JOSH GREEN, M.D.
GOVERNOR OF HAWAIʻI
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

KENNETH S. FINK, M.D., M.P.H., M.G.A.
DIRECTOR OF HEALTH
KA LUNA HOʻOKELE

STATE OF HAWAI'I
DEPARTMENT OF HEALTH
KA ʻOIHANA OLAKINO
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

Date

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Thirty-second State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Scott K. Saiki, Speaker
and Members of the House of
Representatives
Thirty-second State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of the

Early Lung Cancer Screening Working Group Report, pursuant to Act 162, Session Laws of Hawaii 2022. In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at:

https://health.hawaii.gov/opppd/department-of-health-reports-to-2024-legislature/

Sincerely,

Kenneth S. Fink, M.D., M.P.H., M.G.A.
Director of Health

Enclosures

c: Legislative Reference Bureau
Hawaii State Library System (2)
Hamilton Library

REPORT TO THE THIRTY-SECOND LEGISLATURE

STATE OF HAWAI‘I

2024

IN ACCORDANCE WITH THE PROVISIONS OF
HOUSE CONCURRENT RESOLUTION NO. 207
EARLY LUNG CANCER SCREENING WORKING GROUP

PREPARED BY

STATE OF HAWAI‘I
DEPARTMENT OF HEALTH
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION DIVISION
IN CONJUNCTION WITH
UNIVERSITY OF HAWAI‘I CANCER CENTER

JULY 2024

EARLY LUNG CANCER SCREENING WORKING GROUP
PURSUANT TO HOUSE CONCURRENT RESOLUTION NO. 207

Background

House Concurrent Resolution ("HCR") No. 207 requests the Department of Health ("DOH") to convene an Early Lung Cancer Screening Work Group ("ELCSWG") to continue the efforts of the Early Lung Cancer Screening Task Force ("ELCSTF") established pursuant to Act 162, Session Laws of Hawai‘i ("SLH") 2022. Act 162, established the ELCSTF within the DOH to research the steps and resources necessary to increase early lung cancer screening in Hawai‘i. The DOH submitted a January 2023 Interim Report to the Legislature indicating that the initial meeting of the ELCSTF had been delayed until after the 2022 election, as there would be changes in leadership in various State and County departments. The ELCSTF was scheduled to sunset on July 31, 2023 and additional time was needed to ensure that the activities required by Act 162 was carried out to address and reduce the impact lung cancer has on Hawai‘i's diverse population.

HCR No. 207 requests the DOH to convene an ELCSWG to continue the efforts of the ELCSTF established pursuant to Act 162, SLH 2022, in researching the steps and resources necessary to increase early lung cancer screening in Hawai‘i. Individuals requested to serve as members of the ELCSWG include a representative from the Office of the Governor, Senate, and House of Representatives, DOH, Department of Human Services, University of Hawai‘i John A. Burns School of Medicine, University of Hawai‘i Cancer Center ("UHCC"), and each County.

The chairperson of the ELCSWG is required to invite representatives from the following organizations: The United States Department of Veterans Affairs; ALA; American Cancer Society (ACS); Hawai‘i Primary Care Association; an organization representing health care providers with relevant expertise on lung cancer screening; each health insurer operating in the state, including TRICARE; each health care system operating in the state; and any other State agencies, stakeholders, or advocates, as recommended by the majority of the working group.

The ELCSWG is requested to:

1. Review all available research, studies, and models for increasing early lung cancer screening rates in the State;
2. Conduct or initiate new studies as the Working Group deems necessary;
3. Create a public awareness campaign to inform Hawai‘i residents about early lung cancer screening;
4. Submit an interim report of its findings and recommendations, including any proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2024; and
5. Submit a final report of its findings and recommendations, including any proposed legislation, to the Legislature no later than July 31, 2024. The report shall include:
    (A) An analysis of the costs associated with early lung cancer screening.
    (B) Guidelines used by health insurance providers to determine coverage for early lung cancer screening.
    (C) A list of qualified facilities in the State that perform lung cancer screenings.
    (D) Protocols for health care providers and health care systems to identify populations at high risk for lung cancer.

(E) An explanation of how health care providers are made aware of available insurance coverage for early cancer screenings.
(F) A discussion of cultural and social barriers associated with lung cancer screenings.
(G) Policy recommendations for increasing early lung cancer screenings.
(H) A work plan that identifies the steps needed in the next five years to increase lung cancer screenings in the State.

Final Report

Introduction

Lung cancer remains a significant burden to patients and healthcare systems in Hawai‘i. It is the second most commonly diagnosed malignancy in men and women, with an average of 826 new cases (467 males, 359 females) diagnosed each year in the state (Hawai‘i Cancer at a Glance, 2014-2018). Importantly, lung cancer is the leading cause of cancer mortality in both sexes, with an average of 544 deaths (314 males, 230 females) statewide each year. About three-quarters of lung cancer patients present at a late stage, at which point treatment is largely palliative, and survival is poor. Lung cancer screening is currently targeted at high-risk populations, defined based on age and smoking history. Early studies showed that screening using low-dose computed tomography (LDCT) provides a stage shift resulting in more people being diagnosed earlier when treatment with curative intent is possible. The National Lung Screening Trial (NLST) and the Nederlands–Leuvens Longkanker Screenings Onderzoek (NELSON) trial were two large randomized controlled trials showing that LDCT reduces lung cancer mortality among smokers and ex-smokers (by 20% and 26% at 6.5 and 10 years, respectively (1, 2) This was the first time that a screening modality was demonstrated to be effective in reducing risk of lung cancer.

Lung Cancer Screening Guidelines: Following the publication of the NLST findings in 2011, lung cancer screening was recommended by the U.S. Preventive Services Task Force (USPSTF) in 2013 (3). Annual LDCT screening was recommended for adults aged 55 to 80 years who had at least a 30-pack-year smoking history (i.e., the equivalent of smoking a pack-a-day for 30 years or two packs-a-day for 15 years, etc.) and currently smoke or have quit within the past 15 years. The USPSTF guidelines were modified in 2021 to expand the age range to 50 to 80 years and reduce the minimum pack-year history to 20 pack-years of smoking. The American Cancer Society issued its own guidelines recommending annual LDCT screening for people who smoke, or used to smoke, and have at least a 20-pack-year history of smoking (i.e., getting rid of the requirement for ex-smokers of having quit within 15 years).

Although lung cancer screening is not overly taxing for the patient (it takes less than one hour and only uses low doses of radiation), its nature differs from other cancer screening modalities in ways that makes it more difficult to implement. It uses a relatively new technology (computed tomography) not available in all clinics, and whether patients meet the eligibility criteria for it (above) is more difficult to ascertain. Unlike colorectal, breast, and cervical cancer screening which are based on age only, lung cancer screening requires estimation of lifetime history of smoking (“pack-years”= number of cigarettes/day x duration of smoking in years). This is not always straightforward as smokers may change their daily number of cigarettes over time and may quit smoking and start again. They may not remember amounts and start/quit dates precisely. This information is not always asked in the care delivery setting or stored in the patients’ medical record. The most commonly utilized electronic health record (EHR) system in Hawai‘i, Epic, utilizes the most recent entry for pack-years to calculate risk and eligibility for lung cancer screening, and may therefore inaccurately calculate eligibility (or risk) for lung cancer screening in those patients who have resumed smoking or dramatically changed the number of cigarettes smoked per day (4). Due to this complexity, it is also difficult to estimate the proportion of a patient population who meet the eligibility criteria (i.e., the denominator in computing rate of utilization) making planning and evaluation difficult at the practice and community levels.

Given the complexities noted above, several studies have been done that demonstrate increased lung cancer screening when using multiple concurrent approaches, including maximizing the use of the EHR to aid in identification or decision-making about screening eligibility (5, 6). These "best practices" informed the design of the healthcare facility survey utilized to gain information for Task 1, Sections (C), (D), and (E).

(1) **Review of all available research, studies, and models for increasing lung cancer screening in the State to determine:**

(A) An analysis of the costs associated with early lung cancer screening & future research needed.

Economic evaluation – the comparative analysis of costs and outcomes associated with an intervention - can help balance the benefits and potential costs or challenges of screening. A recently published literature review provided an updated systematic review and synthesis of the cost-effectiveness of lung cancer screening with LDCT compared to no screening or screening with chest X-ray (CXR) (7).

Forty-five published evaluations were identified in this review, three conducted alongside screening trials and 42 modeling studies. Thirty-nine evaluations (86.7%) found lung cancer screening with LDCT to be cost-effective. Several findings were broadly consistent across studies: cost-effectiveness was optimal in those aged 55–75 years and with a smoking history of at least 20 pack-years. The results show variation in the age range criteria for screening, and studies remained cost-effective with lower ages of 40 up to 80 years. It was noted that biennial screening was often more cost-effective than annual screening and would likely result in fewer additional findings and radiation exposure. A smoking cessation intervention alongside screening improved cost-effectiveness, but which quit-smoking intervention was optimal remained unclear. Risk prediction models using more parameters to target participants for screening did not have more cost benefits than those using age and smoking alone.

In conclusion, most studies conclude that screening for lung cancer with LDCT, as currently recommended, is cost-effective. Further economic analysis specific to Hawai‘i would not be feasible or necessary.

(B) Guidelines used by health insurance providers to determine coverage for early lung cancer screening in Hawai‘i.

Documentation available from each of the major insurance providers in Hawai‘i was assessed for the specific eligibility criteria used for insurance coverage for lung cancer screening with LDCT and ease of access to information. A document summarizing each insurance plan's coverage and excerpts of specific sources are provided in Appendix 1. The findings are summarized as follows.

Hawai‘i's major health insurance providers offer insurance coverage for lung cancer screening. The information sources are identical for insurance plan participants and healthcare providers. Insurance benefits documentation for the three major health insurance providers (i.e., Hawaii Medical Service Association (HMSA), Kaiser, and Hawaii Medical Assurance Association (HMAA)) indicated that lung cancer screening was covered. However, participants and care providers must read through separate, unlinked documents to find this

information. Other health insurance providers (Aloha Care, University Health Alliance (UHA), Ohana Health Plan, Compass Rose Health Plan) also indicated in their documentation that lung cancer screening was covered. However, finding coverage information was also difficult, and lung cancer was generally not listed in the same sections as more common cancer screening for breast, colorectal, and cervical cancers. For Med-QUEST Plan participants, the information regarding cost coverage was unclear, and lung cancer screening was generally not listed in the covered screening modalities. Prior authorization through referral by a Primary Care Provider (PCP) was indicated for some insurance providers, and for others there was no indication whether it was necessary. For HMSA, pre-approval is no longer required as of June 2023.

Also, the eligibility criteria for LDCT screening varied. Most insurance providers used the current USPSTF criteria (adults aged 50-80 who have a 20-pack-year smoking history and currently smoke or have quit within the past 15 years), but the HMSA, Kaiser Medicare Advantage plans, and the Ohana Health Plan listed a different age criterion (50-77 yrs.), which follows the Centers for Medicare and Medicaid Services (CMS) eligibility criteria for coverage.

In conclusion, we found much variability in the documentation and difficulty accessing information related to lung cancer screening from the various health insurance providers in Hawai‘i. Additionally, national-level advocacy is needed for CMS to expand its age range to 50-80 years. Until then, it will be difficult for all insurers to follow USPSTF recommendations.

(C) A list of qualified facilities in the state that perform lung cancer screenings.

A brief survey was sent to all hospitals and health systems in Hawai`i in April 2024 to answer items (C), (D), and (E). A blank copy of the survey is in Appendix 2, along with a high-level summary of de-identified responses.

Table 1. Healthcare facilities in Hawai‘i providing lung cancer screening via LDCT

Island	Region	Health Care Facility
O‘ahu	Central	Kaiser Moanalua Medical Center (Hawai‘i Permanente) Pali Momi Medical Center (HPH)
	Leeward	Queen’s West O‘ahu - hospital and office building (QHS)
	Honolulu	Kaiser Mapunapuna Medical Office (Hawai‘i Permanente) Kuakini Medical Center Queen’s Manamana (Punchbowl) - hospital and office building (QHS) Straub Benioff Medical Center (HPH) Kapi‘olani Medical Center for Women and Children (HPH)

Island	Region	Health Care Facility
Kauai	East	Wilcox Memorial Hospital (HPH) Samuel Mahelona Memorial Hospital (HHSC)
	West	Kauai Veteran's Memorial Hospital (HHSC)
Maui	Central	Maui Health System Kaiser (Hawai‘i Permanente): Maui Lani Medical Office
Hawai‘i Island	North	North Hawai‘i Community Hospital (Queen's Health System)
	East	Hilo Medical Center (HHSC) Hawai‘i Radiologic Associates
	West	Kona Community Hospital (HHSC) Hawai‘i Radiologic Associates

Low-dose CT scanning is also available in some facilities located in Windward O‘ahu or the North Shore of O‘ahu. However, essential software components and/or staffing are missing or insufficient to offer lung cancer screening. As of April 2024, the following neighbor islands do not have on-island access to this screening service: Lana‘i, Moloka‘i, and Ni‘ihau.

(D) Protocols for health care providers and health care systems to identify populations at high risk for lung cancer.

