%	20%
Diabetic Supplies - Non-Preferred Formulary	42	No	20%	20%
Diabetic Supplies - Preferred Formulary	42	No	None	None
Insulin - Generic Drugs	42	No	20%	20%
Insulin - Non-Preferred Formulary Drugs	42	No	30%	30%
Insulin - Preferred Formulary Drugs	42	No	20%	20%
Mail Order Diabetic Drugs - Generic Drugs	42	No	20%	Not Covered
Mail Order Diabetic Drugs - Non-Preferred Formulary Drugs	42	No	30%	Not Covered
Mail Order Diabetic Drugs - Preferred Formulary Drugs	42	No	20%	Not Covered
Mail Order Diabetic Supplies - Non-Preferred Formulary	42	No	20%	Not Covered
Mail Order Diabetic Supplies - Preferred Formulary	42	No	None	Not Covered
Mail Order Insulin - Generic Drugs	42	No	20%	Not Covered
Mail Order Insulin - Non-Preferred Formulary Drugs	42	No	30%	Not Covered
Mail Order Insulin - Preferred Formulary Drugs	42	No	20%	Not Covered
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs	***If you have an HMSA drug plan with benefits for U.S. Preventive Services Task Force recommended drugs, the HMSA drug plan benefits will apply and not the benefits of this plan.***			

* = **see page** 13	more info. on page:	Annual Deductible Applies?	Copayment Is (Percentage copayments are based on eligible charges)	
			Participating	**Nonparticipating**
Mail Order - USPSTF recommended drugs	42	No	None	Not Covered
USPSTF recommended drugs	42	No	None	None

CHAPTER 4

This Chapter Covers

About this Chapter 23
Hospital and Facility Services 24
Emergency Services 26
Online Care 26
Telehealth 27
Physician Services 27
Surgical Services 28
Testing, Laboratory, and Radiology 29
Chemotherapy and Radiation Therapy 30
Other Medical Services and Supplies 30
Rehabilitation Therapy 34
Special Benefits – Disease Management and Preventive Services 36
Special Benefits for Men 37
Special Benefits for Women 37
Special Benefits for Homebound, Terminal, or Long-Term Care 39
Behavioral Health – Mental Health and Substance Abuse 40
Organ and Tissue Transplants 41
Other Organ and Tissue Transplants 42
Drugs and Supplies 42

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.

Continuity of Care

You may be eligible for continuity of care if you are a continuing care patient receiving a course of treatment from a participating provider and one of the following occurs:

- the contractual relationship between the participating provider and HMSA is terminated;
- benefits provided under your plan with respect to the participating provider are terminated because of a change in the terms of the participation of such participating provider in such plan; or
- you are under a group health plan and the contract between such group health plan and HMSA is terminated.

With respect to the above occurrences, the term “terminated” does not include a termination of a contract for failure to meet applicable quality standards or for fraud.

For more details, see *Chapter 10: General Provisions, Continuity of Care*.

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 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,
- x-ray related to surgery, and
- general nursing services.

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,
- diagnostic and therapy services,
- regular and special diets, and
- general nursing 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,
- drugs,
- dressings,
- oxygen,
- antibiotics,
- hospital blood transfusion services,
- regular and special diets, and
- general nursing services.

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.

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. Also, you owe the difference between the facility's private room charge and HMSA's maximum allowable fee for private rooms. You may call HMSA for a list of these conditions.

- Newborn nursery care. Covered for the baby's nursery care after birth in accord with the time periods specified later in this chapter under *Maternity and Newborn Length of Stay*.

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

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

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

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.
- 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.

Physician Services

Anesthesia

Covered, as required by the attending provider and when appropriate for your condition. Services include:

- General anesthesia.
- Regional anesthesia.
- Monitored anesthesia when you meet HMSA's high-risk criteria.

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.

Consultation Services

Covered, as needed for surgical, obstetrical, pathological, radiological, or other medical conditions when all of these statements are true:

- The attending physician must require the consultation.
- If the consultation is for inpatient services, you must be confined as a registered bed patient.
- 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.
- The consultation must be for reasons other than to comply with requirements by the hospital or extended care facility.

Physician Visits – Emergency Room

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:

- 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 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.

Please note: Routine preventive care is described under *Special Benefits – Disease Management and Preventive Services*.

Physician Visits – Hospital

Covered, when you are an inpatient in a hospital. Newborn care is covered in accord with the time periods specified later in this chapter under *Maternity and Newborn Length of Stay*.

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.

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.
Newborn Circumcision	Covered.
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.
Oral Surgery	Covered, but only when the dentist performs surgery that could be performed by a physician or a dentist. Coverage is limited to: • the removal of tumors and cysts; • surgery to correct injuries; • cutting and draining of cellulitis; • cutting of sinuses, salivary glands, or ducts; • reduction of dislocations and removal of jawbone joint; and • major oral surgery for augmentation (building up) of the gum ridge.
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.
Surgical Supplies	Covered.

Testing, Laboratory, and Radiology

Allergy Testing	Covered.
Allergy Treatment Materials	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.
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 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 – Disease Management and Preventive Services* section.

Radiology

Covered. Examples of radiology include:
- Computerized Tomography Scan (CT Scan).
- Diagnostic mammography.
- Nuclear Medicine.
- Ultrasound.
- X-rays.

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

Chemotherapy and Radiation Therapy

Chemotherapy – Infusion/Injections

Covered, including chemical agents and their administration to treat malignancy. Chemotherapy drugs must be FDA approved.

Please note: Coverage includes at least one antineoplastic (monoclonal antibodies) drug.

Please note: 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 *Stem-Cell Transplants (including Bone Marrow Transplants)* in the section *Other Organ and Tissue Transplants.*

Radiation Therapy

Covered.

Please note: 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 *Stem-Cell Transplants (including Bone Marrow Transplants)* in the section *Other Organ and Tissue Transplants.*

Other Medical Services and Supplies

Advance Care Planning

Covered.

Ambulance (air)

Covered, for intra-island or inter-island air ambulance services to the nearest, adequate hospital to treat your illness or injury.

We will cover your ambulance transportation if the following apply:
- 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.

Please note: 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"*.

Ambulance (air) – to the Continental United States

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 www.hmsa.com.

Please note: Air ambulance services to the continental US must be precertified. See *Chapter 5: Precertification*.

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

Ambulance (ground)

Covered, for ground ambulance services to the nearest, adequate hospital to treat your illness or injury.

We will cover your ambulance transportation if the following apply:
- 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.

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).*

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
- insulin pumps.

Please note: Benefits for insulin pump tubing can be found in *Drugs and Supplies* section.

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.

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 confirmation surgery
- Hospital room and board
- Hormone injection therapy

	• Laboratory monitoring • Other gender confirmation 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 an HMSA drug plan with a similar benefit, there shall be no duplication or coordination of benefits between this plan and your HMSA drug plan. ***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*****:** Certain services must have precertification. See *Chapter 5: Precertification.*
Injections – Self-Administered	Covered, for FDA approved injectable drugs. If you have an HMSA drug plan with a similar benefit, there shall be no duplication or coordination of benefits between this plan and your HMSA drug plan. ***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, Preventive Health 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 $6,930 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.

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

Cardiac Rehabilitation

Covered in accord with HMSA's then current medical policy for cardiac rehabilitation which can be found at www.hmsa.com.

Dr. Ornish's Program for Reversing Heart Disease™

Covered in accord with HMSA's then current policy available at www.hmsa.com and when all of the following are true:

- Program services are provided by practitioners who contract with HMSA to provide program services, and
- 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. 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, 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.

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

Annual Preventive Health Evaluation (preventive visit)

Covered, for one annual preventive health evaluation for members who are 22 and older when received from their primary care provider, including an assessment of any other preventive screenings you might need. See *Disease Management and Preventive Services Programs and Preventive Health Services* for other screenings covered by this plan.

Please note: Similar services for members under age 22 are covered as set forth in *Well-Child Care.*

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.

Covered in accord with HMSA's Diabetes Prevention Program policy available at www.hmsa.com.

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),
- behavioral health conditions (mental health and substance abuse), and
- normal and at-risk pregnancies.

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

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 Health Services

Covered in accord with HMSA's medical policy for preventive health. Preventive health services include, but are not limited to the following recommendations or guidelines:

- Screenings and counseling services with a grade A or B recommendations by the U.S. Preventive Services Task Force (USPSTF).
- Bright Futures Recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA).
- Preventive care and screening for women supported by HRSA guidelines.
- Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices (ACIP).

Please note: USPSTF, HRSA, and ACIP recommendations may change. If you need more details about these 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.

Coverage may include (but is not limited to):

- Periodic evaluations such as well-woman visits
- Immunizations
- Cancer screenings such as mammograms, pap smears or colonoscopy
- Preventive counseling and screening for diabetes or depression
- Screening for HIV, syphilis, gonorrhea and chlamydia

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

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*.

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 to find the latest benefits available to our members.

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 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*.

Vasectomy

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

Special Benefits for Women

Artificial Insemination

Covered.

Coverage for other related services such as office visits, labs, and radiology are described in other sections of this Guide.

Breast Pump

Covered, for purchase of one device including attachments per pregnancy.

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 www.hmsa.com.

Please note: Hospital-grade rentals must be precertified. See *Chapter 5: Precertification*.

Contraceptive IUD

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.

Contraceptive Implants

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.

Contraceptive Injectables

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.

In Vitro Fertilization

Covered. While you are enrolled or have been enrolled with HMSA (in either a group or individual plan), coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure ("IVF Benefit") per:

- HMO product (e.g., Health Plan Hawaii) or
- PPO product (e.g., Preferred Provider Plan/Comprehensive Medical Plan).

If you have exhausted the above benefits under prior coverage with HMSA, you will be entitled to a one-time additional single IVF Benefit under your group plan, but only if you did not ever receive an IVF Benefit under an HMSA plan with that group.

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.

If you have a male partner, you must meet all of the following criteria:

- 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:
  - Endometriosis;
  - Exposure in utero to diethylstilbestrol (DES);
  - Blockage or surgical removal of one or both fallopian tubes; or
  - Abnormal male factors contributing to the infertility.
- You and your male partner have been unable to attain a successful pregnancy through other covered infertility treatments.

If you do not have a male partner, you must meet the following criteria:

- You are not known to be otherwise infertile, and
- You have failed to achieve pregnancy following three cycles of physician directed, appropriately timed intrauterine insemination.

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

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*.

Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit

Covered, for:

- routine prenatal visits,
- delivery, and
- one postpartum visit.

Coverage for other maternity related services such as nursery care, labor room, hospital room and board, pregnancy termination, diagnostic tests, labs, and radiology are described in other sections of this Guide.

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*.

Pregnancy Termination

Covered.

Tubal Ligation

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

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

Case Management Services

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.
- 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.

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:
- 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*:** The following do not in and of themselves constitute a mental health disorder:
- Epilepsy,
- neurocognitive disorders,
- intellectual disabilities, or
- other developmental disabilities and addiction to or abuse of intoxicating substances.

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.

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.
- Pharmacy care. Benefits for drugs to treat autism spectrum disorders are described later in this chapter under *Drugs and Supplies.*

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.*

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
- 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*.

Other Organ and Tissue Transplants

Covered, but only as described in this section and *Organ and Tissue Transplants.*

Also, all transplants must receive our approval. Without approval for the specified transplants, benefits are not available. See *Chapter 5: Precertification*.

Heart Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification*.

Heart and Lung Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification.*

Liver Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification*.

Lung Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification.*

Pancreas Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification.*

Simultaneous Kidney/Pancreas Transplants

Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification*.

Small Bowel and Multivisceral Transplants

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*.

Stem-Cell Transplants (including Bone Marrow Transplants)

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.*

Drugs and Supplies

Covered, but only drugs to treat autism spectrum disorders, oral chemotherapy drugs, contraceptives, diabetic drugs, supplies and insulin, and U.S. Preventive Services Task Force Recommended Drugs. Coverage will be provided only when the drugs and supplies are:

- Approved by the FDA, under federal control,
- Prescribed by a licensed Provider,
- Dispensed by a licensed pharmacy or Provider, and
- You do not have an HMSA drug plan or your HMSA drug plan does not cover the drug or supply covered in this section.

Please note: The list of U.S. Preventive Services Task Force (USPSTF) recommended drugs may change. Examples of drugs recommended include, but are not limited to, aspirin and folic acid. If you need more information about the USPSTF recommended drugs, 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*:** Some drugs and supplies must have precertification. See *Chapter 5: Precertification*.

Benefits for drugs and supplies vary depending on whether the drug is a generic drug, a Preferred Formulary drug, or Non-Preferred Formulary drug.

Benefit Limitations

Contraceptive benefits are limited to one contraceptive method per period of effectiveness.

Over-the-counter contraceptives are covered when you receive a written prescription for the contraceptive.

Diabetic supplies are limited to coverage for:

- Syringes.
- Needles.
- Lancets.
- Lancet devices.
- Test strips.
- Acetone test tablets.
- Insulin pump tubing.
- Calibration solutions.

Copayment amounts for covered drugs or supplies are for a maximum 30-day supply or fraction thereof. A 30-day supply means a supply that will last you for a period consisting of 30 consecutive days. For example, if the prescribed drug must be taken by you only on the last five days of a one-month period, a 30-day supply would be the amount of the drug that you must take during those five days.