To assess protocols consistent with the nationwide surveillance of lung cancer screening, we conducted a literature review of current lung screening surveys and instruments to determine the local use and availability of LDCT versus other lung cancer screening modalities. Our search identified quantitative and qualitative assessments targeted to providers and patients (8-10). Informed by these studies and with local provider input, we drafted and fielded a print and online provider survey (Appendix 3) and a separate hospital/health system facility survey (Appendix 2) to assess all primary care clinics and hospitals in the state. These assessments provided information for sections (C), (D) and (E), elucidating care processes, promoters and barriers to lung cancer screening and the necessary follow-up of abnormal screenings.

The hospital/health system facility (i.e., "Healthcare facility (HCF)") survey (Appendix 2) was emailed to the Chief Executive Officer, Chief Medical Officer, and/or physician champion(s) for lung cancer screening at each facility. They were asked to complete the survey for all hospitals or clinics offering lung cancer screening via LDCT in their health system. The radiology department provided details on some processes for all responding facilities. Physician leaders from Hilo Medical Center also forwarded the survey to the Hawai‘i Radiologic Associates, which provides advanced radiology services to both East and West Hawai‘i Island. Surveys were not sent to Critical Access Hospitals (CAH) on Hawai‘i Island, Maui, and Lana‘i

as they do not have a CT scanner or full capability (personnel, software, etc.) to perform LDCT. Neither Maui Health System nor Kahuku Hospital, the CAH on O‘ahu, responded. All nine other health systems or hospitals responded, with one of them not performing LDCT. To calculate the detailed survey responses noted in Appendix 2, 8 was used as the denominator.

The provider survey was distributed via several channels, including through the Hawai‘i Primary Care Association and a large email list of more than 800 clinicians and practices who receive information about the annual Hawai‘i Health Workforce Summit. As a result, we had 33 responses to the surveys from a range of practice types, with eight respondents from Federally Qualified Health Centers (FQHC) representing providers for all islands except Lana‘i and Ni‘ihau. Summarized responses are noted below, but a more detailed breakdown of the responses can be found in Appendix 3.

Protocols: Several larger health systems utilize their EHR to identify those eligible for lung cancer screening. However, only one currently utilizes age, smoking status (current or former), and pack-year information to determine eligibility. One other uses age and smoking status, and another provides a prompt based on age only. Three (38%) use a “Best Practice Advisory” or similar prompt, which appears on the individual patient chart when the clinician opens an encounter. This prompts the clinician to look at the patient’s risk factors (age, smoking history) and guides them to order a LDCT for lung cancer screening. In one health system, a dedicated nurse navigator at the central or system level obtains a master listing, reaches out to eligible patients, and informs the provider to place the order. In other systems, quality program staff (medical assistants, nurses, or radiology staff) identify patients. However, these strategies are not consistently utilized across the larger health systems nor in smaller health systems. Depending on the EHR used by individual provider offices, they may have some capacity for using ‘best practice advisory’ features. However, most providers and smaller health systems do not have a systematic (automatic) method of identifying patients eligible for lung cancer screening. Instead, they rely on the individual physician or health provider to identify eligible patients and refer them for screening. The process to manually identify eligible patients is labor intensive and not feasible, even for those facilities reporting doing this.

Challenges related to the EHR as the main tool for determining eligibility for screening:

- Lack of staff and/or resources to set up this particular functionality in the EHR.
- Lack of staff and/or resources to widely implement and monitor across the board.
- Inconsistent completion of the “smoking history” section [to calculate pack-year history] or changing smoking status, with the EHR only able to calculate risk based on the current entry.
- Lack of linkages between distinct EHR systems in different practices/facilities (i.e., Epic vs. Elation).

Other systemic factors posing challenges to identifying individuals at high risk:

- Insufficient time (11) during the clinic visit and/or inadequate reimbursement for preventive care services contributes to primary care providers' challenges. Strategies to increase lung cancer (or any cancer) screening cannot solely rely on the primary care providers and/or their supporting employer or provider organization (if applicable) to identify patients.
- Limited time to address these health maintenance issues for patients with acute comorbidities (these patients are often eligible).

- Advanced team care models (12) are cost-prohibitive for most in small private practice.
- Decreased awareness by eligible patients and/or misconceptions regarding cost.
- Challenges for staff to calculate pack-years without detailed interviews.
- Even if identified and outreached by the provider/provider organization, the highest-risk patients may face transportation barriers or work numerous low-paying jobs and have difficulty scheduling LDCT.
- Unclear guidelines for asymptomatic individuals at risk – asymptomatic chronic obstructive pulmonary disease patients.
- No clear guidelines for identifying clients who have recently transitioned to e-cigarettes from combustible cigarettes.

Systemic factors supporting identifying individuals at high risk:

- Strategic allocation of resources for radiology and coordinated marketing and referral process to increase screening.
- Strategies that automate certain processes as much as possible, to minimize impact on workflow in the office. In other words, optimal use of the EHR. This is possible within a large provider organization or health maintenance organization with sufficient resources to operationalize a comprehensive approach to lung cancer screening and timely follow-up of abnormal results.

To influence morbidity from lung cancer, there must be processes in place to ensure timely communication, timely ordering of any follow-up scan (for abnormalities), clinician follow-up of the results, prompt referral to a treating provider, and good communication with providers and patients. The HCF survey also showed that 50% had information systems that allow for automatic forwarding or CC of results to the ordering provider. A few facilities have a formal quality assurance mechanism in place based in the imaging departments (38%), an organized lung cancer program (25%), or within their Accountable Care Organization (1 of 2). In all cases, however, it is up to the ordering provider to order the follow-up CT for abnormal findings. This is a major barrier as noted below, a combined 87% of responses).

The most common barriers noted by the HCF survey to patients receiving timely follow-up of abnormal screening LDCT was, in descending order:

- Communication protocols are in place (between radiology and ordering provider), but the ordering physician does not order the follow-up imaging (63%).
- Insufficient staffing and/or time in the ordering provider's office (25%).
- Suboptimal patient understanding of the importance of follow-up (38%).
- Transportation challenges (38%).
- Suboptimal communication between radiology and ordering provider (25%).
- Patient out of pocket costs (actual or fear of) (25%).

Results from the HCF survey are interwoven throughout this report and inform the recommendations in various sections. Please see Appendix 2 for the results summary.

In conclusion, we recommend the following be addressed, ideally, by a working group of the Healthcare Association of Hawai‘i (HAH) acute care facilities:

1. Share promising practices (across health systems) so that each health system or health

facility can identify one or two steps to facilitate/automate the following processes:

a. Explore proactive strategies, with input from primary care teams, to increase the accurate entry of pack-year smoking history on the EHR (i.e., consider a patient-entered pack-year calculator incorporated into a patient portal or a form [with the data entered by a medical assistant]).
b. Identifying eligible patients based on risk factors found in the EHR (i.e., age, smoking status, pack-year history).
c. Prompting the PCP via Best Practice alerts in Epic or similar (or implementing standing orders).
d. Ordering a LDCT after physician review of the Best Practice alert.
e. Triggering a timely order for a follow-up CT scan if a lung nodule is detected, utilizing the American College of Radiology Lung-RADS v2022 (or latest version at the time of implementation) (13).

2. Utilize a nurse navigator or quality program staff to identify and reach out to eligible patients, and request the provider to order the LDCT.
3. As the larger health systems develop and/or refine their referral processes for screening-identified lung nodules, ensure these processes are disseminated widely to providers throughout the state.
4. Centralized monitoring of progress in lung cancer screening by the hospitals/large health systems (which is where the great majority of screening occurs now).

(E) An explanation of how healthcare providers are made aware of available insurance coverage for early cancer screenings.

Because the USPSTF has issued a "B" recommendation for lung cancer screening, all insurers are required by the Affordable Care Act provisions to cover lung cancer screening in eligible populations. Furthermore, the American College of Radiology provides resources to radiology providers to ensure proper documentation, coding, and quality measures for successful reimbursement. A review of all health insurers in Hawai‘i reveals coverage [see (B) above]. Still, it is challenging to find the information, and there is inconsistency, as many have not updated their documents to the 2021 USPSTF guidelines. Adding to the lack of clarity is the fact that the CMS (Medicare) eligibility determination uses an age range of 50-77 years vs. the USPSTF 50-80 eligibility age-range.

Physicians affiliated with Hawai‘i Pacific Health (HPH)/Hawai‘i Health Partners, Kaiser (Hawai‘i Permanente Medical Group), and Queen Health Systems/Queen's Clinically Integrated Physician Network (Queen's) are informed about lung cancer screening, coverage, and improved processes within their own system and network via e-mail, memos, messages on Epic, continuing education (grand rounds, webinars), and have published protocols for providers. At HPH and Hawai‘i Permanente Medical Group lung cancer screening is a system-wide quality measure and target (i.e., incorporated into the value-based care metrics). Physicians affiliated with other hospitals receive updates in email and newsletters and via grand rounds. Most hospitals/health systems have published protocols for providers. A few smaller facilities recently became capable of offering lung cancer screening, but have yet to make a widespread information and marketing effort to their affiliated providers.

In conclusion, we recommend the following in order to ensure that health providers are aware of insurance coverage:

- HPH and Queen's should review and update their websites to include brief information to providers and patients on coverage eligibility [at a minimum, use the CMS eligibility criteria (age 50-77) or the more widely used USPSTF criteria (age 50-80)].
- Health insurers should update their provider manuals to use the current CMS eligibility criteria (at a minimum) or the current age range stated in the USPSTF recommendations (50-80 years). Information on lung cancer screening should be included in a separate "cancer screening" section to make it easier to find.
- Work with local specialty societies for primary care internal medicine (American College of Physicians Hawaii), family medicine (Hawaii Academy of Family Physicians), independent provider organizations, and ACOs to provide continuing education opportunities for physicians, advanced practice nurses, and physician assistants regarding lung cancer screening guidelines, insurances, resources, and referral pathways.

Our survey results show that many providers are familiar with and refer to either the ACS or the USPSTF guidelines for screening criteria.

(F) A discussion of cultural and social barriers associated with lung cancer screenings.

To augment the quantitative survey data from providers described in Section (D), we also collected qualitative data using key informant interviews to provide in-depth information on these providers' utilization of LDCT and uncover any cultural or social barriers or supports for using these services. Interviewed providers were recruited from those completing the survey. Using quota sampling, we interviewed a healthcare provider with Electronic Medical Records (EMR) systems and organizational practices that supported LDCT referrals and a healthcare provider seeking to improve their referral procedures.

Barriers

- In both health systems, the lack of clarity regarding vaping as contributing to the eligibility criteria for LDCT was described. Many clients had converted to vaping and did not report their smoking history accurately as they now considered themselves as non-smokers.

Facilitators

- In both health systems, as mentioned above, staff training on methods to accurately access smoking history contributes to improved referral processes. In health systems with good LDCT screening procedures, systems built into the EMR contribute to the determination of clients' smoking status and duration. In systems seeking to improve, dedicated interpersonal staff training supported improved client smoking and duration assessment.

Additionally, we conducted interviews with (n=5) smokers, including focus group interviews with members of the Native Hawaiian community (n=7), a population who is at higher lung cancer risk. Key informant interviewees were all current smokers, and all focus group participants, with the exception of one (who quit?), were current smokers. Standardized cigarette smoking questionnaire items were used to assess pack-years for all smoker interviewees. The range of pack-years among participants ranged from 10 pack-years to 64 pack-years with the average pack-years among all interviewees at 24 pack-years. Six interviewees were eligible for LDCT, and 5 were not eligible. Three focus group interviewees were smokers under the age of 40, with an average age of 52 for all participants.

Cultural barriers to LDCT were identified for Native Hawaiians and Pacific Islanders that were similar to barriers for other health promotion practices. However, these preliminary data are limited in scope due to the small number of interviews conducted. The collection of more in-depth interviews with smokers from all communities is warranted in the future. The key barriers identified so far for each group are described below.

Culture: Native Hawaiian

1. Knowledge - Lack of information about the screening procedures was a key barrier. Few providers have offered to screen eligible Native Hawaiian patients. Also, for those who had some knowledge of lung cancer screening, there were misconceptions about the procedure, including the lack of understanding that it is a non-invasive test and conducted at the outpatient level.
2. Collectivism/Communality - Native Hawaiian interview and focus group participants described the importance of screening being supported through group educational processes and also voiced the need for social support to promote and utilize LDCT screening.
3. Timing and Culturally Sensitive Services - Community members also expressed the need for screening services that would be more responsive to the needs of clients who have transportation, work-related, or childcare barriers to screening attendance. Roles as family providers (work schedules) and as family caregivers limit opportunities to seek screening, and many facilities do not offer the flexibility or resources to support these needs.
4. Modeling - Given the high mortality rate for lung cancer in the Native Hawaiian community, fear of a positive diagnosis was a clear deterrent to seeking LDCT screening.

Culture: Pacific Islander

1. Language and translation - Limited English proficiency particularly about medical procedures and terms were a primary barrier to screening for Pacific Islanders. Informants expressed confusion about the medical procedures that they had received and could not distinguish the purpose of screening tests that they were prescribed. Although many had interactions with healthcare providers, primary concerns surrounded other acute or chronic conditions needing attention.
2. Acculturation - Another barrier to care expressed by Pacific Islanders was unfamiliarity with Western medical care in Hawai‘i. Participants describe experiences of fragmented care at different facilities which contributed to their lack of understanding of the overall purpose of their medical care.

(G) Policy recommendations for increasing early lung cancer screenings.

Based on the results of our surveys, interviews, and/or literature reviews on best practices, the following policy recommendations are offered:

Insurance Providers

Based on our review of all insurance plan coverage documents in Hawai‘i, insurance providers should be encouraged to:

1. Standardize their lung cancer screening eligibility criteria given the variation noted in the upper age limit (77 vs. 80 years). Ideally, all would cover screening based on the USPSTF criteria.

2. Produce a one-pager on lung cancer screening and follow-up diagnostic procedures that they cover for distribution in PCP offices.

Healthcare Systems, Hospitals, and Accountable Care Organizations
They should be encouraged to:
1. Ensure that all healthcare system websites with a cancer screening page list the current USPSTF criteria for LDCT. At a minimum, the web pages should be updated with the latest CMS eligibility criteria (since that is the basis for most insurers).
2. Explore proactive strategies to increase the accuracy of entering pack-year smoking history into the EHR. This will enable the full utilization of the EHR to identify patients eligible for screening, facilitate future ordering and help to monitor the use of LDCT at the health system level. Examples of patient-entered pack-year calculator (for example, https://shouldiscreen.com/English/pack-year-calculator) could be offered in a facility utilizing a patient-facing portal (i.e., MyChart - questionnaire).
3. Utilize a nurse navigator or qualified program staff to identify and reach out to eligible patients and request the provider to order the LDCT.
4. Share promising practices (across health systems) so that each health system or health facility can identify one or two steps to facilitate/automate the processes to identify eligible patients ⇒ prompt the PCP (or implement standing orders) ⇒ order ⇒ trigger an auto follow-up a lung nodule is detected.
5. As the larger health systems develop and/or refine their referral processes for lung nodules, ensure these processes are disseminated widely to providers throughout the state.
6. Provide educational updates (i.e., webinars) or simple published protocols to increase lung cancer screening.

Department of Health (DOH)
DOH should be encouraged to:
1. DOH and HAH can decide the best methods of regularly surveying facilities to track LDCT use over the years and to distinguish baseline vs. interval screening.
2. The Hawaii Tobacco Quitline (HTQL) should encourage those who smoke (or assist them) in determining their risk factors and eligibility for lung cancer screening. They should encourage them to discuss screening with their primary care provider if they are eligible. The HTQL could also house a patient-entered risk assessment (designed for our local populations) which, if patients are determined to be eligible for screening, would also prompt them to ask their PCP to place an order for a LDCT. Examples are below, but the risk calculators in 2b and 2c need further adaptation for our populations
    a. https://www.lung.org/lung-health-diseases/lung-disease-lookup/lung-cancer/saved-by-the-scan/quiz (this is more simple, based on either Medicare or USPSTF guidelines)
    b. https://shouldiscreen.com/English
    c. https://screenlc.com/dpp-vue/index.html

The work plan below notes some of the more straightforward policy recommendations.

(H) A work plan that identifies the steps needed in the next five years to increase lung cancer screenings in the State.

Short Term (1-2 years)

1. Create a task force or working group within DOH/Hawai‘i Comprehensive Cancer Coalition (HCCC) to:
    a. With a multisector group (i.e., HCCC lung cancer screening working group), develop short-, medium- and long-term evaluation measures.
    b. Develop a process to routinely reevaluate the appropriateness of applying emerging technologies (i.e., biomarkers, newer screening modalities) and adapt guidance and processes that improve access to and efficacy of lung cancer screening.
    c. Work on developing the media campaign strategies (refer to section (3) below).
        i. First identify more feasible strategies that require minimal new research (i.e., a generalized campaign and/or education campaign targeted to providers; adapt national messages for local use).
2. Creation of working group(s) within the HAH to share best practices for Hawai‘i hospitals to address recommendations from section (D), including centralized tracking of LDCTs across the state.
3. Insurers to update their coverage guidance to be consistent with current USPSTF guidelines and have the information more easily accessible to health providers and patients [refer to section (E)].
4. Work with care provider organizations and specialty organizations to increase awareness of current guidelines and processes as they unfold (i.e., screening and/or follow-up of lung nodules) [refer to section (D) and (E)].
5. The HTQL should encourage current smokers (or assist them) in determining their risk factors and eligibility for lung cancer screening. They should encourage them to discuss screening with their primary care provider if they are eligible.

Medium Term (3-4 years)

1. With input from the working group within the DOH /HCCC, a localized media campaign should be developed to reach smokers and former smokers over the age of 45, and for specific medically underserved groups, including rural, Native Hawaiians, and Pacific Islanders [refer to section (3) below].
2. Evaluation of all media campaigns should include tracking the costs and reach of each media channel utilized, and the uptick of referrals by providers for LDCT screening.
3. Tracking follow-up of positive findings.
4. Tracking of interval screenings.

Long Term (5+ years)

1. As evidence and guidelines evolve, major hospitals and health systems should develop a “health maintenance due” process for lung cancer screening.
2. The tracking of the shift in lung cancer diagnoses toward earlier stages expected to occur within a few years as the result of a screening uptake should also be implemented.

(2) **<u>Conduct or initiate new studies, as necessary.</u>**
Research needed with local funding (i.e., State, Hawai‘i Community Foundation, American Lung Association - Hawai‘i):

1. Understand motivators/barriers to screening, with an emphasis on cultural barriers:
    a. Prior research in other cancer sites (i.e., colorectal cancer) and our preliminary findings implicate culture-specific factors that influence cancer screening. A systematic, in depth study to identify cultural motivators and barriers is needed to develop interventions tailored to local racial and ethnic populations in Hawai‘i.
2. Develop approaches to incorporate lung cancer screening with smoking cessation interventions in high-risk groups:
    a. CMS (14) encourages providers to promote lung cancer screening when patients are seeking help to quit smoking ("teachable moment"). However, preliminary findings [see Section (F)] suggest that some individuals may be reluctant to get screened for lung cancer due to perceived stigmatization based on being a smoker. Thus, research is needed to develop effective approaches to promote both behaviors in the same setting.
3. Facilitate implementation (15) of screening in smokers with a focus on high-risk populations:
    a. In order to assess the efficacy of any media campaign and whether barriers to screening are being addressed, implementation research is needed. This research should evaluate the best strategies for reaching out to those eligible for screening and for the follow-up of positive screens with regard to care provider capacity and patients' adherence to recommendations.

Research needed with national funding:
As a follow-up to the surveys and focus groups conducted for this report, extramurally funded research is needed to:

1. Identify best lung cancer risk prediction models to reduce screening eligibility disparities among Hawai‘i ethnic and racial groups: Because of the different baselines in lung cancer risk across the different racial and ethnic groups in Hawai‘i, there remains disparities in eligibility among these populations, as demonstrated in data from the Multiethnic Cohort Study (16). Incorporation of risk-based approaches has been shown to improve screening efficiency (17). However, not all risk models perform equally, especially across races/ethnicities. A comparison between an African American-specific lung cancer risk prediction model and a general model found that the population-specific model was superior in predicting risk in African Americans (18), suggesting that population-specific lung cancer risk prediction models may better identify screening populations for Hawai‘i's racial and ethnic groups and a systematic evaluation of the available risk prediction models should be considered. The data from the Multiethnic Cohort (https://www.uhcancercenter.org/mec) could be used to further adapt existing risk calculators to factor in our unique populations. These include:
    i. Simple models using either Medicare or USPSTF guidelines https://www.lung.org/lung-health-diseases/lung-disease-lookup/lung-cancer/saved-by-the-scan/quiz
    ii. Other screening tools that do not accurately factor in our unique population and would need further adaptation:
        1. https://shouldiscreen.com/English
        2. https://screenlc.com/dpp-vue/index.html
2. Consider and utilize emerging clinical biomarkers to improve screening indications. Biomarkers may be useful for the early detection of lung cancer and reduce the number of

unnecessary appointments and radiological tests. Currently, no effective biomarker are yet available, but a few promising biomarkers are being tested (19) in clinical trials. Further research to identify which biomarkers may help to augment screening indications, particularly, in our multiethnic populations is needed.

3. Extend research to identify screening protocols that would be cost-effective for individuals at lower lung cancer risk, such as never-smokers with a family history of lung cancer or with other risk exposures, or smokers who have quit for more than 15 years.
    a. Never-smoking Asian women have been shown to be at increased lung cancer risk compared to their White counterparts. The Taiwan Lung Cancer Screening for Never-Smoker Trial (TALENT) identified effective criteria for screening in that population. Research is needed to identify such criteria in Hawai‘i's population which comprises large numbers of never-smoking Asian women.
    b. Preliminary findings from key informant interviews [See Section (F)], suggested that some individuals who quit smoking >15 years may desire to be screened to lower their risk of dying from lung cancer. These individuals would be ineligible for screening based on the current USPSTF guidelines. Research is needed to identify those among long term quitters who are at highest risk.

(3) <u>Create a public awareness campaign to inform Hawai‘i residents about early lung cancer screenings.</u>

The HCCC should create a working group of stakeholders to promote increased uptake of lung cancer screening to help inform the components of a public awareness campaign. This group would serve in an advisory role to the campaign and should consist of health systems representatives, tobacco and cancer prevention advocacy organizations, and other organizations. Representatives from specific organizations such as Papa Ola Lokahi, the Hawai‘i Rural Health Association, the Hawai‘i Health and Harm Reduction Center and others should be included to address unique high-risk audiences for lung cancer.

The public awareness campaign should consider using the most salient media for each audience, including healthcare organizations and medical care providers. For providers, the campaign can include the use of e-mail, memos, organizational newsletters, messages on EHRs, and continuing education formats (i.e., grand rounds, webinars). Mass and minor, and social media formats and channels should be used to disseminate messages broadly for current smokers or former smokers. In all campaign formats, it is recommended that CMS Guidelines for screening be promoted consistently since they are the most inclusive and used by insurers.

National LDCT campaign messages should be adapted to fit local identities and characteristics. Additionally, it will be important to create messages and media tailored for specific groups in Hawai‘i who experience disparities in smoking rates, health care access, utilization, and risks for lung disease. These specific groups can include Native Hawaiians, Pacific Islanders, rural populations, and sexual and gender minority groups (19-22).

Messages promoting LDCT screening for these distinct groups experiencing disparities should be similar to the concepts used in smoking cessation messages. These groups are known to respond to different factors (i.e., spirituality and communality in Native Hawaiians and acculturation characteristics in Pacific Islanders (19-22)). This will refine key LDCT messages to be salient across all groups in the state, regardless of age, gender, ethnicity, socioeconomic

status, and other characteristics. As determined from interviews and focus groups, few smokers know about the LDCT procedure itself, that it is a noninvasive medical outpatient procedure similar to having a CT scan. The time needed for the actual procedure is approximately one hour. Therefore, this information should be included in media messages encouraging eligible clients.

Formative media research, including focus groups and key informant interviews, should be utilized to refine and test national messages tailored for local use (8, 23). This formative research should also be used to develop and test the best media concepts, messengers, and channels that will resonate with local groups experiencing disparities in tobacco use, and access to and utilization of healthcare.

Smoking cessation and acknowledgment of those who have successfully quit smoking should be integrated into any LDCT screening recommendations. Cessation, counseling services can be used as vehicles to promote screening. All messages should encourage ever-smokers to check their eligibility status by using pack-years computation tools such as:

- https://www.lung.org/lung-health-diseases/lung-disease-lookup/lung-cancer/saved-by-the-scan
- https://shouldiscreen.com/English/pack-year-calculator

Evidence-based strategies should be utilized to create messages and media to build behavioral propensities to adopt LDCT screening. Suggested frameworks include the Health Belief Model (HBM) (8, 24). The HBM identifies what encourages or discourages people from utilizing health promotional services. HBM constructs include perceived susceptibility, disease severity, benefits, barriers, cues to action, and self-efficacy regarding preventative behaviors. The HBM can be used to measure changes in knowledge, the refinement of attitudes (reducing fear of diagnosis), and self-efficacy to schedule LDCT screening in collaboration with healthcare providers as a result of the public awareness campaign.

Another recommended theoretical component of LDCT promotions includes the use of Social Cognitive Theory (SCT) (24, 25). SCT describes a dynamic process in which people learn from each other by observing the actions of others (modeling) and identifying the benefits of those actions. Key concepts from SCT that can be used in the creation of messages promoting LDCT can include reciprocal determinism, observational learning, expectations, self-efficacy, and reinforcements. Use of SCT can include the incorporation of appropriate models performing or testifying about their LDCT screening experiences and the benefits of this screening. The use of these health communication frameworks and theories can provide intermediate measures of the public awareness campaign's effectiveness.

Indirect measurement of the specific media and formats should be used including media reach estimates for mass media, click through and other response data for web-based and social media advertising. If budgeting permits, population-based surveys or exit interviews can be used to assess exposure to messages by all audiences.

Impact measures on the overall effects of any media promotions should be conducted which would include increases in screening rates during the media promotional period, relative to the costs of the media campaign. This type of analysis can be done intermittently throughout a campaign to determine the most cost effective methods to increase LDCT screening rates (23).