If you get more than a 30-day supply under one prescription:

- you must pay an additional copayment for each 30-day supply or fraction thereof, and
- The pharmacy will fill the prescription in the quantity specified by your Provider up to a 12-month supply for contraceptives. For all other drugs or supplies the maximum benefit payment is limited to two more 30-day supplies or fractions thereof.

Definitions

Biological products

- Biological products, or biologics, are medical products. Many products are made from a variety of natural sources –(i.e., human, animal, or microorganism). It may be produced by biotechnology methods and other cutting-edge technologies. Like drugs, some biologics are intended to treat diseases and medical conditions. Other products are used to prevent or diagnose diseases. Examples may include:
  - Vaccines.
  - Blood and blood products for transfusion and /or manufacturing into other products.
  - Allergenic extracts that are used for both diagnosis and treatment, i.e., allergy shots.
  - Human cells and tissues used for transplantation (e.g., tendons, ligaments and bones).
  - Gene therapies.
  - Cellular therapies.
  - Tests to screen potential blood donors for infectious agents such as HIV.
- ***Reference product*** refers to the original FDA-approved biologic product that a biosimilar is based.
- ***Biosimilar product*** – A biological product that is FDA-approved based on a showing that it is highly similar to an already FDA-approved reference product. It has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Only minor differences in clinically inactive components are allowable in biosimilar products.
- ***Interchangeable biologic product*** – An FDA-approved biologic product that meets the additional standards for interchangeability to an FDA-approved reference product included in:
  - The Hawaii list of equivalent generic drugs and biological products.
  - The Orange Book.
  - The Purple Book.
  - Other published findings and approvals of the United States Food and Drug Administration.

In accordance with any applicable state and federal regulations and laws, an interchangeable biological product may be substituted for the reference product by a pharmacist without the intervention of the healthcare provider who prescribed the reference product.

Brand name drug is a drug that is marketed under its distinctive trade name. A brand name drug is or at one time was protected by patent laws or deemed to be biosimilar by the U.S. Food and Drug Administration. A brand name drug is a recognized trade name prescription drug product, usually either the innovator product for new drugs still under patent protection or a more expensive product marketed under a brand name for multi-source drugs and noted as such in the national pharmacy database used by HMSA.

Generic drug is a drug, supply, or insulin that is prescribed or dispensed under its commonly used generic name rather than a brand name. Generic drugs are not protected by patent and are identified by HMSA as "generic". A generic drug shall meet any of the following:

- It is identical or therapeutically equivalent to its brand counterpart in dosage form, safety, strength, route of administration and intended use.
- It is a non-innovator product approved by the FDA under an Abbreviated New Drug Application (an application to market a duplicate drug that has been approved by the FDA under a full New Drug Application).
- It is defined as a generic by Medi-Span or an equivalent nationally recognized source.
- It is not protected by patents(s), exclusivity, or cross-licensure.
- Generic drugs include all single-source and multi-source generic drugs as set forth by a nationally recognized source selected and disclosed by HMSA.
- Unless explicitly defined or designated by HMSA, once a drug has been deemed a generic drug it must be considered a generic drug for purposes of benefit administration.

Non-Preferred Formulary drug, supply, and insulin is a brand name drug, supply, or insulin that is not identified as preferred on the HMSA Select Prescription Drug Formulary.

Oral chemotherapy drug is an FDA-approved oral cancer treatment that may be delivered to the patient for self-administration under the direction or supervision of a Provider outside of a hospital, medical office, or other clinical setting.

Over-the-counter drugs are drugs that may be purchased without a prescription.

Preferred Formulary drug, supply and insulin is a brand name drug, supply or insulin identified as preferred on the HMSA Select Prescription Drug Formulary.

Prescription drug is a medication required by Federal law to be dispensed only with a prescription from a licensed provider. Medications that are available as both a Prescription Drug and a nonprescription drug are not covered as a Prescription drug under this plan.

Drug Benefit Management

We have arranged with Participating Providers to assist in managing the usage of certain drugs, including drugs listed in the HMSA Select Prescription Drug Formulary.

- We have identified certain kinds of drugs listed in the HMSA Select Prescription Drug Formulary that require preauthorization of HMSA. The criteria for preauthorization are that:
  - the drug is being used as part of a treatment plan,
  - there are no equally effective drug substitutes, and
  - the drug meets Payment Determination and other criteria established by us.

  A list of these drugs in the HMSA Select Prescription Drug Formulary has been distributed to all Participating Providers.

- Participating providers may prescribe up to a 30-day supply for first time prescriptions of maintenance drugs and contraceptives. For subsequent refills, the participating provider may prescribe up to a 12-month supply for contraceptives, and a maximum 90-day supply for all other drugs after confirming that:
  - You have tolerated the drug without adverse side effects that could cause the drug to be discontinued, and
  - Your Provider has determined that the drug is effective.

Mail Order Providers

Benefits for mail order drugs, supplies, and insulin are only available through contracted providers. Call your nearest HMSA office listed on the back cover of this Guide for a list of contracted providers. If you receive mail order drugs and supplies from a provider that does not contract with HMSA, no benefits will be paid.

The contracted provider will fill the prescription in the quantity specified by the Provider up to a 12-month supply for contraceptives. For all other drugs or supplies, copayment amounts are for a maximum 90-day supply or fraction thereof. A 90-day supply means a supply that will last you 90 consecutive days or a fraction thereof. You must pay a 90-day copayment even if the prescription is written for less than a 90-day supply or the pharmacy dispenses less than 90 doses or less than a 90-day supply. Situations in which this would occur include, but are not limited to:

- You are prescribed a drug in pill form that must be taken only on the last five days of each month. A 90-day supply would be fifteen pills, the number of pills you must take during a three-month period.
- You are prescribed a 30-day supply with two refills. The mail order pharmacy will fill the prescription in the quantity specified by the Provider, in this case 30 days, and will not send you a 90-day supply. You owe the 90-day copayment even though a 30-day supply has been dispensed.
- You are prescribed a 30-day supply of a drug that is packaged in less than 30-day quantity, for example, a 28-day supply. The pharmacy will fill the prescription by providing you a 28-day supply. You owe the 90-day copayment. If you are prescribed a 90-day supply, the pharmacy would fill the prescription by giving you three packages each containing a 28-day supply of the drug. Again, you would owe a 90-day copayment for the 84-day supply.

Unless your Provider directs the use of a brand name drug by clearly indicating it on the prescription, your prescription will be filled with the generic equivalent when available and permissible by law.

Refills are available if indicated on your original prescription and only after two-thirds of your prescription has already been used.

Refills

Except for certain drugs managed under Drug Benefit Management, refills will be paid if indicated on your original prescription and only after two-thirds of your prescription has already been used. At the discretion of your pharmacist, you may refill your prescriptions for maintenance drugs earlier if you need to synchronize such prescriptions to pick them up at the same time. Your copayment for each prescription may be adjusted accordingly.

Please note: Certain limitations or restrictions apply. Please see our Medication Synchronization policy at www.hmsa.com.

You May Owe Additional Amounts When There is a Generic Equivalent

This plan requires the substitution of Generic Drugs listed on the FDA Approved Drug Products with Therapeutic Equivalence Evaluations for a brand name drug. Exceptions will be made when a Provider directs that substitution is not permissible. If you choose not to use the generic equivalent, we will pay only the amount that would have been paid for the generic equivalent. This provision will apply even if the generic equivalent is out-of-stock or is not available at the pharmacy.

In the event a generic equivalent is out-of-stock or not available, you may wish to purchase the generic equivalent from another pharmacy.

CHAPTER 5

This Chapter Covers

Definitions 47

Definitions

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 and
  - 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.

Chapter 5: Precertification

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.

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

This Chapter Covers

About this Chapter 49
Counseling Services 49
Coverage Under Other Programs or Laws 50
Dental, Drug, and Vision 50
Fertility and Infertility 51
Preventive and Routine 51
Provider Type 52
Transplants 52
Miscellaneous Exclusions 53

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 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 those oral surgery services listed in *Chapter 4: Description of Benefits* under *Surgical Services, Oral Surgery.* 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:

- Drugs and supplies except as stated in *Chapter 4: Description of Benefits* under *Drugs and Supplies* and as identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations.
- Drugs from foreign countries.
- Replacement for lost, stolen, damaged, or destroyed 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.

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 contraceptives except as described in *Chapter 3: Summary of Benefits and Your Payment Obligations* and *Chapter 4: Description of Benefits* under *Special Benefits for Women* and *Drugs and Supplies*.

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.*
- In vitro fertilization services that are inconsistent with the benefit maximums described in *Chapter 4: Description of Benefits* under *Special Benefits for Women, In Vitro Fertilization.*

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.

This limitation is not intended to affect coverage of physical exams or associated screening procedures that would otherwise have been covered, and that have separately and incidentally been requested or required by a third party.

Routine Circumcision

You are not covered for routine circumcision except as stated in *Chapter 4: Description of Benefits* under the *Surgical Services* section.

Routine Foot Care

You are not covered for services or supplies related to routine foot care.

	Provider Type
Complementary and Alternative Medicine Provider	You are not covered for complementary and alternative medicine services or supplies including but not limited to: • botanical medicine, • aromatherapy, • herbal/nutritional supplements, • medication techniques, • relaxation techniques, • movement therapies, • energy therapies, and • massage therapy when not part of rehabilitative therapy.
Dietitian	You are not covered for nutritional counseling services except as described in *Chapter 4: Description of Benefits.* See *Other Medical Services and Supplies, Medical Nutrition Therapy* or *Special Benefits – Disease Management and Preventive Services, Preventive Health Services*.
Provider is an Immediate Family Member	You are not covered for professional services or supplies when furnished to you by a provider who is within your immediate family. ***Immediate Family*** is a parent, child, spouse, or yourself.
Provider Nondiscrimination	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.
Social Worker	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. ***Please note:*** 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.

	Transplants
Living Donor Transport	You are not covered for expenses of transporting a living donor.
Living Organ Donor Services	You are not covered for organ donor services if you are the organ donor.
Mechanical or Non-Human Organs	You are not covered for mechanical or non-human organs, except for artificial hearts when used as a bridge to a permanent heart transplant.
Organ Purchase	You are not covered for the purchase of any organ.
Transplant Services or Supplies	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.
Transportation Related to Organ and Tissue Transplants	You are not covered for transportation for organ or tissue transplant services or transportation of organs or tissues.

Miscellaneous Exclusions

Act of War

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.

Acupuncture

You are not covered for services or supplies related to acupuncture.

Airline Oxygen

You are not covered for airline oxygen.

Ambulance (air)

You are not covered for air ambulance services except as described in *Chapter 4: Description of Benefits.* The following air ambulance services are not covered:

- Transportation from the continental US to Hawaii.
- Transportation within the continental US.
- Transportation for patients whose condition allows for transportation via commercial airline.
- Transportation on a commercial airline.

Biofeedback

You are not covered for biofeedback and any related tests.

Blood

You are not covered for blood except as described in *Chapter 4: Description of Benefits.*

Carcinoembryonic Antigen (CEA)

You are not covered for carcinoembryonic antigen when used as a screening test.

Cardiac Rehabilitation

You are not covered for cardiac rehabilitation services except as described in *Chapter 4: Description of Benefits* under *Cardiac Rehabilitation* and *Dr. Ornish's Program for Reversing Heart Disease™.*

Chemotherapy (High-Dose)

You are not covered for high-dose chemotherapy except when provided in conjunction with stem-cell transplants described in *Chapter 4: Description of Benefits* under *Stem-Cell Transplants (including Bone Marrow Transplants).*

Complementary and Alternative Medicine Services

You are not covered for complementary and alternative medicine services or supplies including, but not limited to:

- botanical medicine,
- aromatherapy,
- herbal/nutritional supplements,
- medication techniques,
- relaxation techniques,
- movement therapies,
- energy therapies, and
- massage therapy when not part of rehabilitative therapy.

Complications of a Non-Covered Procedure

You are not covered for complications of a non-covered procedure, including complications of recent or past cosmetic surgeries, services or supplies.

Convenience Treatments, Services or Supplies

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:

- ramps,
- home remodeling,
- hot tubs,
- swimming pools,
- deluxe/upgraded items, or
- personal supplies such as surgical stockings.

Cosmetic Services, Surgery or Supplies

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.

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 your employer made on an enrollment form 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 your employer 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.

Genetic Testing

You are not covered for genetic tests except as stated in *Chapter 4: Description of Benefits* under *Testing, Laboratory, and Radiology* and *Special Benefits – Disease Management and Preventive Services*.

Growth Hormone Therapy

You are not covered for growth hormone therapy except as stated in *Chapter 4: Description of Benefits* under *Other Medical Services and Supplies*.

Hair Loss

You are not covered for services or supplies related to the prevention and/or treatment of baldness or hair loss regardless of condition. This includes hair transplants and topical medications.

Hypnotherapy

You are not covered for hypnotherapy.

Incontinence Supplies

You are not covered for incontinence supplies including but not limited to pads, diapers, protective underwear, underpads, gloves and wipes.

Intradiscal Electro Thermal Therapy (IDET)

You are not covered for intradiscal electro thermal therapy.

Massage Therapy

Massage therapy is not covered unless rendered as part of an approved rehabilitative therapy treatment plan.

Microprocessor (Upper/Lower Prostheses and Orthoses)

You are not covered for microprocessor or computer controlled, or myoelectric parts of upper and lower limb prosthetic and orthotic devices.

Motor Vehicles

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.

Non-Medical Items

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:

- 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);
- hygienic equipment;
- exercise equipment;
- items primarily for participation in sports or leisure activities, and
- educational equipment.