(4) <u>Submit an interim report. Present interim findings of the project to the ELCSTF.</u>
Interim findings were presented to the ELCSTF in November 2023 and April 2024. The DOH submitted a December 2023 HCR No. 207 Interim Report to the Legislature reporting it's findings and recommendations.

Summary

Other U.S. states have been successful in improving lung cancer screening rates by conducting implementation research tailored to their setting and populations, and by coordinating their public and private initiatives. This report highlights the importance of creating a DOH/HCCC working group and a HAH taskforce, respectively tasked to develop general and targeted, culturally sensitive, public awareness campaigns aimed at increasing knowledge and utilization of lung cancer screening and to improve care providers' awareness and referral procedures for LDCT screening.

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APPENDICES

1. Summary Report of Lung Cancer Screening Insurance Coverage and Barriers (2023-2024)
    a. HMSA - Akamai Advantage-2024 Complete (Evidence of Coverage)
    b. HMSA - Akamai Advantage-2024 Complete Plus (Evidence of Coverage)
    c. HMSA - EUTF member-2023 Guide to Benefits
    d. HMSA - EUTF HMO-2023 Guide to Benefits
    e. HMSA Utilization Review Matrix 2022-0101
    f. Kaiser Permanente - Summary of Preventive Services
    g. Kaiser Permanente - Summary of Benefits and Coverage
    h. HMAA - Comprehensive Plus Plan-2024 Description of Coverage
    i. HMAA - Option Plus One-2024 Description of Coverage
    j. HMAA - Preventative Services for Adults and Children
    k. AlohaCare Advantage Plus (HMO SNP)-2023 Evidence of Coverage
    l. UHA One Plan-2024 Medical Benefits Guide
    m. OHANA - HMO D-SNP-2024 Evidence of Coverage
    n. Compass Rose Health Plan Standard Option - 2024 Summary of Benefits and Coverage
2. Healthcare Facility Questionnaire and Results
3. Provider Survey Questionnaire and Results

Summary Report of
Lung Cancer Screening Insurance coverage and barriers (2023-2024)

Goal: Documentation available from each of the major insurance providers in Hawai‘i was assessed for the specific eligibility criteria on insurance coverage for lung cancer screening with low-dose computed tomography (LDCT) and ease of accessing information.

Summary of Findings: The major health insurance providers for the state of Hawai‘i do offer insurance coverage for lung cancer screening. The information sources are the same for insurance plan participants as for health care providers. Insurance benefits documentation for the three major health insurance providers (HMSA, Kaiser, and HMAA) indicated that lung cancer screening was covered. However, participants and care providers would generally need to read through separate, unlinked, documents to find this information. Other health insurance providers (Aloha Care, UHA, Ohana Health Plan, Compass Rose Health Plan) also indicated in their documentation that lung cancer screening was covered. However, finding coverage information was also difficult and lung cancer was generally not listed along more common cancer screening services, such as for breast, colorectal, and cervical cancers. For Quest Plan participants, the information regarding cost coverage was not clear, and lung cancer screening was generally not listed in the screening modalities that are covered. Prior authorization through referral by a Primary Care Provider was indicated for some insurance providers and for others there was no indication whether it was necessary. For HMSA, pre-approval is no longer required as of June 2023. Also, the eligibility criteria for LDCT screening varied. Most insurance providers used the current USPSTF criteria (adults aged 50-80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years), but the HMSA and Kaiser Medicare Advantage plans and the Ohana Health Plan listed a different age criterion (50-77 yrs). In conclusion, we found that there was much variability in the documentation, and a lack of ease to access information, related to lung cancer screening in the documentation from the various health insurance providers in the state of Hawai‘i.

Details for Insurance Coverage:

Theme 1: Is insurance coverage information easy to find in the available documentation?

Hawaii Medical Service Association (HMSA) - yes, covered
Source: Website: https://www.hmsa.com/health-plans/
Date Accessed: July 2023

- Individual/family plans: *Description of Plan Benefits* document did not explicitly state lung cancer screening service under the "Preventive Services" section (p. 45). One has to look further to find a separate document called the *Preventive Health Services list*, which does state lung cancer screening. No link exists to the list in the Plan Benefits document.

- (Medicare Advantage plans: The description of the plan benefits did mention lung cancer screening explicitly in a single document.)

Kaiser - yes, covered
Source: Website: https://healthy.kaiserpermanente.org/hawaii/support/forms/health-plans/individual-family-summary-benefits-coverage
Date Accessed: July 2023

- Individual/family plans: *Summary of Benefits and Coverage* states the service as "Preventive Care/Screening/Immunization." (no link in document). However, one has to separately search for the Preventive Services offered by Kaiser to explicitly find that lung cancer screening is part of the list.

- Medicare Advantage: *2023 Summary of Benefits Document* states that it costs $0 for preventive care and advises patient to see the **Evidence Of Coverage** (**EOC**) for details. Website contains a reference contact number to avail of more information and a link to EOC pdf, where lung cancer screening coverage is listed.

Hawaii Medical Assurance Association (HMAA) - yes, covered
Source: Website: https://www.hmaa.com/healthplans/
Date Accessed: July 2023

- Under the "Screening Services" section of the *Description of Coverage* (p. 34), it states that members are "Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following: …"; lung cancer screening is not listed under "the following" services. Instead, one must go to the link provided to find lung cancer screening. However, since the link to the service list was provided in the document under the paragraph, the information was easy to find.

AlohaCare - yes, covered
Source: Website: https://www.alohacare.org/
Date Accessed: July 2023

- *Summary of Benefits* vs *Evidence of Coverage* document for Medicare Advantage plan. On the website, under the "Medical and Dental Coverage" tab, it states: "For a complete listing of benefits, see your 2023 Summary of Benefits." In the *Summary of Benefits* document, under the "Preventive Care" section, it states "For a complete list of preventive care services, please see the Evidence of Coverage." There is no link to find the Evidence of Coverage document. One must find it on their own by Google Search or finding it under the separate "Member Documents" tab. LDCT screening is not listed in the "Preventive Services – Adult" list, unlike breast and colorectal screening. However, a call was made to their customer service and it was confirmed that LDCT screening is covered with the recommendation from their primary care provider.

UHA - yes, covered
Source: Website: https://www.uhahealth.com/our-plans
Date Accessed: July 2023

- Section 4 UHA's *Medical Benefits Guide* lists Preventive Care services that are covered such as breast, colorectal, and cervical cancer screenings; lung cancer screening is not listed. Nonetheless, referring to Section 5, the guide states that "*UHA covers all U.S. Preventive Services Task Force (USPSTF) A and B recommended screening services at 100% as required under the provisions of the Affordable Care Act (ACA). Preventive Care Benefits are not subject to the Annual Deductible and are available immediately*." However, there is no link or reference for USPSTF's recommended screening services. One has to search with a browser for this information separately to find lung cancer screening as a recommendation.

OhanaHealth Plan - yes, covered
Source: Website: https://www.wellcare.com/en/Hawaii/Find-My-Plan
Date Accessed: July 2023

- For Medicare members, on the OhanaHealth plan website, clicking on the "Medicare" tab will automatically open the Wellcare website. No information on benefits or lung screening is available on the Medicare Basics tab. One has to click on the "need a plan" tab, input the respective zip code, and choose a plan to look into. A webpage entailing the chosen plan will provide PDFs available for download. Specifically, the EOC document lists screening for lung cancer with LDCT as a covered service.

Compass Rose Health Plan - yes, covered
Source: Website: https://www.compassrosebenefits.com/CRBG/Health_Plan.aspx
Date Accessed: July 2023

- Medicare advantage:
  When viewing the general Medicare Advantage tab on the Compass Rose Health Plan website, a summary of benefits is available, however the category "Preventive services" is listed without any examples. On the same webpage, one has to click a link that leads to the "*Compass Rose Medicare Advantage Website*," then click "*Review benefits and cost*" which would open another webpage, and download the *Plan basics guide* PDF to determine that LDCT is covered with $0 copay.

- High Plan Option
  When viewing the compass rose health plan option on the website, a summary of plan benefits lists Preventive Screenings as being covered; however, there is no list of what this option entails. On the same webpage, one can click the link titled "2023 *FEHB Plan Brochure"*. Under "*Preventive care, adult*", the document designates cancer screenings as a service for which coverage is provided. However, one would have to click the link to the complete list of services under the USPSTF guidelines to find that lung cancer screening is included.

Theme 2: Is Language clear for Quest Plan participants)?

HMSA – coverage unsure

- **Quest Integration**: Under Routine Care for Adults, it lists breast, colorectal, and cervical cancer screenings, but not lung cancer screening. But, under the "Diagnostic Testing" section, it lists "*Medically necessary diagnostic testing to include: Screening and diagnostic radiology and imaging*" as covered.

Kaiser – coverage unsure

- **Quest Integration**: The member Handbook lists preventive services for adults ages 21 or older as covered. Services such as breast, colorectal, and cervical cancer screenings are listed, but lung cancer screening is not.

AlohaCare – coverage unsure

- **Quest Integration**: Guide to Medicaid benefits lists preventive services for adults ages 21 or older. Services such as breast, colorectal, cervical, and prostate cancer screenings are listed, but lung cancer screening is not.

OhanaHealth Plan - covered

- Member booklet lists covered preventive services "including but not limited to..". That this pertains specifically to lung cancer screening is mentioned only under "*diagnostic and screening laboratory*".

Theme 3: Is a Prior Authorization required?

AlohaCare

Prior authorization is required.

HMSA

HMSA lifted its prior authorization requirement for coverage in June 2023.

Kaiser

- Individual & Family Plan

"*In general, benefits are available only for care you receive from, or arranged by, your PCP, and at a Kaiser Permanente facility*"

- Medicare Advantage
  (part of eligibility) "*...receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner*"

UHA

No information on lung cancer prior authorization

Compass Rose Health Plan

No information on lung cancer prior authorization

'Ohana Health Plan

- Need a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner

Theme 4: Is information on screening eligibility given?

- HMSA
  - Individual/Family plans: USPSTF guidelines (Ages 50 to 80 yrs with 20 pack-year history. Once every 12 months for current smokers or former smokers who quit within past 15 years)
  - Medicare Advantage plans: Ages 50 to 77 with 20 pack-year history. Once every 12 months for current smokers or former smokers who quit within past 15 years
- Kaiser
  - Refer to the USPSTF guidelines (Individual and Family Plans: 50-80 yrs; with 20 pack-year history. Once every 12 months for current smokers or former smokers who quit within past 15 years)
  - Medicare Advantage: 50-77 yrs
    - 20 pack-years
    - Quit smoking within last 15 years
- HMAA
  - Refer to the USPSTF guidelines.
  - adults aged 50-80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.
- UHA
  - Refer to the USPSTF guidelines.
    Adults agend 50-80 yrs; 20 pack-years; quit smoking within last 15 years

- ‘Ohana Health Plan
    - 50-77 yrs
    - At least 20-pack years
    - Quit smoking within last 15 years
    - Eligible every 12 months

- Compass Rose Health Plan
    - High Option
        - (Based on USPSTF) 50-80 yrs
        - 20 pack-years
        - Quit smoking within last 15 years
    - Medicare Advantage
        - No eligibility info

Evidence of Coverage

HMSA Akamai Advantage
Complete (PPO)

2024

MedicareRx
Prescription Drug Coverage

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

H3832_1150_8700_837535 _AA_Complete_24_C

January 1 – December 31, 2024

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of *HMSA Akamai Advantage Complete (PPO)*.

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2024. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

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

This plan, *HMSA Akamai Advantage Complete*, is offered by Hawai‘i Medical Service Association (HMSA) (HMSA Akamai Advantage®). (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Hawai‘i Medical Service Association (HMSA). When it says “plan” or “our plan,” it means *HMSA Akamai Advantage Complete.*)

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

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

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2025.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

OMB Approval 0938-1051 (Expires: February 29, 2024)

2024 Evidence of Coverage

Table of Contents

CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in *HMSA Akamai Advantage Complete*, which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, *HMSA Akamai Advantage Complete*. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

HMSA Akamai Advantage Complete is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/affordable-care-act/individuals-and-families for more information.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care and services and the prescription drugs available to you as a member of *HMSA Akamai Advantage Complete*.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned or just have a question, please contact Customer Relations.

Section 1.3 Legal information about the *Evidence of Coverage*

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

The contract is in effect for months in which you are enrolled in *HMSA Akamai Advantage Complete* between January 1, 2024, and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of *HMSA Akamai Advantage Complete* after December 31, 2024. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve *HMSA Akamai Advantage Complete* each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States

Section 2.2 Here is the plan service area for *HMSA Akamai Advantage Complete*

HMSA Akamai Advantage Complete is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes the City & County of Honolulu (island of Oahu).

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Relations to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

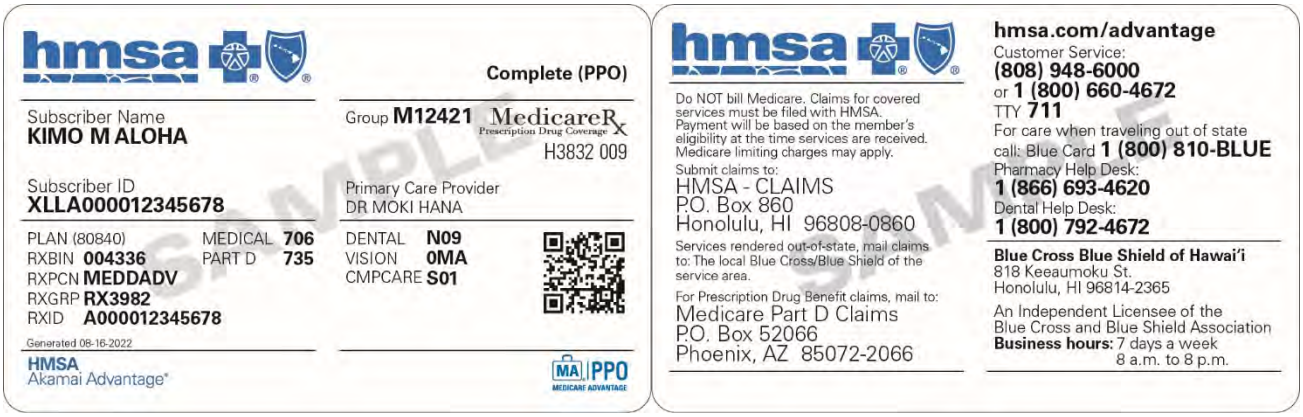
Section 2.3 U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify *HMSA Akamai Advantage Complete* if you are not eligible to remain a member on this basis. *HMSA Akamai Advantage Complete* must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



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

If your plan membership card is damaged, lost, or stolen, call Customer Relations right away and we will send you a new card.

Section 3.2 *Provider Directory*

The *Provider Directory* lists our current network providers, durable medical equipment suppliers, and pharmacies.

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

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

The most recent list of providers is available on our website at www.hmsa.com/advantage. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have your copy of the *Provider Directory*, you can request a copy (electronically or in hardcopy form) from Customer Relations. Requests for hard copy Provider Directories will be mailed to you within three business days.

Section 3.3 The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in *HMSA Akamai Advantage Complete*. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the *HMSA Akamai Advantage Complete* Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.hmsa.com/advantage) or call Customer Relations.

SECTION 4 Your monthly costs for *HMSA Akamai Advantage Complete*

Your costs may include the following:

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

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for *HMSA Akamai Advantage Complete*. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Y**ou must continue paying your Medicare premiums to remain a member of the plan.** This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

When you first enroll in *HMSA Akamai Advantage Complete*, we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
  - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
  - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount is $34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $34.70, which equals $4.858. This rounds to $4.86. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year,** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.

- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

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

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

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

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

SECTION 5 More information about your monthly premium

Section 5.1 If you pay a Part D late enrollment penalty, there are several ways you can pay your penalty

There are four ways you can pay the penalty.

Option 1: Paying by check, in person or by phone

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

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

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

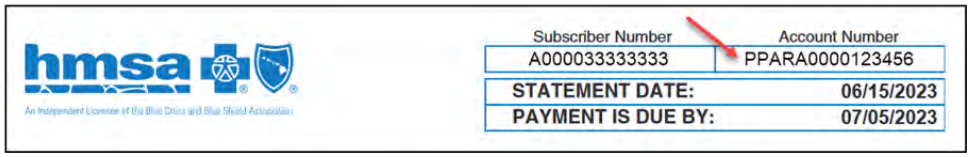
If you are submitting a payment for multiple accounts, please include either both bill stubs or both member ID numbers and Account Numbers which is located on the upper right hand of your premium billing statement with the check and clear instructions on how much you would like credited to each account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

You can also pay your bill by calling the toll-free IVR payment system phone number on your bill (1-855-613-9221). You will be able to pay using your checking or savings account or using a credit or debit card. To pay by phone, you will need the Account Number on your bill, and the routing and account number of your bank account or the credit or debit card you plan to use.

When paying by phone:

- Call toll free at 1-855-613-9221; it’s available 24 hours, 7 days a week.
- Only enter the last portion of the account number beginning with PPARA which appears at the top of your bill, ignoring the letters and all leading zeroes.

Example:



There are no additional fees to use our Pay by Phone services!

Option 2: You can have the Part D late enrollment penalty paid directly from your bank account

You can have your Part D late enrollment penalty automatically withdrawn from your bank checking or savings account each month. If you don’t currently have your Part D late enrollment penalty automatically withdrawn from your bank account but you want to, call Membership Services and ask about HMSA’s Automatic Payment Service. This Automatic Payment Service is available only through banks located within the state of Hawaii.

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

Option 3: You can set up online bill pay

You can sign up for My Account using your HMSA membership card. In My Account, you can set up VueBill to make a one-time payment or recurring payments. Please visit our website at www.hmsa.com/Media/Default/documents/2500-50067-Vuebill-Guide-for-Individual-Members(F)(S-F).pdf for more information.

Register on www.HMSA.com:

Your My Account allows you to view claims, update personal information, and manage your health plan with ease. To sign up:

- Go to www.hmsa.com and click Member Login.
- Click Create an Account and follow the instructions.
- You will need your subscriber ID number from your HMSA membership card and a valid email address to complete registration. For an example of the HMSA membership card, please see Section 3.1.

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

To sign up for automatic payments:

- Log into you're my Account using your Email Address and Password
- Click on Profile and select Pay My Bill.
- This will show a PDF copy of your bills and payment history.
- Add a form of payment on Payment Accounts using a Debit Card, Credit Card, US Checking Account, or US Savings Account.
- Then go to Automatic Payments to schedule the payment method to pay your bill every 1st of the month.
- You can watch this video to see all the things you can do online: https://www.youtube.com/watch?v=_adJPXP-ZYc

Option 4: Having your Part D late enrollment penalty taken out of your monthly Social Security check

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

Changing the way you pay your Part D late enrollment penalty. If you decide to change the way you pay your Part D late enrollment penalty, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making

sure that your Part D late enrollment penalty is paid on time. To change your Part D late enrollment penalty payment method, send your written request to:

HMSA
ATTN: Membership Services
P.O. Box 860
Honolulu, HI 96808-0860

Or you may call HMSA's Membership Services at (808) 948-6174 on Oahu or 1-800-782-4672 toll-free on the Neighbor Islands or U.S. Mainland. TTY users should call 711.

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

What to do if you are having trouble paying your Part D late enrollment penalty

Your Part D late enrollment penalty is due in our office by the fifth day of the month. If we have not received your payment by the fifth day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your Part D late enrollment penalty, if owed within 30 days. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your Part D late enrollment penalty on time, please contact Customer Relations to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your Part D late enrollment penalty, you will have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual Medicare open enrollment period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for the penalty you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 9 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your Part D late enrollment penalty within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint or you can call us at (808) 948-6174 or 1-800-782-4672, 8:00 am to 5:00 pm, Hawaii Standard Time, Monday through Friday. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if owed, or need to start paying a late enrollment penalty. This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose "Extra Help", you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

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

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

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

If any of this information changes, please let us know by calling Customer Relations.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Relations. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2:
Important phone numbers and resources

SECTION 1 *HMSA Akamai Advantage Complete* contacts (how to contact us, including how to reach Customer Relations)

Section 1.1 How to contact our plan's Customer Relations

For assistance with claims, billing, or member card questions, please call or write to *HMSA Akamai Advantage Complete* Customer Relations. We will be happy to help you.

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

Section 1.2 How to contact us when you are asking for a coverage decision or appeal about your medical care or Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

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

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

Section 1.3 How to contact us when you are making a complaint about your medical care or Part D prescription drugs

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

Section 1.4 Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)) for more information.

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

Method	Payment Requests about Routine Vision Items and Services – Contact Information
CALL	From Oahu: (808) 948-6000 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 8:00 am - 8:00 pm, 7 days a week.
TTY	711 Calls to this number are free. This number is available 8:00 am - 8:00 pm, 7 days a week.
WRITE	First American Administrators, Inc. Attn: OON Claims PO Box 8504 Mason, OH 45040-7111
WEBSITE	You can download the payment request form at www.eyemedonline.com/managed-vision-care/member-forms/out-of-network-claim#/.

Section 1.5 How to contact case management if you are experiencing multiple or complex conditions

Case management is available to help members and their families experiencing multiple or complex conditions.

The goal of case management is to provide members with access to care, services, and coordination of care to reach optimum health or improved capabilities. Through a collaborative process, a case manager works with providers, family members, community case managers, and facilities (including nursing homes, skilled nursing facilities, hospices, and foster homes) to coordinate health care services and health plan benefits. Coordinating services and providing individualized case management ensures that members understand their options and have access to the best possible care.

Your PCP can refer you to case management. For more information about the case management program, please call 1-855-329-5461, Monday through Friday, 8 am to 5 pm TTY users call 711.

Method	Case management – Contact Information
CALL	1-855-329-5461
TTY	711

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

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

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool**: Provides Medicare eligibility status information. • **Medicare Plan Finder**: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

Method	Medicare – Contact Information
WEBSITE (continued)	You can also use the website to tell Medicare about any complaints you have about *HMSA Akamai Advantage Complete:* • **Tell Medicare about your complaint:** You can submit a complaint about *HMSA Akamai Advantage Complete* directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

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

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://www.shiphelp.org (Click on SHIP LOCATOR in middle of page)
- Select your STATE from the list. This will take you to a page with phone numbers and resources specific to your state.

Method	Hawaii SHIP – Contact Information
CALL	From Oahu: (808) 586-7299 From the Neighbor Islands: 1-888-875-9229 Calls to these numbers are free.
TTY	1-866-810-4379 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Hawaii SHIP Executive Office on Aging Hawaii State Department of Health No. 1 Capitol District 250 South Hotel St. Suite 406 Honolulu, HI 96813-2831
WEBSITE	www.hawaiiship.org

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare members in each state. For Hawaii, the Quality Improvement Organization is called Livanta.

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

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta (Hawaii's Quality Improvement Organization) – Contact Information
CALL	1-877-588-1123 Calls to this number are free. This number is available 9:00 am – 5:00 pm, Monday through Friday. 11:00 am – 3:00 pm, Saturday through Sunday. 24-hour voicemail service is available..
TTY	1-855-887-6668 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-855-694-2929
WEBSITE	www.livantaqio.com/en/states/hawaii

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

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

SECTION 6 Medicaid

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

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

To find out more about Medicaid and its programs, contact State of Hawai‘i Department of Human Services Med-QUEST Division.

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

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8:00 am to 7:00 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- You can contact Customer Relations. Please have the following information available: Member name, member ID number, "Extra Help" information (such as the subsidy level), and any written documentation you have concerning the "Extra Help" you are eligible to receive. Customer Relations phone numbers are on the back cover of this document.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Relations if you have questions.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP

formulary qualify for prescription cost-sharing assistance through the HIV Drug Assistance Program (HDAP).

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

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

SECTION 8 How to contact the Railroad Retirement Board

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

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	www.rrb.gov/

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

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

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

CHAPTER 3:
Using the plan for your medical services

SECTION 1 Things to know about getting your medical care as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are network providers and covered services?

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

Section 1.2 Basic rules for getting your medical care covered by the plan

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

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

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
  - The providers in our network are listed in the *Provider Directory.*
  - If you use an out-of-network provider, your share of the costs for your covered services may be higher.

- Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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

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

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

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

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

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

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

Usually, these providers practice in the areas of:

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

What can my PCP do for me?

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

Services your PCP will help coordinate:

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

How do you choose your PCP?

There are several ways you can choose a PCP:

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

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

Changing your PCP

You may change your PCP for any reason at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan or you will pay more for covered services.

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

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

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

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

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

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

Who will coordinate my care?

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

What's prior authorization?

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

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

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you access for continued care.
- If you are undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. An in-network provider, such as your PCP, can request prior authorization so that we can cover the service at in-network cost sharing.
- If you find out that your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

How do I access palliative care?

As a member of our plan, you may access palliative care, which is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering, through the *Supportive Care* benefit or the *Hospice care* benefit, depending on your eligibility and election. You should work with your primary care provider, specialists, and palliative care/hospice care provider to discuss how palliative care can integrate with your treatment plan. Transitional concurrent care may be available while you receive

palliative care. For more information on the *Supportive Care* and *Hospice care* benefits, see Chapter 4, Section 2.1 (*Medical Benefits Chart, what is covered and what you pay*).

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

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive non-emergent care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a medical emergency and what should you do if you have one?

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

If you have a medical emergency:

- **Get help as quickly as possible**. Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network. You are covered for emergency medical services or urgently needed care (not scheduled or elective care) in a foreign country. For more information, see the Medical Benefits Chart in Chapter 4 of this document. When you receive emergency/urgent care outside the country, you will need to pay the bill and ask for an itemized bill for your services. When you return to the United States, send the itemized bill and proof of payment to us along with a note describing your emergency/urgent care. If you did not pay your bill in U.S. dollars, the plan will reimburse you in U.S. dollars at the current exchange rate. See Chapter 7, Section 2 for more information on how to submit a bill for reimbursement, and the Medical Benefits Chart in Chapter 4 for more information.

What is covered if you have a medical emergency?

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

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

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. If your care requires prior authorization, your PCP will work with us and submit a prior authorization request. Your follow-up care will be covered by our plan. If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost-sharing.

What if it wasn’t a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, the amount of cost-sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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

What are urgently needed services?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

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

You are covered for emergency medical services or urgently needed care (not scheduled or elective care) in a foreign country. For more information, see the Medical Benefits Chart in Chapter 4 of this document.