Non-Related Items Exclusion

You are not covered for any service, procedure, or supply that is directly or indirectly related to a non-covered service, procedure, or supply.

Private Duty Nursing

You are not covered for private duty nursing.

Prohibited by Law

You are not covered for services or supplies we are prohibited from covering under the law.

Radiation (High-dose)

You are not covered for high-dose radiotherapy except when provided in conjunction with stem-cell transplants described in *Chapter 4: Description of Benefits* under *Stem-Cell Transplants (including Bone Marrow Transplants)*.

Radiation (Nonionizing)

You are not covered for treatment with nonionizing radiation.

Recreational Therapy

You are not covered for recreational therapy and/or programs such as:

- wilderness therapy,
- health resorts,
- horseback riding,
- swimming with dolphins,
- outdoor skills programs,
- relaxation or lifestyle programs, and
- any other services provided in conjunction or related to (or as part of) those programs.

Repair/Replacement

You are not covered for the repair or replacement of any item covered under the manufacturer or supplier warranty, including:

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

	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.
Reversal of Gender Confirmation Surgery	You are not covered for reversal of gender confirmation surgery, except in the case of a serious medical barrier to completing gender confirmation or the development of a serious medical condition requiring a reversal.
Self-Help or Self-Cure	You are not covered for self-help and self-cure programs or equipment.
Services Related to Employment	You are not covered for services related to getting or maintaining employment.
Stand-by Time	You are not covered for a provider's waiting or stand-by time.
Supplies	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.
Thoracic Electric Bioimpedance (Outpatient/Office)	You are not covered for outpatient thoracic electric bioimpedance in an outpatient setting which includes a physician’s office.
Topical Hyperbaric Oxygen Therapy	You are not covered for topical hyperbaric oxygen therapy.
Travel or Lodging Cost	You are not covered for the cost of travel or lodging.
Vertebral Axial Decompression (VAX-D)	You are not covered for vertebral axial decompression.
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* and *Drugs 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

This Chapter Covers

When to File Claims 57
How to File Claims 57
What Information You Must File 57
Other Claim Filing Information 58

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.

Other Claim Filing Information

Where to Send Claim

For Professional claims, send to:
HMSA – CMS 1500 Claims
P.O. Box 44500
Honolulu, Hawaii 96804-4500

For Facility claims, send to:
HMSA – UB-04 Claims
P.O. Box 32700
Honolulu, Hawaii 96803-2700

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.

CHAPTER 8

This Chapter Covers

Your Request for an Appeal 59
If You Disagree with Our Appeal Decision and You are Enrolled in a Group Plan that is not Self Funded 60
If You Disagree with Our Appeal Decision and You are Enrolled in a Self Funded Group Plan 62

Your Request for an Appeal

Writing Us to Request 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.

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 and You are Enrolled in a Group Plan that is not Self Funded

If you are enrolled in a group plan that is not self funded and you would like to appeal HMSA's decision, you must do one of the following:

- 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, you must request review by an Independent Review Organization (IRO) selected by the Insurance Commissioner.
- For all other issues, you must:
  - 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.

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
- 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.

If You Disagree with Our Appeal Decision and You are Enrolled in a Self Funded Group Plan

If you are enrolled in a self funded group plan and you would like review of HMSA's appeal decision, you must do one of the following:

- 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, you must request review by an Independent Review Organization (IRO) selected by HMSA at random from a panel of three IROs.
- For all other issues, you must:

– Request arbitration with your employer or group sponsor before a mutually selected arbitrator; or
– File a lawsuit against your employer or group sponsor under 29 USC 1132(a) unless your plan is one of the two bulleted types below in which case you must select review by an IRO or 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 HMSA

If you choose review by an IRO you must submit your request in writing within 130 days of HMSA's appeal decision to deny or limit the 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

Within 6 business days following the date of receipt of your request, we will notify you in writing whether your appeal is eligible for external review.

We will assign an IRO to review your appeal. The IRO will inform you of its decision within 45 days after the IRO received the assignment from us.

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 Review by an IRO Selected by HMSA

You may request expedited external review if:
- The timeframe for completion of an expedited internal appeal would seriously jeopardize your life, health, or your ability to regain maximum functioning and you have filed an expedited internal appeal.
- The timeframe for completion of standard external review would seriously jeopardize your life, health, or your ability to regain maximum functioning.
- HMSA's internal appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services and you have not been discharged from a facility.

Upon our determination that you meet the above criteria we will assign an IRO to review your appeal. The IRO will inform you of its decision as expeditiously as your condition or circumstances require but in no event more than 72 hours after it receives the assignment from us.

Request Arbitration

If you choose arbitration, with your employer or group sponsor, 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 receive 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 your employer or group sponsor) must agree on the person to be the arbitrator. If you and your employer or group sponsor 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 arbitration shall be conducted in accord with the Hawaii Uniform Arbitration Act, HRS Chapter 658A, and the rules of Dispute Prevention and Resolution, Inc., to the extent not inconsistent with this *Chapter 8: Dispute Resolution*, and such other arbitration rules as both parties agree upon. The arbitrator may hear and determine motions for summary disposition pursuant to HRS §658A-15(b). The arbitrator shall also hear and determine any challenges to the arbitration agreement and any disputes regarding whether a controversy is subject to an agreement to arbitrate. In order to make the arbitration hearing fair, expeditious and cost-effective, discovery by both parties shall be limited to requests for production of documents material to the

claims or defenses in the arbitration. Limited depositions for use as evidence at the arbitration hearing may occur as authorized by HRS §658A-17(b).

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 Hawaii Uniform Arbitration Act.

Your employer or group sponsor will pay the arbitrator's fee. You must pay your attorney's or witness's fees, if you have any, and your employer or group sponsor must pay theirs. The arbitrator will decide who will pay all other costs of the arbitration.

Your employer or group sponsor waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.

CHAPTER 9

This Chapter Covers

What Coordination of Benefits Means 65
General Coordination Rules 66
Dependent Children Coordination Rules 66
If You Are Hospitalized When Coverage Begins 66
Motor Vehicle Insurance Rules 66
Medicare Coordination Rules 67
Third Party Liability Rules 68

What Coordination of Benefits Means

Coverage that Provides Same or Similar Coverage

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 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 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*.

Medicare Coordination Rules

Medicare as Secondary Payer

Since 1980, Congress has passed legislation making Medicare the secondary payer and group health plans the primary payer in a variety of situations. These laws apply only if you have both Medicare and employer group health coverage, and your employer has the minimum required number of employees as described in the following paragraphs. For more information, contact your employer or the Centers for Medicare & Medicaid Services.

If You are Age 65 or Older

If your group employs 20 or more employees and if you are age 65 or older and eligible for Medicare only because of your age, the coverage described in this plan will be provided before Medicare benefits as long as your employer or group health plan coverage is based on your status as a current active employee or the status of your spouse as a current active employee.

If You are Under Age 65 with Disability

If your employer or group employs 100 or more employees and if you are under age 65 and eligible for Medicare only because of a disability (and not ESRD), coverage under this plan will be provided before Medicare benefits as long as your group health plan coverage is based on your status as a current active employee or the status of your spouse as a current active employee or on the current active employment status of an individual for whom you are a dependent.

If You are Under Age 65 with End-Stage Renal Disease (ESRD)

If you are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), coverage under this plan will be provided before Medicare benefits, but only during the first 30 months of your ESRD coverage. Then, the coverage described in this plan will be reduced by the amount that Medicare pays for the same covered services.

Dual Medicare Eligibility

If you are eligible for Medicare because of ESRD and a disability, or because of ESRD and you are age 65 or older, the coverage under this plan will be provided before Medicare benefits during the first 30 months of your ESRD Medicare coverage if this plan was primary to Medicare when you became eligible for ESRD benefits.

This Plan Secondary Payer to Medicare

If you receive services covered under both Medicare and this plan, and Medicare is allowed by law to be the primary payer, this plan will cover over and above what Medicare pays up to the Medicare approved charge not to exceed the amount this plan would have paid if it had been your only coverage. If you are entitled to Medicare benefits, we will begin paying benefits after all Medicare benefits (including lifetime reserve days) are exhausted.

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;
- **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.

Payment of Benefits Subject to Our Right to Recover Our 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 first-priority right to subrogation and reimbursement 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 payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowner's insurance coverage;
- Medical malpractice coverage; or
- Any other payments from a source intended to compensate you for injuries resulting from an accident or alleged negligence.

As used herein, the term "Third Party," means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as "Third Party Injuries". "Third Party" includes any party responsible for payment of expenses associated with the care of treatment of Third Party Injuries.

If this plan pays benefits under this Guide to Benefits to you for expenses incurred due to Third Party Injuries, then the Plan retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the Third Party Injuries.

By accepting benefits under this plan, you specifically acknowledge the Plan's right of subrogation. In the event you suffer injuries for which a Third Party is responsible (such as someone injuring you in an accident), and the Plan pays benefits as a result of those injuries, the Plan will be subrogated and succeed to the right of recovery against such Third Party to the extent of the benefits the Plan has paid. This means that the Plan has the right, independently of you, to proceed against the Third Party responsible for your injuries to recover the benefits the Plan has paid. In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

By accepting benefits under this plan, you also specifically acknowledge the Plan's right of reimbursement. This right of reimbursement attaches when this plan has paid health care benefits for expenses incurred due to Third Party Injuries and you or your representative has recovered any amounts from a Third Party. By providing any benefit under this Guide to Benefits, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

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, even if the recovery proceeds obtained (by settlement, judgment, award, insurance proceeds, or other payment):

- Do not specifically 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.

No court costs or attorney fees may be deducted from our lien.

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 we are entitled to reimbursement of payments made on your behalf under these rules, and we do not promptly receive full reimbursement pursuant to our request, we shall have a right to set-off from any future payments payable on your behalf under this Guide to Benefits.

Our rights of reimbursement, lien, and subrogation described above, are in addition to all other rights of equitable subrogation, constructive trust, equitable lien and/or statutory lien we may have for reimbursement of these payments. All of these rights are preserved and may be pursued at our option against you or any other appropriate person or entity.

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.

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

CHAPTER 10

This Chapter Covers

Eligibility for Coverage 71
When Coverage Begins 72
When Coverage Ends 72
Continuity of Care 73
Continued Coverage 74
Confidential Information 76
Dues and Terms of Coverage 77
ERISA Information 78

Eligibility for Coverage

When You are Eligible for Coverage

You may enroll in this coverage when you are first eligible according to your employer's rules for eligibility. If you do not enroll in this coverage when you first become eligible or by the first day of the month immediately following the first four consecutive weeks of employment, you will not be eligible to enroll until the next open enrollment period. ***Open Enrollment*** happens once a year. However, if we agree that there was unusual and justifiable cause for submitting your enrollment form late, you may enroll sooner.

Categories of Coverage

There are different categories of coverage you may hold.

- With single coverage, you the subscriber, are the only one covered.
- With family coverage, you the subscriber, and your spouse, and each of your eligible, dependent children are eligible for enrollment in the plan. Each covered family member enrolled in the plan must be listed on the subscriber's enrollment form or added later as a new dependent.

Enrollment Process

You must enroll your spouse or child(ren) by naming him or her on the enrollment form or other form and submitting it within 31 days of the date the spouse or child becomes eligible. If you do not enroll within this time frame, you may enroll at the next open enrollment period. Open enrollment takes place once a year.

If you decline enrollment in this plan for yourself or your dependents (including your spouse) because of other health plan coverage, you may be able to enroll yourself or your dependents in this plan at a later date if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must enroll by complying with our usual enrollment process within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

What You Should Know about Enrolling Your Child(ren)

In general, you may enroll a child if the child meets all of these requirements:

- The child is 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).
- The child is under 26 years of age.

Also, you may enroll children who meet all of the criteria in one of these categories:

- Children with Special Needs
- Children Who Are Newborns or Adopted.

Children with Special Needs

You may enroll your child if he or she is disabled by providing us with written documentation acceptable to us demonstrating that:

- Your child is incapable of self-sustaining support because of a physical or mental disability.
- Your child's disability existed before the child turned 26 years of age.
- Your child relies primarily on you for support and maintenance as a result of his or her disability.

You must provide this documentation to us within 31 days of the child's 26th birthday, or anticipated enrollment with HMSA, and subsequently at our request but not more frequently than annually.

Children Who are Newborns or Adopted

You may enroll a newborn or adopted child, effective as of the date listed below, if you comply with the requirements described below and enroll the child in accord with our usual enrollment process:

- The birth date of a newborn, providing you comply with our usual enrollment process within 31 days of the child's birth.
- The date of adoption, providing you comply with our usual enrollment process within 31 days of the date of adoption.
- The birth date of a newborn adopted child, providing we get notice of your intent to adopt the newborn within 31 days of the child's birth.
- The date the child is placed with you for adoption, providing we get notice of the placement within 31 days of the placement. Placement occurs when you assume a legal obligation for total or partial support of the child in anticipation of adoption.

Qualified Medical Child Support Order (QMCSO)

Qualified Medical Child Support Orders or QMCSOs are court orders that meet certain federal guidelines and require a person to provide health benefits coverage for a child. Claims for benefits for a child covered by a Qualified Medical Child Support Order may be made by any of the following:

- The child.
- The child's custodial parent.
- The child's court-appointed guardian.
- Any benefits otherwise payable to the member with respect to any such claim shall be payable to the child's custodial parent or court-appointed guardian.

If you would like more information about how HMSA handles QMCSOs, you may call HMSA's Customer Service. Our phone number is listed on the back cover of this Guide.

When Coverage Begins

When You are Eligible to Receive Benefits

This coverage takes effect and you are eligible for benefits on your effective date, as long as:

- Your initial dues were paid; and
- We accepted your enrollment form and gave you written notice of your effective date.

When Coverage Ends

Reasons for Coverage Termination

Unless prohibited by state or federal law, your coverage will end at the end of the month in which any of these take place:

- You choose to end this coverage. In this case, you must provide written notice of your intent to terminate 30 days before the termination date.
- You or your employer or group sponsor fails to make payments to us when due, or your employer or group sponsor decides to discontinue this coverage, and we have given 10-days advance written notice to your employer and the Director of the Hawaii Department of Labor and Industrial Relations.
- Your employer or group sponsor decides to replace this coverage with another coverage and there is no lapse in coverage.

• We end our agreement with your employer or group sponsor, and we have given 10-days advance written notice to your employer and the Director of the Hawaii Department of Labor and Industrial Relations.
• For *the subscriber*, upon your retirement, termination of employment, severance from the group, or termination of this Agreement.
• For *the subscriber's spouse* enrolled in the plan as an eligible dependent, upon your termination of coverage or upon the dissolution of the marriage.
• For *the subscriber's children* enrolled in the plan as an eligible dependent, when any of the following occurs:
  – The subscriber's coverage ends; or
  – The child fails to meet the criteria outlined earlier in this chapter under *What You Should Know about Enrolling Your Child(ren).*

Notifying Us When Your Child's Eligibility Ends

You must inform us, in writing, if a child no longer meets the eligibility requirements. You must notify us 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 us by July 1.

If you fail to inform us 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.

Termination for Fraud

Your eligibility for coverage will end if you or your employer use this coverage fraudulently or intentionally misrepresent or conceal material facts on your enrollment form or in any claim for benefits.

If we determine that you or your employer 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.

Continuity of Care

Continuing Care Patient

You may be eligible for continuity of care if you are a continuing care patient receiving a course of treatment from a participating provider and one of the following occurs:
• the contractual relationship between the participating provider and HMSA is terminated;
• benefits provided under your plan with respect to the participating provider are terminated because of a change in the terms of the participation of such participating provider in such plan; or
• you are under a group health plan and the contract between such group health plan and HMSA is terminated.

With respect to the above occurrences, the term "terminated" does not include a termination of a contract for failure to meet applicable quality standards or for fraud.

A "Continuing Care Patient" is defined as an individual who, with respect to a provider:
• is undergoing a course of treatment for a serious and complex condition from the provider,
• is undergoing a course of institutional or inpatient care from the provider,
• is scheduled for non-elective surgery from the provider, including receipt of post-operative care from such provider with respect to such a surgery,

- is pregnant and undergoing a course of treatment for the pregnancy from the provider, or
- is or was determined to be terminally ill and is receiving treatment for such illness from such provider.

For purposes of the "Continuing Care Patient" definition, a serious and complex condition means either:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that is (i) life-threatening, degenerative, potentially disabling, or congenital and (ii) requires specialized medical care over a prolonged period of time.

If we determine you are eligible for continuity of care, we will inform you of the options under transitional care. If you qualify for transitional care, you may elect to continue your current benefits and copayments under this Plan with respect to the course of treatment furnished by such provider relating to your status as a continuing care patient. Plan benefits will apply, beginning on the date HMSA's notice of termination is provided and ending 90 days later or when you are no longer eligible as a continuing care patient, whichever is sooner.

No Surprises Act Emergency Services and Surprise Bills

Under the No Surprises Act ("NSA"), a provider or emergency facility may not bill or hold you liable for a payment amount that exceeds the copayment requirement had such service or item been received from a participating provider unless you signed a valid consent allowed by law.

If coverage is approved and applies, benefits for services rendered subject to the NSA will be paid directly to the nonparticipating provider. Services or items subject to the NSA are:

- Emergency Services rendered by a nonparticipating provider;
- Non-emergency items and services furnished or rendered by a nonparticipating provider at certain participating health care facilities, provided the beneficiary has not validly waived the applicability of the NSA; and
- Air ambulance services covered by the Plan and provided by nonparticipating air ambulance providers.

Please note: Copayment amounts will apply toward meeting the annual deductibles and annual copayment maximums.

Continued Coverage

Continued Coverage Under Federal Law - COBRA Rights

When your coverage ends under this Agreement you may have the opportunity to continue your group coverage for a limited time under the Consolidated Omnibus Budget Reconciliation Act (COBRA). The act applies to employers with 20 or more employees.

Qualifying Events

COBRA entitles you and your eligible dependents, if already covered, to continue this coverage if coverage is lost due to any of the following qualifying events:

- Employer or group sponsor from whom you retired files bankruptcy under federal law.
- Death of the employee covered under this coverage.
- Divorce or legal separation.
- Child no longer meets our eligibility rules.
- Enrollment in Medicare.
- Termination of employment for reasons other than gross misconduct, or if your work hours are reduced to the point that you are no longer eligible for coverage.

Please note that dependents covered as domestic partners are not eligible for COBRA coverage.

If you lose your coverage, contact your employer or group sponsor immediately. You are entitled to receive a COBRA election form within 44 days if the qualifying event is a termination of employment or reduction in hours. If the qualifying event is divorce, legal separation, or a child ceasing to be a dependent child, the form and notice must be provided to you within 14 days after you notify your employer of the event.

Please note: You or your spouse is responsible for notifying your employer or group sponsor of your divorce or legal separation, or if a child loses eligibility status under our rules for coverage.

If you or your spouse believes you have had a qualifying event and you have not received your COBRA election form on a timely basis, please contact your employer.

Payment of COBRA Premiums

If you or your dependents are entitled to and elect COBRA continuation coverage, you must pay your employer the premiums for the continuing coverage that may be up to 102% of the full cost of the coverage. In the case of a disabled individual whose coverage is being continued for 29 months, you or your dependents may be required to pay up to 150% of the full cost of the coverage for any month after the 18th month.

Within 45 days of the date you elect COBRA coverage you must pay an initial COBRA premium to cover from the date of your qualifying event to the date of your election. You will be notified of the amount of the premiums you must pay thereafter. If you fail to make the initial payment or any subsequent payment in a timely fashion (a 30 days grace period applies to late subsequent payments), your COBRA coverage will terminate.

What You Must Do

If you wish to continue your coverage, you must complete an election form and submit it to your employer within 60 days of the later of the date:

- You are no longer covered; or
- You are notified of the right to elect COBRA continuation coverage.

You or your dependents must notify your employer in the following circumstances:

- If coverage for you or your dependents is being continued for 18 months under COBRA and it is determined under Title XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event which would have caused coverage to terminate, then you or your dependent must notify your employer of such determination . Notice must be provided within 60 days of the determination of disability. Notice must also be given within 30 days of any notice that you or your dependent is no longer disabled.
- If coverage for a dependent would terminate due to your divorce, a legal separation, or the dependent's ceasing to be a dependent under this plan, then you or your dependent must provide notice to your employer of the event. This notice must be given within 60 days after the later of the occurrence of the event or the date coverage would terminate due to the occurrence of the event.

If notice is not provided on time, COBRA coverage will not be available to you or your dependents.

Adding Your Child

If during the period of COBRA coverage, a child is born to you or placed with you for adoption and you are on COBRA because you terminated employment or had a reduction in hours, the child can be covered under COBRA and can have election rights of his or her own. Please be aware that dependent children of domestic partners are not eligible for COBRA continuation coverage.

Length of Coverage Under COBRA

Continuation coverage ends at the earliest of one of these events:

- The last day of the 18-, 29-, or 36-month maximum coverage period, whichever is applicable. If you or any of your dependents who has elected COBRA coverage is determined to be disabled under the Social Security Act during the first 60 days of continuation coverage, your COBRA coverage may continue for up to 29 months. The 29-month period will apply to you and your eligible dependents who elected COBRA coverage. You must provide notice of the disability determination to your employer within 60 days after the determination.

• The first day (including grace periods, if applicable) on which timely payment is not made by you.
• The date on which the employer ceases to maintain any group health plan (including successor plans).
• The date the qualified beneficiary enrolls in Medicare benefits. ***Qualified Beneficiary*** means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan:
  – as the spouse of the covered employee; or
  – as the dependent child of the covered employee.
• The first day on which a beneficiary is actually covered by any other group health plan. However, if the new group health plan contains an exclusion or limitation relating to any preexisting condition of the beneficiary, then coverage will end on the earlier of the satisfaction of the waiting period for preexisting conditions contained in the new group health plan, or the occurrence of any one of the other events stated in this chapter.

If the new group health plan contains a preexisting condition exclusion, the preexisting condition exclusion period will be reduced by the qualified beneficiary's preceding aggregate periods of creditable coverage (if any). The creditable coverage is applicable to the qualified beneficiary as of the enrollment date in the new group health plan as long as there has been no interruption of coverage longer than 63 days. Creditable Coverage means any of the following:
• A group health plan.
• Health insurance coverage.
• Part A or B of Medicare.
• Medicaid.
• Chapter 55 of Title 10, United States Code.
• A medical care program of the Indian Health Service or of a tribal organization.
• A state health benefits risk pool.
• A health plan offered under Chapter 89 of Title 5, United States Code.
• A public health plan as defined in government regulations.
• A health benefit plan under section 5(e) of the Peace Corps Act.

You may request a certificate of creditable coverage by calling HMSA Customer Service. Our phone number is listed on the back cover of this Guide.

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 Subscriber Dies

Upon the death of a subscriber, the subscriber’s spouse enrolled in the plan as an eligible dependent, may become a subscriber under an individual payment plan. In the event a subscriber’s spouse becomes a subscriber under an individual payment plan, all dependent children of the deceased subscriber and the subscriber’s spouse may continue to be enrolled as members under such individual payment plan.

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.

Dues and Terms of Coverage

Dues

You or your employer or group sponsor must pay us on or before the first day of the month in which benefits are to be provided. We have the right to change the monthly dues after 30 days written notice to your employer or group sponsor. HMSA will accept dues payments directly from:

- you,
- your employer or group sponsor,
- your family,
- government programs,
- Ryan White HIV/AIDS programs,
- Native American tribal organizations and/or governments, and religious institutions and other not-for-profit organizations where the following criteria is met:
  - The assistance is provided on the basis of the insured's financial need;
  - The organization is not a healthcare provider; and
  - The organization is financially disinterested (i.e., the organization does not receive funding from an entity that has a pecuniary interest in the payment of health insurance claims and/or benefits).

In accordance with applicable law and regulatory guidance, HMSA declines dues payments from third-parties not included above. Notwithstanding the above, HMSA will not decline dues payments from third-parties for payments of dues for COBRA group health plan continuation coverage. Upon termination of a member's COBRA continuation coverage, and subsequent re-enrollment in other (non-COBRA) HMSA coverage, the general prohibition on third-party payments described above will apply.

Timely Payment

If you or your employer or group sponsor fail to pay monthly dues on or before the due date, we may end coverage, unless all dues are brought current within 10 days of our written notice of default to your employer or group sponsor and the state of Hawaii Department of Labor and Industrial Relations. We are not liable for benefits for services received after the termination date. This includes benefits for services you receive if you are enrolled in this coverage under the provisions of the:

- Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Terms of Coverage

By submitting the enrollment form, you also accept and agree to the provisions of our constitution and bylaws now in force and as amended in the future. You also appoint your employer or group as your administrator for dues payment and for sending and receiving all notices to and from HMSA concerning the plan.

Authority to Terminate, Amend, or Modify Coverage

Your employer or group sponsor has the authority to modify, amend, or end this coverage at any time. If your employer or group sponsor ends this coverage, you are not eligible to receive benefits under this coverage after the termination date. Any amendment or modification proposed by your employer or group sponsor must be in writing and accepted by us in writing.

We have the authority to modify the Agreement as long as we give 30 days prior written notice to your employer or group sponsor regarding the modification.

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.

ERISA Information

The Employee Retirement Income Security Act of 1974 (ERISA) provides that you will be entitled to:

- Examine all plan documents and copies of documents (such as annual reports) filed by the plan with the United States Department of Labor. You may examine these documents without charge at the plan administrator's office or at specified locations.
- Get copies of plan documents from the plan administrator upon written request. The plan administrator may request a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report if your employer or group sponsor has 100 or more participants in your plan. The plan administrator is required by law to furnish you with a copy of this summary annual report.

In addition to creating rights for you and other participants, ERISA imposes duties upon the people responsible for the operation of your employee benefit plan. The people responsible are called fiduciaries of the plan. Fiduciaries have a duty to operate your employee benefit plan prudently and in the interest of you and your family members. HMSA and the plan administrator (your employer or group sponsor), are fiduciaries under this Agreement; however, HMSA's duties are limited to those described in this Agreement, and the plan administrator is responsible for all other duties under ERISA. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from getting a covered benefit or exercising your rights under ERISA. In general, federal law prohibits health plans from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. Plans may require authorization for lengths of stay in excess of these time parameters. If your claim for a covered benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to request an appeal and reconsideration of your claim. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request plan documents from the plan administrator and do not receive it within 30 days, a federal court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the document, unless the document was not sent because of matters reasonably beyond the control of the plan administrator.

If you have a claim for benefits that is denied or ignored (in whole or in part), you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person or entity you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator, i.e., your employer or group sponsor. If you have questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your phone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20010.

CHAPTER 11

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.