Section 3.3 Getting care during a disaster

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

Please visit the following website: www.hmsa.com/advantage for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

SECTION 4 What if you are billed directly for the full cost of your services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

HMSA Akamai Advantage Complete covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

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

SECTION 5 How are your medical services covered when you are in a clinical research study?

Section 5.1 What is a clinical research study?

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Section 5.2 When you participate in a clinical research study, who pays for what?

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

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

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

> *Here's an example of how the cost sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

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

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies*. (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1 What is a religious non-medical health care institution?

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

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

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

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

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

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

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

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion

pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

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

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

- Prosthetics and Orthotics
- Walkers
- Supply items

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

- Wheelchairs
- Hospital beds
- Insulin pumps
- PAP devices

Durable medical equipment items which will never have ownership transferred:

- Continuous Passive Motion (CPM) devices
- Ventilators

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

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

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

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

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

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

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

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

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

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

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of *HMSA Akamai Advantage Complete*. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- **Copayment** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

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

- Your **in-network maximum out-of-pocket amount** is $6,700. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for Part D prescription drugs, and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $6,700 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is $10,000. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount. In addition,

amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $10,000 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to balance bill you

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

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has balance billed you, call Customer Relations.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

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

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.

- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from *HMSA Akamai Advantage Complete*.
  - Covered services that need approval in advance to be covered as in-network services are marked by an endnote. In addition, Medicare Part A and Part B services that are rendered by out-of-network providers as a result of a referral from a network provider are covered at the lesser of the in-network or out-of-network cost-sharing only if prior authorization was approved by HMSA.
  - You never need approval in advance for out-of-network services from out-of-network providers.
- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

Important Benefit Information for all Enrollees Participating in Wellness and Health Care Planning (WHP) Services:

- Because *HMSA Akamai Advantage Complete* participates in Medicare Advantage VBID Hospice Component program, you will be eligible for the following WHP services, including advance care planning (ACP) services:
  - Your PCP or other physician may explain or discuss advance care directives with you, your family, or caregiver. You may access these services during a physician office visit or as part of

your Annual Wellness Visit. Advance care planning discussion is voluntary and you may decline the offer of these services if you choose.

Note: Medicare approved *HMSA Akamai Advantage Complete* to provide WHP and the Medicare Advantage VBID Hospice Component as part of the Value-Based Insurance Design (VBID) program. This program lets Medicare try new ways to improve Medicare Advantage plans.

 You will see this apple next to the preventive services in the benefits chart.

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

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

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In-Network and Out-of-network** There is no coinsurance or copayment for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for the patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.	**In-Network** $0 copayment for each Medicare-covered acupuncture for chronic low back pain visit with a primary care provider in the primary care provider's office, or from an advanced practice registered nurse, nurse practitioner, or physician assistant. $50 copayment for each Medicare-covered acupuncture for chronic low back pain visit from a specialist. 20% of the cost for each Medicare-covered acupuncture for chronic low back pain visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic. **Out-of-network** $40 copayment for each Medicare-covered acupuncture for chronic low back pain visit with a primary care provider in the primary care provider's office, or from an advanced practice registered nurse, nurse practitioner, or physician assistant. $60 copayment for each Medicare-covered acupuncture for chronic low back pain visit from a specialist. 40% of the cost for each Medicare-covered acupuncture for chronic low back pain visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain (continued) Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Transportation starts where an injury or illness took place or first needed emergency care. Transportation ends at the nearest appropriate facility that can provide care. Non-emergency air ambulance transportation between Hawaii and the Mainland U.S. requires prior authorization by the plan.	**In-Network and Out-of-network** $250 copayment per one-way trip per ambulance provider per day for Medicare-covered ambulance benefits. Air ambulance is covered only in emergency situations based on Medicare guidelines. (1)
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every calendar year. **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In-Network and Out-of-network** There is no coinsurance or copayment for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In-Network and Out-of-network** There is no coinsurance or copayment for Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you get these services
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every calendar year for women age 40 and older • Clinical breast exams once every 24 months	**In-Network and Out-of-network** There is no coinsurance or copayment for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Cardiac rehabilitation is covered for a limited number of sessions when medically necessary.	**In-Network** $30 copayment for each Medicare-covered cardiac rehabilitation service ordered by your physician. $50 copayment for each Medicare-covered intensive cardiac rehabilitation service ordered by your physician. **Out-of-network** 40% of the cost for each Medicare-covered cardiac rehabilitation service ordered by your physician. 40% of the cost for each Medicare-covered intensive cardiac rehabilitation service ordered by your physician.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In-Network and Out-of-network** There is no coinsurance or copayment for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In-Network and Out-of-network** There is no coinsurance or copayment for cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test and pelvic exam every 12 months • We cover an HPV test once every five years for asymptomatic members aged 30 to 65 years in conjunction with the Pap smear test	**In-Network and Out-of-network** There is no coinsurance or copayment for Medicare-covered preventive Pap and pelvic exams. There is no coinsurance or copayment for a Medicare-covered preventive HPV test.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	**In-Network** $15 copayment for each visit for Medicare-covered services. **Out-of-network** 40% of the cost for each visit for Medicare-covered services.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	**In-Network and Out-of-network** There is no coinsurance or copayment for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay $0 for each Medicare-covered colorectal cancer screening exam for your doctors' services. In a hospital outpatient setting, you also pay the hospital $0 for each Medicare-covered colorectal cancer screening exam. The Part B deductible doesn't apply. $0 copayment for each Medicare-covered barium enema.

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening (continued) • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: **Preventive Dental Services: *** • Oral exams: 2 per calendar year • Cleanings: 2 per calendar year • Full mouth X-rays or Panoramic X-ray: 1 set per 5 calendar years • Bitewing X-rays: 1 set per calendar year except when performed within 12 months of full mouth x-rays or panoramic x-ray • Fluoride: 2 treatments per calendar year • Silver Diamine Fluoride: 2 treatments per calendar year **Additional Comprehensive Dental Services: *** • Fillings: 2 per calendar year • Extractions: 4 per calendar year	**In-Network** $50 copayment for each visit for Medicare-covered dental benefits. $0 copayment for preventive and additional comprehensive dental services.* (2) **Out-of-network** 40% of the cost for each visit for Medicare-covered dental benefits. 40% of the cost for preventive and additional comprehensive dental services.* (2)
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In-Network and Out-of-network** There is no coinsurance or copayment for an annual depression screening visit.

Services that are covered for you	What you must pay when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**In-Network and Out-of-network** There is no coinsurance or copayment for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. There are quantity limits for diabetic test strips. If your doctor believes you require a higher number of test strips, they can request an exception. We cover the following preferred brands and manufacturers of supplies to monitor your blood glucose: • FreeStyle • FreeStyle InsuLinx • FreeStyle Lite • FreeStyle Precision Neo • OneTouch Ultra 2 • OneTouch Verio • Precision Xtra You can also ask your pharmacist to tell you which brands and manufacturers we cover. Generally, we will not cover other brands and manufacturers of diabetic supplies unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to *HMSA Akamai Advantage Complete* and are using a brand of diabetic supplies that is not preferred, we will continue to cover this brand for up to 100 days. During this time, you should talk with your doctor to decide the preferred brand that is medically appropriate for you after this 100-day period.	**In-Network** $0 copayment for Medicare-covered blood glucose monitors, including continuous glucose monitors, and other diabetes monitoring supplies. 20% of the cost for Medicare-covered therapeutic shoes or inserts. $0 copayment for members eligible for the diabetes self-management training preventive benefit. **Out-of-network** 40% of the cost for Medicare-covered blood glucose monitors, including continuous glucose monitors, and other diabetes monitoring supplies. 40% of the cost for Medicare-covered therapeutic shoes or inserts. $0 copayment for members eligible for the diabetes self-management training preventive benefit.

Services that are covered for you	What you must pay when you get these services
Diabetes self-management training, diabetic services and supplies (continued) • Other supplies to monitor your blood glucose: Medicare-covered Continuous Glucose Monitoring System (CGMS), and related supplies • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.hmsa.com/advantage.	**In-Network** 20% of the cost for Medicare-covered durable medical equipment and related supplies. Your cost sharing for Medicare oxygen equipment coverage is 20% of the cost, every rental payment. Your cost sharing will not change after being enrolled for 36 months. If prior to enrolling in *HMSA Akamai Advantage Complete* you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in *HMSA Akamai Advantage Complete* is 20% of the cost. Authorization rules may apply. (1) **Out-of-network** 40% of the cost for Medicare-covered durable medical equipment and related supplies. Your cost sharing for Medicare oxygen equipment coverage is 40% of the cost, every rental payment. Your cost sharing will not change after being enrolled for 36 months.

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies (continued)	If prior to enrolling in *HMSA Akamai Advantage Complete* you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in *HMSA Akamai Advantage Complete* is 40% of the cost. For cost-sharing for home infusion therapy services (if billed separately), see *Home infusion therapy*.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	**In-Network and Out-of-network** $100 copayment for each Medicare-covered emergency room visit. If you are admitted to the hospital within 24 hours for the same condition, you pay $0 for the emergency room visit. If you get additional services at an out-of-network facility as part of your emergency room visit, your cost is the cost-sharing you would pay to a network provider. For cost-sharing for additional services received at the emergency room, see the following: • Inpatient care that began in an emergency room admission, see *Inpatient hospital care.* • Physician services (if billed separately), see *Physician/Practitioner services, including doctor's office visits*. • Services in an outpatient clinic, including same-day surgery, see *Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*. (1) • Laboratory tests, X-rays and other radiology services, and medical supplies such as splints and casts, see *Outpatient diagnostic tests and therapeutic services and supplies*. (1)

Services that are covered for you	What you must pay when you get these services
Emergency care (continued)	• Certain drugs and biologicals that you can't give yourself, see *Medicare Part B prescription drugs*. (1)
For emergency services in a foreign country (**Worldwide coverage***): • Physician services • Outpatient services • Room, board and ancillaries • Emergency transportation	**In-Network and Out-of-network** **Worldwide coverage*** 100% for any amounts above the plan's eligible charges for physician services. (2) 100% for any amounts above the plan's eligible charges for outpatient services. (2) 10% of the cost of the plan's eligible charge for hospital room, board and ancillaries. (2) 10% of the cost for emergency transportation. (2)
Fitness Program – The Silver&Fit® Healthy Aging and Exercise Program The Silver&Fit Healthy Aging and Exercise program provides you access to a Fitness Center Membership, Home Fitness Kit, and Healthy Aging Coaching, plus other features. • Fitness Center Membership: You can access a no-cost Standard Fitness Network membership at one of thousands of participating fitness centers or select YMCAs nationally. (Non-standard services at participating fitness centers/YMCAs are not included in the Silver&Fit program.) If you choose a Standard Fitness Network membership, you may change your fitness center once per month. You can also access the Premium Fitness Network, which includes thousands of additional fitness centers, for a monthly buy-up fee. Fees vary by Premium fitness center. To find a participating fitness center/YMCA or change your fitness center/YMCA, visit www.silverandfit.com or call Silver&Fit Customer Service.* • Home Fitness Kits: You can receive one Home Fitness Kit per calendar year at no additional cost.* • Healthy Aging Coaching: You can access Silver&Fit Healthy Aging Coaching sessions by phone, video, or chat with a trained coach at no additional cost.*	**In-Network and Out-of-network** The Silver&Fit Program Fitness Center Membership $0 monthly fee for Standard Network fitness centers $30-$200 monthly fee for Premium Network fitness centers.* (2) Home Fitness Kits $0 copayment for one Home Fitness Kit per calendar year.* (2) Healthy Aging Coaching $0 copayment for unlimited sessions of Healthy Aging Coaching.* (2)

Services that are covered for you	What you must pay when you get these services
Fitness Program – The Silver&Fit® Healthy Aging and Exercise Program (continued) • Well-Being Club: By setting your preferences for well-being topics on the website, you can discover resources tailored to your interests and healthy aging goals including articles, videos, and live virtual classes and events. • Digital Workouts: You can view on-demand videos through the website's digital workout library, including Silver&Fit Signature Series Classes®. • Silver&Fit Connected!™: The Silver&Fit Connected! tool can assist with tracking your activity. Purchase of some wearable fitness trackers or apps may be required to use the Connected! tool and are not reimbursable by the Silver&Fit program. • Visit www.silverandfit.com to register and access online newsletters, on-demand workout videos, a fitness center search, and the Silver&Fit Connected!™ tool. You can also enroll online to obtain a Silver&Fit card and take it directly to a participating fitness center/YMCA. For details, visit www.silverandfit.com or call Silver&Fit Customer Service at 1-888-354-4934, Monday through Friday, 8 am to 5 pm HST (TTY/TDD 711). *The Silver&Fit program is provided by American Specialty Health Fitness, Inc., (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit, Silver&Fit Signature Series Classes, and Silver&Fit Connected! are trademarks of ASH and used with permission herein. Fitness center participation may vary by location and is subject to change. Kits are subject to change.*	
Health and wellness education programs HMSA Health Education Workshops are fun and interactive workshops to teach members about fitness, nutrition, stress management, and other aspects of health and well-being that can impact physical, emotional and social health. To learn more about HMSA Health Education Workshops, go to www.hmsa.com/healtheducation.	**In-Network and Out-of-network** $0 copayment for covered supplemental health education workshops.