Agreement — The document made up of:
- This Guide to Benefits;
- Any riders or amendments;
- The enrollment form submitted to us; and
- The Agreement between us and your employer or group sponsor.

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.

Chapter 11: Glossary

Annual Deductible

The fixed dollar amount you must pay each calendar year before benefits subject to the annual deductible become available. You cannot pay the annual deductible amount to us in advance. You must meet the deductible on a claim by claim basis.

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.

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 Products

Biological products, or biologics, are medical products. Many products are made from a variety of natural sources (i.e., human, animal, or microorganism). It may be produced by biotechnology methods and other cutting-edge technologies. Like drugs, some biologics are intended to treat diseases and medical conditions. Other products are used to prevent or diagnose diseases. Examples may include:

- Vaccines.
- Blood and blood products for transfusion and /or manufacturing into other products.
- Allergenic extracts that are used for both diagnosis and treatment, i.e., allergy shots.
- Human cells and tissues used for transplantation (e.g., tendons, ligaments and bones).
- Gene therapies.
- Cellular therapies.
- Tests to screen potential blood donors for infectious agents such as HIV.

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.

Biosimilar Product
A biological product that is FDA-approved based on a showing that it is highly similar to an already FDA-approved reference product. It has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Only minor differences in clinically inactive components are allowable in biosimilar products.

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.

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.

Cardiac Rehabilitation
A comprehensive medically supervised program in the outpatient setting that aims to improve the function of patients with heart disease and prevent future cardiac events.

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.

Chemotherapy - Oral
An FDA-approved oral cancer treatment that may be delivered for self-administration under the direction or supervision of a Provider outside of a hospital, medical office, or other clinical setting.

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.

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.

Consultation Services
A formal discussion between physicians on a case or its treatment.

Chapter 11: Glossary

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.

Covered Services

Services or supplies that meet payment determination criteria and are:
- Listed in this Guide in *Chapter 4: Description of Benefits,* and
- Not listed in this Guide in *Chapter 6: Services Not Covered*.

Creditable Coverage

Any of the following: a group health plan; health insurance coverage; Part A or B of Medicare; Medicaid; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5, United States Code; or a public health plan as defined in government regulations health benefit plan under section 5(e) of the Peace Corps Act.

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.

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.

Deductible

The fixed dollar amount you pay for certain covered services before benefits are available in a calendar year.

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 subscriber's spouse and/or eligible child(ren).

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 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.
ERISA	The Employee Retirement Income Security Act of 1974, a federal law that protects your rights under this coverage.
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 your employer made on your membership enrollment form or in any claims for benefits.
Family Coverage	Means coverage for you the subscriber, and your spouse, and each of your eligible, dependent children.
Family Member	The subscriber's spouse and/or children who are eligible and enrolled for this coverage.
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.
Generic Drug	A drug, supply, or insulin that is prescribed or dispensed under its commonly used generic name rather than a brand name. A generic drug is not protected by patent, or is identified by HMSA as "generic".
Group	Those members who share a common relationship such as employment or membership. The group has executed the group plan agreement with us and by getting health coverage through the group, you designate the group as your administrator.
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.

HMSA Select Prescription Drug Formulary
A list of drugs by therapeutic category published by HMSA.

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, 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.

Chapter 11: Glossary

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.

Interchangeable Biologic Product
An FDA-approved biologic product that meets the additional standards for interchangeability to an FDA-approved reference product included in:
- The Hawaii list of equivalent generic drugs and biological products.
- The Orange Book.
- The Purple Book.
- Other published findings and approvals of the United States Food and Drug Administration.

In accordance with any applicable state and federal regulations and laws, an interchangeable biological product may be substituted for the reference product by a pharmacist without the intervention of the healthcare provider who prescribed the reference product.

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
- 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.

Maternity Care
Routine prenatal visits, delivery, and one postpartum visit.

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.
Medication	The treatment of disease without surgery.
Medicine	To diagnose and treat disease and to maintain health.
Member	The subscriber and the subscriber's eligible dependents enrolled in the plan.
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 Health 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 health 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.
Non-Preferred Formulary Drug, Supply, or Insulin	A brand name drug, supply, or insulin that is not listed as preferred on the HMSA Select Prescription Drug Formulary.
Nonparticipating Providers	Providers that are not under contract with HMSA or any other Blue Cross and/or Blue Shield Plan.
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.

Chapter 11: Glossary

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.
Physician	A medical doctor (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.).
Physician Assistant	A practitioner who provides care under the supervision of a physician.
Physician Services	Professional services necessarily and directly performed by a doctor to treat an injury or illness.
Plan	This hospital and health benefits program offered to you as an eligible employee for purposes of ERISA.
Plan Administrator	Your employer or group sponsor for the purposes of ERISA.

Planned Admission	An admission that can be scheduled in advance because the condition, illness or injury is not immediately life-threatening.
Podiatrist	A health care professional who specializes in conditions of the feet.
Podiatry	Care and study of the foot.
Post-Acute Care	Comprehensive inpatient care (medical or behavioral health) designed for an individual who has an acute illness, injury or exacerbation of a disease process. It is goal-oriented treatment rendered immediately after acute inpatient hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments. Post-acute care requires the coordinated services of an interdisciplinary team and is given as part of a specifically designed treatment plan.
Postoperative Care	Care given after a surgical operation.
Postpartum	The period of time after childbirth.
Precertification	The process of getting prior approval for specified services and devices. Failure to get our approval will result in a denial of benefits if the services or devices do not meet HMSA's payment determination criteria. HMSA participating providers agree to get approval for you. All other providers do not agree to get approval for you, therefore you are responsible.
Preferred Formulary Drug, Supply, or Insulin	A brand name drug, supply, or insulin identified as preferred on the HMSA Select Prescription Drug Formulary.
Preoperative Care	Care that occurs, is performed, or is administered before, and usually close to, a surgical operation.
Prescription	The instructions written by a provider with statutory authority to prescribe directing a pharmacist to dispense a particular drug in a specific dose.
Primary Care Provider (PCP)	The provider you choose to act as your personal health care manager, and who renders general medical care focusing on preventive care and treatment of routine injuries and illnesses.
Private Duty Nursing	24-hour nursing services by an approved nurse who is dedicated to one patient.
Prosthetic Appliances	Devices used as artificial substitutes to replace a missing natural part of the body and other devices to improve, aid, or increase the performance of a natural function.
Provider	An approved physician or other practitioner, facility, or other health care provider, such as an agency or program.
Psychological Testing	A standard task used to assess some aspect of a person's cognitive, emotional, or adaptive function.
Psychologist	An approved provider who specializes in the treatment of mental health conditions.
Qualified Beneficiary	Qualified Beneficiary means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan: • as the spouse of the covered employee; or • as the dependent child of the covered employee.

Chapter 11: Glossary

Qualified Medical Child Support Order (QMCSO)
A Medical Child Support Order that creates or recognizes in the person specified in the order the existence of the right to enroll in the health benefit plan for which the plan subscriber or the subscriber's dependents are eligible. To be a Qualified Medical Child Support Order, the order cannot require a health benefit plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act with respect to a group plan.

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

Reference Product
Refers to the original FDA-approved biologic product that a biosimilar is based.

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.

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 subscriber 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.

Skilled Nursing Facility
A facility that provides ongoing skilled nursing services as ordered and certified by your attending Provider.

Specialist
A provider who is specifically trained in a certain branch of medicine related to a service or procedure, body area or function, or disease.

Speech Therapy Services
Services for the diagnosis, assessment and treatment of communication impairments and swallowing disorders.

Spouse
The subscriber's husband or wife as the result of a marriage who is legally recognized in the state of Hawaii.

Stand by Time
Any period of time that is used for waiting, or is idle.

Sub-Acute Care
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.

Subcutaneous Implant
A medication that is surgically placed beneath the skin to release the drug in the bloodstream. An example is the Norplant contraceptive.

Subscriber
The person who meets eligibility requirements and who executes the enrollment form that is accepted in writing by us. It does not include anyone enrolled in the plan as an eligible dependent.

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

Substance Abuse Services Providing medical, psychological, nursing, counseling, or therapeutic services as treatment for alcohol or drug dependence or both. Services may include aftercare and individual, group and family counseling services.

Supportive Care 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.

Surgical Services 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.

Third Party Liability 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.

Transgender Person 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.

Transplant The transfer of an organ or tissue for grafting into another area of the same body or into another person.

Treatment Management and care of the patient to combat a disease or disorder.

Tubal Ligation A sterilization procedure for women.

Us HMSA (Hawai‘i Medical Service Association).

Vasectomy A sterilization procedure for men.

Vision Services Services that test eyes for visual acuity and identify and correct visual acuity problems with lenses and other equipment.

We HMSA (Hawai‘i Medical Service Association).

Well-Being Services 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.

You and Your Family You and your family members enrolled in this plan and eligible for this coverage.

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. Please go to **hmsa.com/contact** before your visit.

HMSA Center in Honolulu

818 Keeaumoku St.
Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center in Pearl City

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

HMSA Center in Hilo

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

HMSA Center in Kahului

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

HMSA Center in Lihue

Kuhio Medical Center | 3-3295 Kuhio Highway, Suite 202
Monday–Friday, 8 a.m.–4 p.m

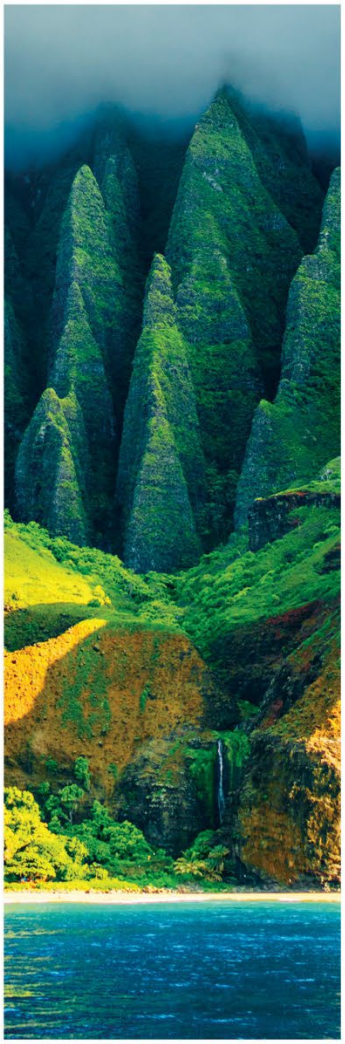
Contact HMSA. We're here with you.

Call (808) 948-6111 or 1 (800) 776-4672.

hmsa.com

@hmsahawaii





Together, we improve the lives of our members and the health of Hawaii.
Caring for our families, friends, and neighbors is our privilege.

hmsa

Plan Certificate



Prescription Drug Rider

January 2025

hmsa
An Independent Licensee of the Blue Cross and Blue Shield Association

HAWAIʻI MEDICAL SERVICE ASSOCIATION

Prescription Drug Benefits Rider

I. ELIGIBILITY

This Rider provides coverage that supplements the coverage provided under HMSA's medical plan. Your coverage under this Rider starts and ends on the same dates as your medical plan coverage.

II. PROVISIONS OF THE MEDICAL PLAN APPLICABLE

All definitions, provisions, exclusions, and conditions of HMSA's Guide to Benefits shall apply to this Rider. Exceptions are specifically modified in this Rider.

III. ANNUAL COPAYMENT MAXIMUM

The ***Annual Copayment Maximum*** for Prescription Drugs and Supplies is the maximum copayment amounts you pay in a calendar year for Prescription Drugs and Supplies. Once you meet the copayment maximum of $3,600 per person or $4,200 per family you are no longer responsible for copayment amounts for Prescription Drugs and Supplies unless otherwise noted.

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

(1) Payments for services subject to a maximum once you reach the maximum.

(2) The difference between the actual charge and the eligible charge that you pay when you receive services from a nonparticipating provider.

(3) Payments for noncovered services.

(4) Any amounts you owe in addition to your copayment for covered services.

IV. DEFINITIONS

When used in this Rider:

(1) **"Biological products"**, or biologics, are medical products. Many products are made from a variety of natural sources (i.e., human, animal, or microorganism). It may be produced by biotechnology methods and other cutting-edge technologies. Like drugs, some biologics are intended to treat diseases and medical conditions. Other products are used to prevent or diagnose diseases. Examples may include:

- Vaccines.
- Blood and blood products for transfusion and /or manufacturing into other products.
- Allergenic extracts, which are used for both diagnosis and treatment (for example allergy shots).
- Human cells and tissues used for transplantation (for example, tendons, ligaments and bone).
- Gene therapies.
- Cellular therapies.
- Test to screen potential blood donors for infectious agents such as HIV.

(2) **"Biosimilar product"** is a biological product that is FDA-approved based on a showing that it is highly similar to an already FDA-approved reference product. It has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Only minor differences in clinically inactive components are allowable in biosimilar products.

In accordance with any applicable state and federal regulations and laws, an interchangeable biological product may be substituted for the reference product by a pharmacist without the intervention of the healthcare provider who prescribed the reference product.

(3) **"Brand Name Drug"** is a drug that is marketed under its distinctive trade name. A brand name drug is or at one time was protected by patent laws or deemed to be biosimilar by the U.S. Food and Drug Administration. A brand name drug is a recognized trade name prescription drug product, usually either the innovator product for new drugs still under patent protection or a more expensive product marketed under a brand name for multi-source drugs and noted as such in the national pharmacy database used by HMSA.

(4) **"Eligible Charge"** is the charge HMSA uses to calculate a benefit payment for a covered service or drug. It is the lesser of the following charges:

(a) The actual charge as shown on the claim, or

(b) HMSA's Allowable Fee. This includes an allowance for dispensing the drug.

HMSA negotiates the cost of covered drugs and supplies from drug manufacturers or suppliers. This may include discounts, rebates, or other cost reductions. Any discounts or rebates received by HMSA will not reduce the charges that your copayments are based on. Discounts and rebates are used to calculate your Tier 3 Cost Share. HMSA also applies discounts and rebates to reduce prescription drug coverage rates for all prescription drug plans.

Participating Providers agree to accept the eligible charge as payment in full for covered drugs or supplies. Nonparticipating providers generally do not. Therefore, if you receive drugs or supplies from a nonparticipating provider, you are responsible for a Copayment plus a Tier 3 Cost Share, if any, plus the difference between the actual charge and the eligible charge.

(5) **"Generic Drug"** is a drug or supply that is prescribed or dispensed under its commonly used generic name rather than a brand name. Generic drugs are not protected by patent and are identified by HMSA as "generic". A generic drug shall meet any one of the following:

(a) It is identical or therapeutically equivalent to its brand counterpart in dosage form, safety, strength, route of administration and intended use.

(b) It is a non-innovator product approved by the FDA under an Abbreviated New Drug Application (an application to market a duplicate drug that has been approved by the FDA under a full New Drug Application).

(c) It is defined as a generic by Medi-Span or an equivalent nationally recognized source.

(d) It is not protected by patents(s), exclusivity, or cross-licensure.

(e) Generic drugs include all single-source and multi-source generic drugs as set forth by a nationally recognized source selected and disclosed by HMSA. Unless explicitly defined or designated by HMSA, once a drug has been deemed a generic drug, it must be considered a generic drug for purposes of benefit administration.

(6) **"HMSA Essential Prescription Formulary"** is a list of drugs by therapeutic category published by HMSA.

(7) **"Interchangeable biologic product"** is an FDA-approved biologic product that meets the additional standards for interchangeability to an FDA-approved reference product included in:

- The Hawaii list of equivalent generic drugs and biological products.
- The Orange Book.
- The Purple Book.
- Other published findings and approvals of the United States Food and Drug Administration.

In accordance with any applicable state and federal regulations and laws, an interchangeable biological product may be substituted for the reference product by a pharmacist without the intervention of the healthcare provider who prescribed the reference product.

(8) **"Non-Preferred Formulary Drug"** is a Brand Name drug or supply that is not identified as preferred or is listed in Tier 3 on the HMSA Essential Prescription Formulary. When you choose Non-Preferred Formulary drugs, your Copayment plus Tier 3 Cost Share may exceed HMSA's payment to the provider.

(9) **"Non-Preferred Formulary Specialty Drug"** is a Specialty Drug or supply that is not identified as a Preferred Formulary Specialty Drug or is listed in Tier 5 on the HMSA Essential Prescription Formulary.

(10) **"Oral Chemotherapy Drug"** is an FDA-approved oral cancer treatment that may be delivered for self-administration under the direction or supervision of a Provider outside of a hospital, medical office, or other clinical setting.

(11) **"Over-the-Counter Drugs"** are drugs that may be purchased without a prescription.

(12) **"Preferred Formulary Drug"** is a drug or supply identified as preferred or is listed in Tier 2 on the HMSA Essential Prescription Formulary.

(13) **"Preferred Formulary Specialty Drug"** is a Specialty Drug or supply that is identified as a Preferred Formulary Specialty or is listed in Tier 4 on the HMSA Essential Prescription Formulary.

(14) **"Prescription Drug"** is a medication required by Federal law to be dispensed only with a prescription from a licensed provider. Medications that are available as both a Prescription Drug and a nonprescription drug are not covered as a Prescription Drug under this Rider.

(15) **"Reference product"** refers to the original FDA-approved biologic product that a biosimilar is based.

(16) **"Specialty Drugs"** have one or more of the following characteristics:

(a) High in cost (more than $600)

(b) Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.

(c) Coordination of care is required prior to drug therapy initiation and/or during therapy.

(d) Unique patient compliance and safety monitoring requirements.

(e) Unique requirements for handling, shipping and storage.

(f) Restricted access or limited distribution.

(17) **"Tier 3 Cost Share"** is a share of the cost of Tier 3 drugs or devices that you must pay in addition to a Copayment. When you choose Tier 3 drugs, your Copayment plus Tier 3 Cost Share may exceed HMSA's payment to the provider.

V. DRUG BENEFITS

You are eligible to receive the following benefits when covered drugs and supplies are obtained with a prescription. Covered drugs and supplies must be 1) approved by the FDA, 2) prescribed by a licensed Provider and 3) dispensed by a licensed pharmacy or Provider. The use of such drugs must be necessary for the diagnosis and treatment of an injury or illness. Drugs must be FDA approved for coverage:

(1) **Covered Prescription Drugs and Supplies.**

(a) Prescription Drugs (including insulin and contraceptives) that are listed in the HMSA Essential Prescription Formulary. Except for drugs and supplies listed in Sections V(1)(b) through V(1)(g), every drug on the plan's formulary is covered in one of the five cost-sharing tiers listed below. In general the higher the cost-sharing tier number, the higher your cost for the drug. Drugs approved as Non-Formulary Exceptions, inclusive of Sections V(1)(b) through V(1)(g), will be subject to Tier 3 copayment plus Tier 3 Cost Share for Non-Specialty drugs and Tier 5 copayment for Specialty drugs

- Tier 1 – mostly Generic Drugs
- Tier 2 – mostly Preferred Formulary Drugs
- Tier 3 – mostly Non-Preferred Formulary Drugs
- Tier 4 – mostly Preferred Formulary Specialty Drugs
- Tier 5 – mostly Non-Preferred Formulary Specialty Drugs

To find out which cost-sharing tier your drug is in, refer to the formulary. Changes to the formulary may occur at any time during your plan year. The current formulary can be found at www.hmsa.com.

(b) Oral Chemotherapy Drugs.

(c) The following diabetic supplies: syringes, needles, lancets, lancet devices, test strips, acetone test tablets, insulin tubing, and calibration solutions.

(d) Contraceptives – Over-the-counter (OTC) when you receive a written prescription for the OTC contraceptive.

(e) Diaphragms and Cervical Caps.

(f) Spacers and peak flow meters (limited to those listed in the HMSA Essential Prescription Formulary).

(g) Drugs Recommended by the U.S. Preventive Services Task Force (USPSTF).

(2) **Benefits for Covered Drugs.**

(a) **Tier 1.**

1. When obtained from a Participating Provider, you owe a $7 Copayment per drug to the Participating Provider. HMSA pays the Participating Provider 100% of the remaining Eligible Charge. For Tier 1 contraceptives, HMSA pays 100% of Eligible Charge. You owe no Copayment.

2. When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $7 Copayment per drug when the claim is submitted

(b) **Tier 2.**

1. When obtained from a Participating Provider, you owe a $30 Copayment per drug to the Participating Provider. HMSA pays the Participating Provider 100% of the remaining Eligible Charge.

2. When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $30 Copayment per drug when the claim is submitted.

(c) **Tier 3.**

1. When obtained from a Participating Provider, you owe a $30 Copayment per drug and a $45 Tier 3 Cost Share per drug. HMSA pays 100% of the remaining Eligible Charge after deducting the Copayment and Tier 3 Cost Share.

2. When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $30 Copayment per drug and a $45 Tier 3 Cost Share per drug when the claim is submitted.

(d) **Tier 4.** Preferred Formulary Specialty Drugs are covered only when purchased from select providers. Contact HMSA to get a list of these providers. When obtained from a provider on the list, you owe a $100 copayment per drug to the provider. HMSA pays the provider 100% of the remaining Eligible Charge.

Benefits for Preferred Formulary Specialty Drugs are limited to a maximum 30-day supply or fraction thereof. Your provider may dispense less than a 30-day supply the first time the prescription is dispensed. Your copayment may be pro-rated when a reduced day supply is dispensed for first time prescriptions.

(e) **Tier 5**. Non-Preferred Formulary Specialty Drugs are covered only when purchased from select providers. Contact HMSA to get a list of these providers. When obtained from a provider on the list, you owe a $200 copayment per drug to the provider. HMSA pays the provider 100% of the remaining Eligible Charge.

Benefits for Non-Preferred Formulary Specialty Drugs are limited to a maximum 30-day supply or fraction thereof. Your provider may dispense less than a 30-day supply the first time the prescription is dispensed. Your copayment may be pro-rated when a reduced day supply is dispensed for first time prescriptions.

(f) **Oral Chemotherapy – Non-Specialty Drugs.**

1. When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment.

2. When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 90% of Eligible Charge when the claim is submitted.

(g) **Oral Chemotherapy – Specialty Drugs.** Covered, but only when purchased from select contracted providers. Limited distribution drugs dispensed by a non-contracted provider will be covered the same as a contracted provider.

1. When obtained from a contracted provider, you owe a $100 copayment per drug or 10% of Eligible Charge, whichever is less. HMSA pays the provider 100% of the remaining Eligible Charge.

(h) **Diabetic Supplies.**

1. **Preferred Formulary.**

a. When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment for diabetic supplies.

b. When obtained from a nonparticipating provider, you owe the entire charge for diabetic supplies. HMSA reimburses you 100% of Eligible Charge when the claim is submitted.

2. **Non-Preferred Formulary**.

a. When obtained from a Participating Provider, you owe a $30 Copayment for diabetic supplies. HMSA pays 100% of the remaining Eligible Charge.

b. When obtained from a nonparticipating provider, you owe the entire charge for diabetic supplies. HMSA reimburses you 100% of the remaining Eligible Charge after deducting a $30 Copayment when the claim is submitted.

(i) **Contraceptives – Over-the-counter (OTC).** Benefits are available when you receive a written prescription for the OTC contraceptive.

1. When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment for OTC contraceptives.

2. When obtained from a nonparticipating provider, you owe the entire charge for OTC contraceptives. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $7 Copayment when the claim is submitted.

(j) **Diaphragms and Cervical Caps.**

1. When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment.

2. When obtained from a nonparticipating provider, you owe the entire charge for the device. HMSA reimburses you 100% of the remaining Eligible Charge after deducting a $10 Copayment per device when the claim is submitted.

(k) **Spacers and Peak Flow Meters**.

1. When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment for spacers and peak flow meters.

2. When obtained from a nonparticipating provider, you owe the entire charge for spacers and peak flow meters. HMSA reimburses you 100% of Eligible Charge when the claim is submitted.

(l) **Drugs Recommended by the U.S. Preventive Services Task Force (USPSTF)**. Contact HMSA for a list of drugs recommended by the USPSTF. Examples of drugs recommended include, but are not limited to, aspirin and folic acid.

1. When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no copayment.

2. When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the Eligible Charge when the claim is submitted.

(m) The Copayment amounts shown in Sections (2)(a) through (2)(l) above are for a maximum 30-day supply or fraction thereof. As used in this Rider, a 30-day supply means a supply that will last you for a period consisting of 30 consecutive days. For example, if the prescribed drug must be taken by you only on the last five days of a one-month period, a 30-day supply would be the amount of the drug that you must take during those five days. Except for Specialty Drugs, if you get more than a 30-day supply under one prescription:

1. You must pay an additional Copayment for each 30-day supply or fraction thereof, and

2. The pharmacy will fill the prescription in the quantity specified by your Provider up to a 12-month supply for contraceptives. For all other drugs or supplies the maximum benefit payment is limited to two more 30-day supplies or fractions thereof.

(n) **Tier 3 Drug Copayment Exceptions.** You may qualify to purchase Tier 3 drugs at the lower Tier 2 copayment if you have a chronic condition that lasts at least three months, and:

1. have tried and failed treatment with at least two lower tier formulary alternatives (or one drug in a lower tier if only one alternative is available) within the same or similar class of drug, or

2. all other comparable lower tier drugs are contraindicated based on your diagnosis, other medical conditions, or other medication therapy.

When prescription drugs become available as therapeutically equivalent over-the-counter drugs, they must have also been tried and failed before a Tier 3 Drug Copayment Exception is approved. You have failed treatment if you meet 1, 2, or 3 below.

1. Symptoms or signs are not resolved after completion of treatment with the lower tier drugs at recommended therapeutic dose and duration. If there is no recommended therapeutic time, you must have had a meaningful trial and sub-therapeutic response.

2. You experienced a recognized and repeated adverse reaction that is clearly associated with taking the comparable lower tier drugs. Adverse reactions may include but are not limited to vomiting, severe nausea, headaches, abdominal cramping or diarrhea.

3. You are allergic to the comparable lower tier drugs. An allergic reaction is a state of hypersensitivity caused by exposure to an antigen resulting in harmful immunologic reactions on subsequent exposures. Symptoms may include but are not limited to skin rash, anaphylaxis or immediate hypersensitivity reaction.

This benefit requires precertification. You or your Provider must provide legible medical records that substantiate the requirements of this section in accord with HMSA's policies and to HMSA's satisfaction.

This exception is not applicable to diabetic supplies, Specialty Drugs, Non-Formulary Exceptions, controlled substances, off label uses, Non-Preferred Formulary medications if there is an FDA approved A rated generic equivalent, or if HMSA has a drug specific policy which has criteria different from the criteria in this section. You can call HMSA Customer Service to find out if HMSA has a drug policy specific to the drug prescribed for you.