Services that are covered for you	What you must pay when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. See Section 3.1 of this chapter for services we do not cover.	**In-Network** $50 copayment for each Medicare-covered diagnostic hearing and balance exam. **Out-of-network** 40% of the cost for each Medicare-covered diagnostic hearing and balance exam.
Help with Certain Chronic Conditions **Dental services – Oral Health for Total Health** This program focuses on health conditions such as diabetes, coronary artery disease, pregnancy, stroke, chronic obstructive pulmonary disease, end stage renal disease, metabolic syndrome, head and neck cancer, oral cancer and Sjögren's syndrome that affect oral health. Programs include additional dental benefits for members identified with specific health conditions and outreach activities to support members and promote oral health. For more information on this program, please visit www.hmsadental.com/members/oral-health-for-total-health/enroll or call Customer Relations (phone numbers are listed on the back cover of this document). Members diagnosed with diabetes, coronary artery disease, stroke, pregnancy, chronic obstructive pulmonary disease, end stage renal disease or metabolic syndrome are eligible for the following services in addition to the plan's dental benefits: **Dental Services: *** • Cleanings: 2 additional per calendar year • Dental deep cleaning: 1 per 2 calendar years Members diagnosed with head and neck cancer, oral cancer or Sjögren's syndrome are eligible for the following services in addition to the plan's dental benefits: **Dental Services: *** • Cleanings: 2 additional per calendar year • Dental deep cleaning: 1 per 2 calendar years • Fluoride: 2 additional treatments per calendar year at least 3 months apart • Oral exams: 2 additional exams per calendar year	**In-Network** $0 copayment for additional dental benefits for members identified with specific health conditions.* (2) **Out-of-network** 40% of the cost for additional dental benefits for members identified with specific health conditions.* (2) For cost-sharing for the plan's dental benefits, see *Dental services*.

Services that are covered for you	What you must pay when you get these services
Help with Certain Chronic Conditions **In-home Health Assessments Program** This program provides an in-home health assessment once per calendar year. A nurse practitioner will conduct the visit, and may also provide health screening recommendations, health prevention tips, and care resource assistance. After the visit, the assessment summary will be shared with the member and the member's PCP or care team, as appropriate. Members who have been diagnosed with chronic conditions including diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, coronary artery disease (CAD), mood disorders, rheumatoid arthritis, dementia, cancer, vascular disease, chronic kidney disease (CKD), nutrition-related disorders, including obesity, or hematological disorders and who either do not have a PCP or need assistance managing their chronic condition with their PCP may be contacted to arrange an in-home health assessment.	**In-Network and Out-of-Network** There is no coinsurance or copayment for the In-home Health Assessments Program.*
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	**In-Network and Out-of-network** There is no coinsurance or copayment for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**In-Network** $0 copayment for Medicare-covered home health agency services. Authorization rules may apply. (1) **Out-of-network** 40% of the cost for Medicare-covered home health agency services.

Services that are covered for you	What you must pay when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	**In-Network** 20% of the cost for Medicare-covered home infusion therapy services furnished by a qualified home infusion therapy supplier if billed separately. **Out-of-network** 40% of the cost for Medicare-covered home infusion therapy services furnished by a qualified home infusion therapy supplier if billed separately. For cost-sharing for durable medical equipment (DME) (if billed separately), see *Durable medical equipment (DME) and related supplies.* For cost-sharing for Medicare Part B prescription drugs (if billed separately), see *Medicare Part B prescription drugs.*
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan. If you choose to remain in your plan you must continue to pay plan premiums. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> *HMSA Akamai Advantage Complete* will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. The plan also covers transitional concurrent care for members enrolled in a network Medicare-certified hospice program for up to 30 days after election. You will get comfort-directed palliative care while continuing to receive outpatient curative treatment	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by *HMSA Akamai Advantage Complete*. **In-Network and Out-of-network** There is no coinsurance or copayment for Medicare-covered hospice services. $0 copayment for prescription drugs and biologics. $0 copayment for inpatient respite care. For cost-sharing for hospice consultation services (one time only) for a member who hasn't elected the hospice benefit but may be considering and be eligible for the hospice benefit, along with their family or caregiver, see *Physician/Practitioner services, including doctor's office visits.*

Services that are covered for you	What you must pay when you get these services
Hospice care (continued) from an interdisciplinary team of practitioners. Transitional concurrent care is not available to members transitioning from the *Supportive Care* benefit into the Medicare hospice benefit. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay cost-sharing according to the plan's rules described in Chapter 3, Section 1.2, "Basic rules for getting your medical care covered by the plan." For services that are covered by *HMSA Akamai Advantage Complete* but are not covered by Medicare Part A or B: *HMSA Akamai Advantage Complete* will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a member who hasn't elected the hospice benefit but may be considering and be eligible for the hospice benefit, along with their family or caregiver.	

Services that are covered for you	What you must pay when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	**In-Network and Out-of-network** There is no coinsurance or copayment for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. For coverage of other vaccines (if you are at risk and the vaccine(s) meet Medicare Part B coverage rules), see *Medicare Part B prescription drugs.* (1)
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. The plan covers the following hospital days per stay: • The plan covers 90 hospital days. • The plan covers 60 Lifetime Reserve Days. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	**In-Network** For Medicare-covered hospital stays: Days 1-6: $370 copayment per day Days 7-60: $50 copayment per day Days 61-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Authorization rules may apply. (1) **Out-of-network** For Medicare-covered hospital stays: Days 1-14: $400 copayment per day Days 15-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. **In-Network and Out-of-network** Per day copayments are applied per hospital stay. If you are transferred but not discharged, it counts as the same hospital stay.

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If *HMSA Akamai Advantage Complete* provides transplant services at a location outside the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Additionally, we will cover transplant at a distant location, as well as lodging and transportation costs for you and a companion if the transplant is not available in Hawaii or if the distant location is deemed more medically favorable, per HMSA's policy. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. The plan covers the following hospital days per stay: • The plan covers 90 hospital days. • The plan covers 60 Lifetime Reserve Days. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to mental health care services provided in a psychiatric unit of a general hospital.	**In-Network** For Medicare-covered hospital stays: Days 1-6: $320 copayment per day Days 7-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. Authorization rules may apply. (1) **Out-of-network** For Medicare-covered hospital stays: Days 1-14: $400 copayment per day Days 15-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. **In-Network and Out-of-network** After you exhaust your Medicare 190-day lifetime limit, for coverage of all other inpatient services, see *Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay*. Per day copayments are applied per hospital stay. If you are transferred but not discharged, it counts as the same hospital stay.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including	For cost-sharing for physician services, see *Physician/Practitioner services, including doctor's office visits*. For cost-sharing for diagnostic tests (like lab tests), x-ray, radium and isotope therapy including technician materials and services, surgical dressings, splints, casts and other devices used to reduce fractures and dislocations, see *Outpatient diagnostic tests and therapeutic services and supplies.* (1) For cost-sharing for prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (or contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued) contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	body organ, including replacement or repairs of such devices, and for cost-sharing for leg, back, arm, back and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition, see *Prosthetic devices and related supplies*. (1) For cost-sharing for physical therapy, speech therapy, and occupational therapy, see *Outpatient rehabilitation services*. (1)
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**In-Network and Out-of-network** There is no coinsurance or copayment for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare members under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In-Network** $0 copayment for the MDPP benefit. **Out-of-network** $0 copayment for the MDPP benefit.

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers or insulin pumps) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Procrit®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.hmsa.com/part-b-step/. We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	**In-Network** 20% of the cost for Medicare-approved charges for prescription drugs covered under Part B of Original Medicare. You won't pay more than $35 for a one-month supply of insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). Authorization rules may apply. (1) **Out-of-network** 40% of the cost for Medicare-approved charges for prescription drugs covered under Part B of Original Medicare. Some drugs may be subject to step therapy. For cost-sharing for home infusion therapy services (if billed separately), see *Home infusion therapy*. You may pay a lower coinsurance for rebatable drugs. For a definition of "rebatable drugs," see Chapter 12 of this document.

Services that are covered for you	What you must pay when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In-Network and Out-of-network** There is no coinsurance or copayment for preventive obesity screening and therapy.
Online Care With HMSA's Online Care, you can see a doctor or other health care provider from the comfort and privacy of home, work, or anywhere you can go online. Medical doctors are available 24 hours a day, 7 days a week and can diagnose conditions, recommend treatment and prescribe medications if necessary. Online therapy and counseling sessions are available by appointment.* To get started, download the free Online Care mobile app or for more information, go to www.hmsaonlinecare.com from a computer. Sessions and eligibility are subject to the HMSA's Online Care Consumer User Agreement.	**In-Network and Out-of-network** **Non-Behavioral Health Visits:** $0 copayment. Maximum 15 minutes.* (2) **Behavioral Health Visits:** $0 copayment. Maximum 60 minutes.* (2)
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of service to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessment Also covered via telehealth from eligible network providers.	**In-Network** $50 copayment for Medicare-approved Opioid Treatment Program services. **Out-of-network** 40% of the cost for Medicare-approved Opioid Treatment Program services.

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Advanced Imaging tests. Advanced imaging studies include MRI, MRA, CT, PET and nuclear cardiology services • Other Medicare-covered diagnostic radiology services (not including X-rays or Advanced Imaging) • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests, therapeutic services and supplies	**In-Network** 20% of the cost for Medicare-covered X-rays. 20% of the cost for Advanced Imaging tests. (1) 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays or Advanced Imaging). 20% of the cost for Medicare-covered radiation therapy services. (1) 20% of the cost for Medicare-covered surgical supplies such as dressings, and splints, casts and other devices used to reduce fractures and dislocations. 20% of the cost for Medicare-covered lab services. $0 copayment for Medicare-covered blood. 20% of the cost for other Medicare-covered diagnostic tests, therapeutic services and supplies. (1) Authorization rules may apply. (1) **Out-of-network** 40% of the cost for Medicare-covered X-rays. 40% of the cost for Advanced Imaging tests. 40% of the cost for Medicare-covered diagnostic radiology services (not including X-rays or Advanced Imaging). 40% of the cost for Medicare-covered radiation therapy services. 40% of the cost for Medicare-covered surgical supplies such as dressings, and splints, casts and other devices used to reduce fractures and dislocations. 40% of the cost for Medicare-covered lab services. $0 copayment for Medicare-covered blood.

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued)	40% of the cost for other Medicare-covered diagnostic tests, therapeutic services and supplies.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-Network** $100 copayment for Medicare-covered observation care. **Out-of-network** 40% of the cost for Medicare-covered observation care.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-Network and Out-of-network** For cost-sharing for services in an emergency department, see *Emergency care.* For cost-sharing for services in an outpatient clinic, including same-day surgery, see *Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers.* (1) For cost-sharing for outpatient hospital observation services, see *Outpatient Hospital Observation.* For cost-sharing for laboratory tests, X-rays and other radiology services, and medical supplies such as splints and casts, see *Outpatient diagnostic tests and therapeutic services and supplies.* (1) For cost-sharing for mental health care, see *Outpatient mental health care*. For cost-sharing for partial hospitalization services, see *Partial hospitalization services*. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. For cost-sharing for certain drugs and biologicals that you can't give yourself, see *Medicare Part B prescription drugs*. (1)

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. Also covered via telehealth from eligible network providers.	(3) **In-Network** $40 copayment for each Medicare-covered individual or group therapy visit. **Out-of-network** 40% of the cost for each Medicare-covered individual or group therapy visit.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-Network** $35 copayment for each Medicare-covered physical and/or speech and language therapy visit ordered by your physician. $35 copayment for each Medicare-covered occupational therapy visit ordered by your physician. Authorization rules may apply. (1) **Out-of-network** 40% of the cost for each Medicare-covered physical and/or speech and language therapy visit ordered by your physician. 40% of the cost for each Medicare-covered occupational therapy visit ordered by your physician.
Outpatient substance abuse services Our plan covers certain treatment services for substance abuse which are covered by Original Medicare. Also covered via telehealth from eligible network providers.	(3) **In-Network** $50 copayment for each Medicare-covered individual or group visit. **Out-of-network** 40% of the cost for each Medicare-covered individual or group visit.

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**In-Network** 20% of the cost for each Medicare-covered visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic. Authorization rules may apply. (1) **Out-of-network** 40% of the cost for each Medicare-covered visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic. **In-Network and Out-of-network** For cost-sharing for physician services (if billed separately), see *Physician/Practitioner services, including doctor's office visits*. For cost-sharing for other outpatient hospital services (if billed separately), see *Outpatient hospital services*.
Over-the-Counter (OTC) Health Products You are eligible for a $65 quarterly benefit to be used in-store or online shopping for over-the-counter (OTC) health and wellness products available through our mail order service and at select retail stores. The benefit renews at the beginning of each quarter of the calendar year (January, April, July, and October), and unused benefit balances do not carry over between quarters. You will receive your HMSA Extra Benefits carrier card with your HMSA Extra Benefits Debit Card in the mail to use towards the purchase of OTC health and wellness products available through United Medco, or at select retail stores. If you order OTC items online, by phone, or by mail, your items will be delivered to your door at no additional cost. Visit https://HMSAExtraBenefits.com to shop online or manage your Extra Benefits account, or call 1-800-790-6019 from 8:00 am - 8:00 pm Hawaii Standard Time, Monday through Friday.	**In-Network** $0 copayment for up to $65 quarterly of over-the-counter (OTC) health and wellness products available through our mail order service and at select retail stores.