(o) **Non-Formulary Exceptions**. If your drug is not listed in one of the five tiers and is not excluded in Section VI of this Rider, you may qualify for a Non-Formulary exception if:

1. you have a condition in which treatment with formulary alternatives within the same or similar class of drug have been tried and failed. You must have tried and failed treatment with all or 3 formulary alternatives, whichever is less; or

2. formulary alternatives are contraindicated based on your diagnosis, other medical conditions, or other medication therapy.

When prescription drugs become available as therapeutically equivalent over-the-counter drugs, they must have also been tried and failed before a Non-Formulary Exception is approved. You have failed treatment if you meet 1, 2, or 3 of the Tier 3 Copayment Exception criteria.

If you qualify for a Non-Formulary Exception you owe the Tier 3 Copayment and Tier 3 Cost Share for Non-Specialty drugs or Tier 5 Copayment for Specialty drugs.

(3) **Limitations on Covered Drugs.**

(a) **Limitations on Prescription Drugs.**

1. Products not approved by the U.S. Food and Drug Administration (FDA) are not covered, except those designated as covered in HMSA's Essential Prescription Formulary (for example Phenobarbital).

2. Compound preparations are covered if they contain at least one Prescription Drug that is not a vitamin or mineral. For compounds made with covered Non-Specialty drugs, you owe the Tier 3 copayment. For compounds made with a covered Specialty drug(s), you owe the Tier 5 copayment. Subject to a and b below:

a. Compound drugs that are available as similar commercially available prescription drug products are not covered.

b. Compound drugs made with bulk chemicals are not covered.

c. Non-FDA approved drugs are not covered

3. Coverage of vitamins and minerals that are Prescription Drugs is limited to:

a. The treatment of an illness that in the absence of such vitamins and minerals could result in a serious threat to your life. For example, folic acid used to treat cancer.

b. Sodium fluoride, if dispensed as a single drug (for example, without any additional drugs such as vitamins) to prevent tooth decay.

(b) **Drug Benefit Management.** HMSA has arranged with Participating Providers to assist in managing the use of certain drugs. This includes drugs listed in the HMSA Essential Prescription Formulary.

1. HMSA has identified certain kinds of drugs in the HMSA Essential Prescription Formulary that require the preauthorization of HMSA. The criteria for preauthorization are that:

a. the drug is being used as part of a treatment plan,

b. there are no equally effective drug substitutes, and

c. the drug meets Payment Determination and other criteria established by HMSA.

A list of these drugs in the HMSA Essential Prescription Formulary has been distributed to all Participating Providers.

2. Participating Providers may prescribe up to a 30-day supply for first time prescriptions of maintenance drugs and contraceptives. For subsequent refills, the Participating Provider may prescribe up to a 12-month supply for contraceptives and a maximum 90-day supply for all other drugs or supplies after confirming that:

a. you have tolerated the drug without adverse side effects that may cause you to discontinue using the drug, and

b. your Provider has determined that the drug is effective.

(c) **Smoking Cessation Drugs.** Coverage of smoking cessation drugs is limited to 180 days of treatment per calendar year.

(d) This Rider requires the substitution of Generic Drugs listed on the FDA Approved Drug Products with Therapeutic Equivalence Evaluations for a Brand Name Drug. Exceptions will be made when a Provider directs that substitution is not permissible. If you choose not to use the generic equivalent, HMSA will pay only the amount that would have been paid for the generic equivalent. This provision regarding reduced benefits shall apply even if the particular generic equivalent was out-of-stock or was not available at the pharmacy. You may seek other Participating Providers when purchasing a generic equivalent in cases when the particular generic equivalent is out-of-stock or not available at that pharmacy.

(e) Except for certain drugs managed under Drug Benefit Management, refills are available if indicated on your original prescription. The refill prescription must be purchased only after two-thirds of your prescription has already been used. For example, for coverage under this Rider, if the previous supply was a 30-day supply, you may refill the prescription on the 21st day, but not earlier. At the discretion of your pharmacist, you may refill your prescriptions for maintenance drugs earlier if you need to synchronize such prescriptions to pick them up at the same time. Your copayment for each prescription may be adjusted accordingly. *Please Note:* Certain limitations or restrictions apply. Please see our Medication Synchronization policy at www.hmsa.com.

(f) There shall be no duplication or coordination between benefits of this drug plan and any other similar benefit of your HMSA medical plan.

(4) **HMSA's 90-Day at Retail Network and Mail Order Prescription Drug Program.**

(a) HMSA has contracted with selected providers to make prescription maintenance medications available for pickup or by mail. Specialty Drugs, including Specialty Oral Chemotherapy Drugs are not available through HMSA's 90-Day at Retail Network or Mail Order Prescription Drug Program.

1. You owe the contracted provider an $11 Copayment per Tier 1 drug, a $65 Copayment per Tier 2 drug, and a $65 Copayment plus a $135 Tier 3 Cost Share per Tier 3 drug. HMSA pays 100% of the remaining charges. For Tier 1 contraceptives, HMSA pays 100% of Eligible Charge. You owe no Copayment.

2. Oral Chemotherapy - Non-Specialty Drugs. You owe the contracted provider no Copayment for non-specialty oral chemotherapy drugs. HMSA pays 100% of the charges.

3. Diabetic Supplies. You owe the contracted provider no Copayment for Preferred Formulary diabetic supplies and a $65 Copayment per Non-Preferred Formulary diabetic supplies. HMSA pays 100% of the remaining charges.

4. Contraceptives - Over-the-counter (OTC). Benefits are available when you receive a written prescription for the OTC contraceptive. You owe the contracted provider no Copayment for OTC contraceptives. HMSA pays 100% of the charges.

5. Spacers and Peak Flow Meters. You owe the contracted provider no Copayment for spacers and peak flow meters. HMSA pays 100% of the charges.

6. USPSTF Recommended Drugs. You owe the contracted provider no Copayment for USPSTF recommended drugs. HMSA pays 100% of the charges.

(b) **HMSA's 90-Day at Retail Network and Mail Order Prescription Drug Program Limitations.**

1. Prescription Drugs are available only from contracted providers. Contact HMSA to get a list of providers. If you receive prescription maintenance drugs from a provider that does not contract with HMSA, no benefits will be paid.

2. Prescription Drugs are limited to prescribed maintenance medications taken on a regular or long-term basis.

3. The contracted provider will fill the prescription in the quantity specified by the Provider up to a 12-month supply for contraceptives. For all other drugs or supplies, copayment amounts are for a maximum 90-day supply or fraction thereof. A 90-day supply is a supply that will last for 90 consecutive days or a fraction thereof. These are examples on how your copayments are calculated:

a. You are prescribed a drug in pill form that must be taken only on the last five days of each month. A 90-day supply would be fifteen pills, the number of pills you must take during a three-month period. You owe the 90-day copayment even though the supply dispensed is fifteen pills.

b. You are prescribed a 30-day supply with two refills. The contracted pharmacy will fill the prescription in the quantity specified by the Provider, in this case 30 days, and will not send you a 90-day supply. You owe the 30-day copayment.

c. You are prescribed a 30-day supply of a drug that is packaged in less than 30-day quantity, for example, a 28-day supply. The pharmacy will fill the prescription by providing a 28-day supply. You owe the 30-day copayment. If you are prescribed a 90-day supply, the pharmacy would fill the prescription by giving you three packages each containing a 28-day supply of the drug. You would owe a 90-day copayment for the 84-day supply.

4. Unless the prescribing Provider requires the use of a Brand Name Drug, your prescription will be filled with the Tier 1 equivalent when available and permissible by law. If a Brand Name Drug is required, it must be clearly indicated on the prescription.

5. Refills are available if indicated on your original prescription. The refill prescription must be purchased only after two-thirds of your prescription has already been used.

VI. EXCLUSIONS

This Rider is subject to all exclusions in HMSA's Guide to Benefits. The Guide to Benefits describes the medical benefits plan that accompanies this Rider.

Except as otherwise stated in this Rider or as designated as covered in the HMSA Essential Prescription Formulary, no payment will be made for:

(1) Products not approved by the U.S. Food and Drug Administration (FDA).

(2) Agents used in skin tests to determine allergic sensitivity.

(3) Appliances and other nondrug items.

(4) Convenience packaged drugs, including kits.

(5) Drugs dispensed to a registered bed patient.

(6) Drugs from foreign countries.

(7) Drugs to treat sexual dysfunction, except suppositories listed in the HMSA Essential Prescription Formulary and used to treat sexual dysfunction due to an organic cause as defined by HMSA.

(8) Immunization agents.

(9) Injectable drugs.

(10) Lifestyle drugs and pharmaceutical products that improve a way or style of living rather than alleviating a disease. Lifestyle drugs that are not covered include, but are not limited to: creams used to prevent skin aging and drugs to enhance athletic performance.

(11) Medical foods.

(12) Over-the-counter drugs that may be purchased without a prescription.

(13) Replacements for lost, stolen, damaged, or destroyed drugs and supplies.

(14) Unit dose drugs.

VII. COORDINATION OF BENEFITS

The coordination of benefits described in Chapter 9 of HMSA's Guide to Benefits in the section labeled "Coverage that Provides Same or Similar Coverage" is modified as follows:

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 because of the primary plan's payment. 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.

Any Tier 3 Cost Share you owe under this plan will first be subtracted from the benefit payment. You remain responsible for the Tier 3 Cost Share owed under this plan, if any.

All other provisions of Chapter 9 of HMSA's Guide to Benefits remain unchanged.

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. Please go to **hmsa.com/contact** before your visit.

HMSA Center in Honolulu

818 Keeaumoku St.
Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center in Pearl City

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

HMSA Center in Hilo

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

HMSA Center in Kahului

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

HMSA Center in Lihue

Kuhio Medical Center | 3-3295 Kuhio Highway, Suite 202
Monday–Friday, 8 a.m.–4 p.m

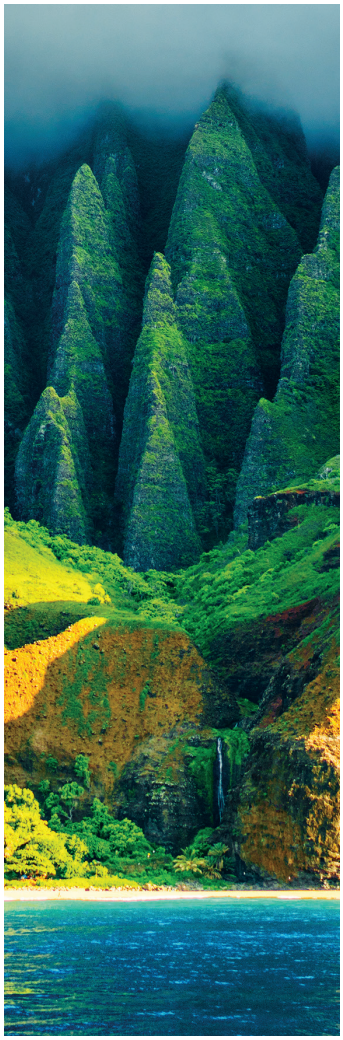
Contact HMSA. We're here with you.

Call (808) 948-6111 or 1 (800) 776-4672.

hmsa.com

@hmsahawaii





Together, we improve the lives of our members and the health of Hawaii.
Caring for our families, friends, and neighbors is our privilege.

hmsa

(00) 4000-796102 PPO 10.23 LE

Plan Certificate



Complementary Care Rider

January 2025

860

hmsa
An Independent Licensee of the Blue Cross and Blue Shield Association

HAWAIʻI MEDICAL SERVICE ASSOCIATION

Complementary Care Rider

I. ELIGIBILITY

This Rider provides coverage that supplements the coverage provided under the HMSA's medical plan. Your coverage under this Rider starts and ends on the same dates as your medical plan coverage.

For eligibility, benefit, or claim questions, call ASH Group's Customer Service at 1-800-678-9133 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.

II. PROVISIONS OF THE MEDICAL PLAN APPLICABLE

All definitions, provisions, limitations, exclusions, and conditions of HMSA's Guide to Benefits shall apply to this Rider, except as specifically modified in this Rider.

III. DEFINITIONS

When used in this Rider:

(1) **"ASH Group"** means American Specialty Health Group, Inc. which has been contracted by HMSA to administer the benefits under this Rider.

(2) **"Acupuncture Services"** are services provided or made available to a Member by a Provider for the treatment or diagnosis of Musculoskeletal and Related Disorders, Nausea and Pain. Acupuncture is the stimulation of a certain point on or near the surface of the body by the insertion and removal of single-use, sterilized, disposable needles and/or electrical stimulation (electro-Acupuncture) to normalize physiological functions, to prevent or modify the perception of Pain, or to treat Musculoskeletal and Related Disorders, Nausea, or conditions that include Pain as a primary symptom. In addition, it may include such services as adjunctive physiotherapy modalities and procedures provided during the same Course of Treatment and in support of Acupuncture Services.

(3) **"Chiropractic Services"** are services provided or made available to a Member by a Chiropractor for treatment or diagnosis of Musculoskeletal and Related Disorders and Pain Syndromes. Chiropractic Services are limited to the management of Musculoskeletal and Related Disorders and Pain Syndromes primarily through chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue. This includes: (1) differential diagnostic examinations and related diagnostic x-rays, radiological consultations, and clinical laboratory studies when used to determine the appropriateness of Chiropractic Services; and (2) the follow-up office visits that must include during the Course of Treatment the provision of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue. In addition, it may include such services as adjunctive physiotherapy modalities and procedures provided during the Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

(4) **"Chiropractor"** means a chiropractor who is duly licensed to practice chiropractic services in the state or jurisdictions in which Chiropractic Services are provided.

(5) **"Continuity of Care"** means that if you are in the course of treatment with a Participating Provider, should that provider end his or her participation in this plan, you may continue seeing that provider and receive participating benefits for a period of time until your documented treatment plan is concluded or you may be safely transferred to another Participating Provider. At such time, if you choose to continue receiving covered services from the provider, participating coverage is available only when the provider agrees to abide by the ASH Group requirements and fee schedule.

(6) **"Course of Treatment"** means a sequence or series of office visits directly related to a diagnosed disease state, illness, or injury and provided in conjunction with a defined clinical outcome.

(7) **"Established Patient"** means someone who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

(8) **"Therapeutic Massage Services"** are services provided by a Provider for treatment of Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders, Pain Syndromes, and/or lymphedema through physical actions, primarily by hand, performed on the body. This may include techniques such as compression, stroking, joint movement, friction, vibration, and percussion.

(9) **"Member Payments"** means charges (such as copayments) that are the direct financial responsibility of the Member and are payable directly to the provider for the provision of certain Covered Services as set forth in Section IV. Schedule of Benefits of this Rider. Member Payments may be collected by a provider (Participating or Nonparticipating) at the time services are provided or subsequently billed to the Member.

(10) **"Musculoskeletal and Related Disorders"** means conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders, and subluxation.

Note: For Acupuncture Services, Musculoskeletal and Related Disorders means conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial Disorders.

(11) **"Musculoskeletal Functional Disorders"** means disorders that are abnormal functions and/or activities-of-daily-living limitations of the body resulting from muscle stiffness, muscle restriction, and/or range of motion limitations.

(12) **"Myofascial Disorders"** means conditions with associated signs and symptoms related to the muscular and surrounding connective tissues. Myofascial Disorders are conditions typically categorized as structural, spasms, or inflammatory disorders or dysfunction of the muscles of the body.

(13) **"Myofascial/Musculoskeletal Disorders"** means conditions with signs and symptoms that relate to the muscular and related systems. Myofascial/Musculoskeletal Disorders are conditions that are typically categorized as structural, spasms, or inflammatory disorders or dysfunction of the muscles of the body, and/or related components of the motor unit (muscles, tendons, fascia, ligaments/capsules, discs, and synovial structures), and related manifestations or conditions.

(14) **"Nausea"** means an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Provider of Acupuncture Services in accordance with professionally recognized, valid, evidence-based standards of practice and includes adult post-operative nausea and vomiting, chemotherapy nausea and vomiting, and nausea of pregnancy.

(15) **"New Patient"** means that a patient has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

(16) **"Nonparticipating Provider"** means a provider who has not entered into an agreement with **ASH Group** to provide Covered Services to Members.

(17) **"Pain"** means the sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder, or condition that may be appropriately treated in accordance with professionally recognized, valid, evidence-based standards of practice.

(18) **"Pain Syndrome"** means acute or chronic Musculoskeletal and Related Disorders including Myofascial/Musculoskeletal Disorder, or Musculoskeletal Functional Disorder, in which the primary symptom consists of sensations of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder, or condition that may be appropriately treated by a Chiropractor.

(19) **"Participating Provider"** means a provider who has entered into an agreement with ASH Group to provide Covered Services to Members. Providers who are employees, independent contractors or owners of Professional Corporations or Group Practices who have not been accepted and credentialed to participate in ASH Group are not considered to be Participating Providers. A directory of participating providers is available at hmsa.com.

(20) **"Provider of Acupuncture Services"** means a provider who is duly licensed to practice acupuncture in the state or jurisdiction in which Acupuncture Services are provided.

IV. SCHEDULE OF BENEFITS

(1) **Copayments**

(a) **Participating Providers**

1. $20 per visit.

(b) **Nonparticipating Providers**

1. 50% of billed charges, up to a maximum of $30 per visit.

Here are two examples showing how the nonparticipating provider works.

- If the billed charge for covered services received during an office visit is $50, then we would pay $25 (50% of $50). The amount you would owe is $25 ($50 less $25).
- If the billed charge for covered services provided during an office visit is $80, then we would pay a maximum of $30 (50% of $80 not to exceed $30) and you would owe $50 ($80 less $30).

(2) **Benefit Maximum**

(a) **Participating Providers**

1. No more than 24 visits per calendar year.

(b) **Nonparticipating Providers**

1. No more than 12 visits per calendar year.

Note: Eligibility for benefits for more than five visits per calendar year from a nonparticipating provider requires approval. See Section VIII of this Rider for details.

The Benefit Maximum for participating and nonparticipating providers is combined meaning that:

- Each visit in a calendar year to a participating provider reduces the number of visits available under the nonparticipating benefits for the rest of that calendar year; or
- Each visit in a calendar year to a nonparticipating provider reduces the number of visits available under the participating benefits for the rest of that calendar year.

(3) **Acupuncture Services.** Acupuncture is provided at each office visit. Exam Services (Evaluation and Management) and/or Adjunctive Therapeutic Procedures and/or Modalities such as acupressure, and moxibustion are covered when provided in conjunction with the Acupuncture treatment during the office visit. Each office visit/Acupuncture treatment with a Provider of Acupuncture Services will count as one visit toward the Benefit Maximum.

V. COVERED SERVICES

(1) **ACUPUNCTURE COVERED SERVICES**

(a) A **New Patient exam or an Established Patient exam for the initial evaluation** of a patient with a new condition or new episode to determine the appropriateness of Acupuncture Services.

(b) **Established patient exams as needed to assess the need to initiate, continue, extend, or change a Course of Treatment.** A reevaluation may be performed during a subsequent office visit or separately. If performed separately, additional coinsurance applies.

(c) **Follow-up office visits** include the provision of Acupuncture Services and/or reevaluation.

(d) **Adjunctive Therapies or Modalities** such as acupressure, moxibustion, or breathing techniques are covered only when provided during the same Course of Treatment and in support of Acupuncture Services. However, the following exception applies for the application of acupressure if: 1) a Participating Provider of Acupuncture Services recommends Acupuncture Services for a Member as a Covered Service but cannot do so in accordance with professionally recognized, valid, evidence-based standards of practice because the insertion of needles is contraindicated (e.g., for a patient with a bleeding disorder); and 2) professionally recognized, valid, evidence-based standards of practice indicate that acupressure would be effective in the treatment of the Member, then Acupuncture Services will include acupressure in that circumstance even if Acupuncture Services are not provided to the Member at the same time and the Member is entitled to receive other Adjunctive Therapies or Modalities in conjunction with the provision of acupressure in that circumstance to the same extent as would be the case if the Member were receiving Acupuncture Services.

VI. LIMITATIONS AND EXCLUSIONS

(1) **GENERAL EXCLUSIONS**

(a) Chiropractic Services and Supplies

(b) Therapeutic Massage Services and Supplies.

(c) BlueCard program.

(d) Services provided in excess of any Benefit Maximum.

(e) Any service or supply that is not permitted by state law with respect to the practitioner's scope of practice.

(f) Any services provided for elective or maintenance care (e.g., services provided to a Member whose treatment records indicate he or she has reached maximum therapeutic benefit).

(g) Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services.

(h) Hypnotherapy, behavior training, sleep therapy, and weight problems.

(i) Thermography, magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacements products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostimulation, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.

(j) Education programs, non-medical lifestyle or self-help, or self-help physical training or any related diagnostic testing.

(k) Services or treatments for pre-employment physicals or vocational rehabilitation.

(l) Any services or treatments for conditions caused by or arising out of the course of employment or covered under Worker's Compensation or similar laws.

(m) Air conditioners /purifiers, therapeutic mattresses, supplies, or any other similar devices or appliances.

(n) Auxiliary aids and services, including but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.

(o) Any services provided by a person who is a Family Member. Family Member means a person who is related to the covered person in any of the following ways: spouse, domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (including stepparent), brother or sister (including stepbrother or stepsister), or child (including legally adopted, step, or foster child). A Family Member also includes individuals who normally live in the covered person's household

(p) Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.

(q) Transportation costs, including local ambulance charges.

(2) **ACUPUNCTURE EXCLUSIONS**

(a) Services, exams (other than the initial examination to determine the appropriateness of Acupuncture Services), and/or treatments for the conditions other than Musculoskeletal and Related Disorders, Nausea, Pain or Pain Syndromes.

(b) Services, examinations, and/or treatments for asthma or addiction, such as nicotine addiction.

(c) Radiological x-rays (plain film studies), magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology, and laboratory services.

(d) Adjunctive therapy not associated with Acupuncture.

(e) Acupuncture performed with reusable needles.

(f) Cupping.

VII. FILING CLAIMS

(1) **For services you receive from a provider who does not file claims for you, follow the below steps to receive reimbursement for Covered Services. There is no submission timeframe for commercial non-participating providers. For Medicare not-participating providers, the claim must be filed 365 days from the date-of-service.**

(a) Complete a separate claim form for each provider of service. You can obtain a claim form on ASHLink.com under the Resources tab.

(b) Provide all of the following information on the claim form (your treating provider can help you get this information):

1. Itemized date(s) of service.
2. Diagnosis code.
3. Procedure code.
4. Billed charge per service.
5. Provider's name and credentials.
6. Provider's full address.
7. Provider's tax ID, employer identification number or Social Security number.
8. National Provider Identifier (NPI) number.

(c) Attach the itemized bill from the provider of service with a claim form.

(d) Send the claim form and bill to:

American Specialty Health Group, Inc.
P.O. Box 509077
San Diego, CA 92150

VIII. UTILIZATION REVIEW

(1) **For Covered Services you receive from a Participating Provider,** utilization review requirements are the responsibility of your provider, not you.

(2) **For services you receive from a Nonparticipating Provider,** utilization review requirements are your responsibility and include a review of medical records after the fifth visit per calendar year. The five-visit waiver applies to all nonparticipating providers who work in the same office under the same tax identification number. The utilization review process requires that you submit specific information. Without complete information, services may not be approved for reimbursement.

(a) **Complete** a Medical Records Cover Sheet or a Clinical Information Summary Sheet (one per patient), both of which are available at www.ashcompanies.com. To ensure your claim is reviewed without delay and to prevent denials resulting from a lack of information, provide complete information on the form.

1. Date of service and what services should be reviewed
2. Patient Age and Gender
3. Chief Complaint
4. Pain Severity
5. Mechanism or Onset
6. Pertinent findings supporting the patient's diagnosis and treatment plan as identified from the physical examination including, at a minimum, Inspection and Palpation findings.
7. National Provider Identifier (NPI) number.

(b) **Send the *Medical Records Cover Sheet* and either the Clinical Information Summary Sheet or the pertinent medical records to:**

ASH Group
P.O. Box 509001
San Diego, CA 92150-9001

Fax: California fax (877) 427-4777, all other states fax (877) 304-2746

Send Claims to:
Claims Departments
ASH Group
P.O. Box 509001
San Diego, CA 92150-9001

(3) **ASH Group will respond within one week of receipt of the completed form.** Notification of the clinical decision will be mailed or faxed directly to the provider and will include the name and phone contact information of the peer-clinician who rendered the decision. Services provided during the review period will be reimbursed if they are determined to be medically necessary and approved by ASH Group.

IX. EXPLANATION OF BENEFITS (EOB)

ASH Group notifies you of any financial responsibilities you have (other than Copayments) in a document called the Explanation of Benefits (EOB). The EOB is not a bill, but rather, communicates important information about services you receive including the total amount charged, the allowed amount, the amount covered by ASH Group, and the amount that you pay.

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. Please go to **hmsa.com/contact** before your visit.

HMSA Center in Honolulu

818 Keeaumoku St.
Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center in Pearl City

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

HMSA Center in Hilo

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

HMSA Center in Kahului

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

HMSA Center in Lihue

Kuhio Medical Center | 3-3295 Kuhio Highway, Suite 202
Monday–Friday, 8 a.m.–4 p.m

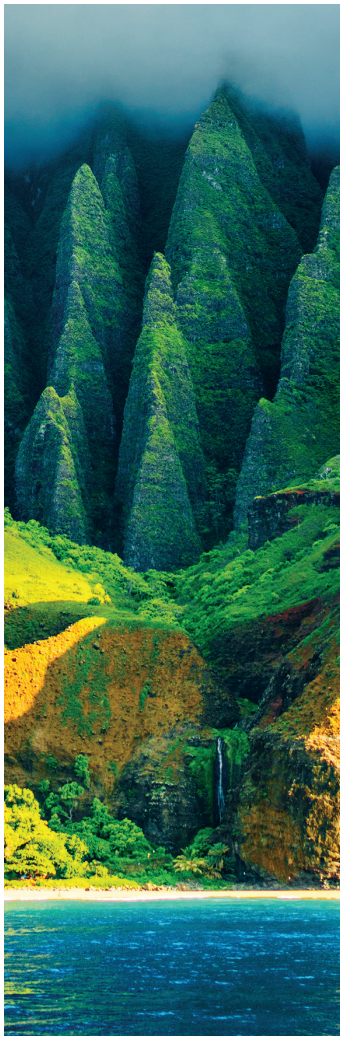
Contact HMSA. We're here with you.

Call (808) 948-6111 or 1 (800) 776-4672.

hmsa.com

@hmsahawaii





Together, we improve the lives of our members and the health of Hawaii.
Caring for our families, friends, and neighbors is our privilege.

hmsa

(00) 4000-796102 PPO 10.23 LE