Services that are covered for you	What you must pay when you get these services
Partial hospitalization services and Intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	**In-Network** $50 copayment for Medicare-covered partial hospitalization program services. $50 copayment for Medicare-covered intensive outpatient program services. **Out-of-network** 40% of the cost for Medicare-covered partial hospitalization program services. 40% of the cost for Medicare-covered intensive outpatient program services.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including for: primary care provider visits, specialist visits, mental health therapy or substance abuse therapy visits, visits with an advanced practice registered nurse, nurse practitioner, or physician assistant, or Opioid Treatment Program services o You have the option of receiving these services either through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, then you must use a network provider that currently offers the service by telehealth • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other locations approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate or treat symptoms of a stroke regardless of their location	(3) **In-Network** $0 copayment for each primary care provider visit in the primary care provider's office or in the member's home for Medicare-covered benefits. $0 copayment for each visit with an advanced practice registered nurse, nurse practitioner, or physician assistant in the provider's office or in the member's home for Medicare-covered benefits. $50 copayment for each specialist visit for Medicare-covered benefits. $0 copayment for certain telehealth services from eligible network providers. For a list of primary care providers, please refer to the *Provider Directory*. **Out-of-network** $40 copayment for each primary care provider visit for Medicare-covered benefits. $40 copayment for each visit with an advanced practice registered nurse, nurse practitioner, or physician assistant for Medicare-covered benefits.

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	$60 copayment for each specialist visit for Medicare-covered benefits. **In-Network and Out-of-network** For cost-sharing for hearing and balance exams, see *Hearing services*. For cost-sharing for non-routine dental care covered by Medicare, see *Dental services.*

Services that are covered for you	What you must pay when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	**In-Network** $50 copayment for each visit for Medicare-covered services. **Out-of-network** 40% of the cost for each visit for Medicare-covered services.
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In-Network** $0 copayment for an annual digital rectal exam. **Out-of-network** $0 copayment for an annual digital rectal exam. **In-Network and Out-of-network** There is no coinsurance or copayment for an annual PSA test.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see *Vision Care* later in this section for more detail.	**In-Network** 20% of the cost for Medicare-covered prosthetic devices and related supplies. Authorization rules may apply. (1) **Out-of-network** 40% of the cost for Medicare-covered prosthetic devices and related supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Pulmonary rehabilitation is covered for a limited number of sessions when medically necessary.	**In-Network** $15 copayment for each Medicare-covered pulmonary rehabilitation service ordered by your physician. Authorization rules may apply. (1) **Out-of-network** 40% of the cost for each Medicare-covered pulmonary rehabilitation service ordered by your physician.

Services that are covered for you	What you must pay when you get these services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In-Network and Out-of-network** There is no coinsurance or copayment for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months **Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening*: the member must receive a order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In-Network and Out-of-network** There is no coinsurance or copayment for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In-Network and Out-of-network** There is no coinsurance or copayment for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, *Medicare Part B prescription drugs.*	**In-Network** 20% of the cost for Medicare-covered renal dialysis services which includes but is not limited to: • Outpatient dialysis treatments • Self-dialysis training • Home dialysis equipment and supplies • Certain home support services $0 copayment for Medicare-covered kidney disease education services. $0 copayment for Medicare-covered inpatient dialysis. **Out-of-Network** 20% of the cost for Medicare-covered renal dialysis services which includes but is not limited to: • Outpatient dialysis treatments • Self-dialysis training • Home dialysis equipment and supplies • Certain home support services $0 copayment for Medicare-covered kidney disease education services. $0 copayment for Medicare-covered inpatient dialysis. **In-Network and Out-of-network** For cost-sharing for physician services (if billed separately), see *Physician/Practitioner services, including doctor's office visits*.

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.) Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	**In-Network** For Medicare-covered SNF stays: Days 1-20: $0 copayment per day Days 21-60: $200 copayment per day Days 61-100: $0 copayment per day Authorization rules may apply. (1) **Out-of-network** For Medicare-covered SNF stays: Days 1-50: $200 copayment per day Days 51-100: $0 copayment per day **In-Network and Out-of-network** After you exhaust your Medicare SNF benefit, for coverage of other inpatient services, see *Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay*. No prior Medicare-covered acute level of care hospital stay is required. Cost-sharing for a SNF stay is based on a benefit period. For more information, see definition of a *Benefit Period* in Chapter 12.

Services that are covered for you	What you must pay when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	**In-Network and Out-of-network** There is no coinsurance or copayment for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**In-Network** $25 copayment for each Medicare-covered SET for PAD service ordered by your physician. **Out-of-network** 40% of the cost for each Medicare-covered SET for PAD service ordered by your physician.

Services that are covered for you	What you must pay when you get these services
Supportive Care services A comprehensive approach to care if you have a serious or advanced illness including Stage 3 or 4 cancer, advanced Congestive Heart Failure (CHF), advanced Chronic Obstructive Pulmonary Disease (COPD), or any advanced illness that meets the requirements of the Supportive Care policy. You will get comfort-directed care, while continuing to receive curative treatment from an interdisciplinary team of practitioners. Supportive Care is only available when you are referred by your physician. • We cover Supportive Care referral visits during which you are advised of Supportive Care options, regardless if you are later admitted to Supportive Care • Coverage is limited to 90 calendar days of services in a 12 month period that begins the first day Supportive Care services are provided* To receive Supportive Care, you must not be enrolled in a Medicare-certified hospice program. (For more information about the Medicare-certified hospice program, see *Hospice care*.)	**In-Network** Authorization rules may apply. (1) **In-Network and Out-of-network** $0 copayment for Supportive Care services*. (2)

Services that are covered for you	What you must pay when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. For emergency services or urgently needed care (not scheduled or elective care) in a foreign country (**Worldwide coverage***): • Physician services • Outpatient services • Room, board, and ancillaries • Emergency transportation	**In-Network and Out-of-network** $50 copayment to the facility for each covered urgently needed care visit. If you get additional services at an out-of-network facility as part of your urgently needed care visit, your cost is the cost-sharing you would pay to a network provider. For cost-sharing for physician services (if billed separately), see In-Network *Physician/Practitioner services, including doctor's office visits*. **Worldwide coverage*** 100% for amounts above the plan's eligible charges for physician services. (2) 100% for any amounts above the plan's eligible charges for outpatient services. (2) 10% of the cost of the plan's eligible charge for hospital room, board and ancillaries. (2) 10% of the cost for emergency transportation. (2)

Services that are covered for you	What you must pay when you get these services
Vision care Medicare-covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each calendar year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant	**In-Network** $10 copayment for Medicare-covered eye exams to diagnose and treat diseases and injuries of the eye. $0 copayment for Medicare-covered glaucoma screening once per calendar year. $0 copayment for one Medicare-covered pair of eyeglasses with standard frames or contact lenses from a Medicare-approved provider after each Medicare-covered cataract surgery. **Out-of-network** 40% of the cost for Medicare-covered eye exams to diagnose and treat diseases and injuries of the eye. $0 copayment for Medicare-covered glaucoma screening once per calendar year. $0 copayment for one Medicare-covered pair of eyeglasses with standard frames or contact lenses from a Medicare-approved provider after each Medicare-covered cataract surgery. **In-Network and Out-of-network** See Chapter 12 for a definition of *Medicare-approved provider*. If you receive consultation, diagnosis, or treatment by a specialist, see *Physician/Practitioner services, including doctor's office visits* for cost-sharing.

Services that are covered for you	What you must pay when you get these services
Vision care (continued) Supplemental covered services include: • One routine eye exam every calendar year* • The plan will pay up to $300 every calendar year for any combination of eyeglasses with standard frames, contact lenses, and contact lens fitting* • International travel solution: We cover the following services when you travel abroad*: o Receive a temporary pair of glasses in case of an emergency o Get help to find an eye doctor (Out-of-network benefits apply) (See Section 3.1 of this chapter for a list of exclusions)	**In-Network** $10 copayment for one routine eye exam every calendar year.* **Out-of-network** 40% of the cost for one routine eye exam every calendar year.* **In-Network and Out-of-network** 100% for any amounts above the plan coverage limit for routine eyewear. Plan pays up to $300 every calendar year, for any combination of frames, lenses, contact lenses, or contact lens fitting.*
Welcome to Medicare preventive visit The plan covers the one-time **Welcome to Medicare** preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the **Welcome to Medicare** preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your **Welcome to Medicare** preventive visit.	**In-Network** $0 copayment for EKG service performed as a screening as part of the **Welcome to Medicare** preventive visit. **Out-of-Network** $0 copayment for EKG service performed as a screening as part of the **Welcome to Medicare** preventive visit. **In-Network and Out-of-network** There is no coinsurance or copayment for the **Welcome to Medicare** preventive visit.

Notes to the Benefits Chart

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

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

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

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

Section 2.2 Getting care using our plan's optional visitor/traveler benefit

If you do not permanently move, but you are continuously away from our plan's service area for more than six months, we usually must disenroll you from our plan. However, we offer a visitor/traveler program, which will allow you to remain enrolled when you are outside of our service area for less than 12 months. Under our visitor/traveler program you may receive all plan covered services at in-network cost-sharing. Please contact the plan for assistance in locating a provider when using the visitor/traveler benefit.

If you are in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you have not returned to the plan's service area within 12 months, you will be disenrolled from the plan.

The visitor/traveler program includes Blue Medicare Advantage PPO network coverage of all Part A, Part B and supplemental benefits offered by your plan outside your service area in 48 states, the District of Columbia, and 1 territory: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and West Virginia. For some of the states listed, MA PPO networks are only available in portions of the state.

(This list is current as of September 2023 and may change. For an updated list of states and to learn more, visit www.hmsa.com/health-plans/medicare/travel-program/.)

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

When you see Blue Medicare Advantage PPO providers in any geographic area where the visitor/traveler program is offered, you will pay the same cost-sharing level (in-network cost-sharing) you would pay if you

received covered benefits from in-network providers in their service area. Please see the Medicare Benefits Chart for cost-sharing information.

Your Liability Calculation

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

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

Nonparticipating Healthcare Providers Outside Our Service Area

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

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

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

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	**Not covered under any condition**	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition**	
Full-time nursing care in your home.	**Not covered under any condition**	
Home-delivered meals	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	**Not covered under any condition**	
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	
Non-routine dental care.		• Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Outpatient prescription drugs received in a foreign country	**Not covered under any condition**	
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition**	
Private room in a hospital.		• Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	**Not covered under any condition**	
Routine chiropractic care		• Manual manipulation of the spine to correct a subluxation is covered.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.	No payment will be made for: broken, lost or stolen lenses, contact lenses or frames; sunglasses; prescription inserts for diving masks and any protective eyewear; non-prescription industrial or safety glasses; non-standard items for lenses including tinting, blending, oversized lenses and invisible bifocal and trifocals, repair and replacement of frame parts and accessories.	• Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Routine eye exam and any combination of eyeglasses with standard frames, contact lenses, and contact lens fitting are covered as supplemental benefit. See *Vision care* for more information about the services we cover.
Routine foot care		• Some limited coverage provided according to Medicare guidelines, (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids.	**Not covered under any condition**	
Services considered not reasonable and necessary, according to Original Medicare standards.	**Not covered under any condition**	

CHAPTER 5:
Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Section 1.1 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*).
- Your drug must be used for a medically accepted indication. A medically accepted indication is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider Directory*, visit our website (www.hmsa.com/advantage), and/or call Customer Relations.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Customer Relations or use the *Provider Directory*. You can also find information on our website at www.hmsa.com/advantage.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy. Home infusion pharmacies service all islands even though they may not be physically located on each island.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Relations.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (*Note*: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider Directory* or call Customer Relations.

Section 2.3 Using the plan's mail-order service

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

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

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

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

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

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

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

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

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

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

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

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

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4 How can you get a long-term supply of drugs?

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

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Provider Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Relations for more information.

2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Customer Relations** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

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

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

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

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

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

The plan has a *List of Covered Drugs (Formulary).* In this *Evidence of Coverage*, **we call it the "Drug List" for short**.

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

The drugs on the "Drug List" are only those covered under Medicare Part D.

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

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- -- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The "Drug List" includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the "Drug List", when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Customer Relations. See Chapter 4, Section 2.1 for information about our over-the-counter benefit.

What is *not* on the "Drug List"?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the "Drug List". In some cases, you may be able to obtain a drug that is not on the "Drug List". For more information, please see Chapter 9.

Section 3.2 There are five cost-sharing tiers for drugs on the "Drug List"

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

- **Cost-Sharing Tier 1: Preferred Generic**
  Tier 1 is the lowest tier and includes preferred generic drugs and may include some brand drugs.
- **Cost-Sharing Tier 2: Generic**
  Tier 2 includes generic drugs and may include some brand drugs.
- **Cost-Sharing Tier 3: Preferred Brand**
  Tier 3 includes preferred brand drugs and non-preferred generic drugs.
- **Cost-Sharing Tier 4: Non-Preferred Drug**
  Tier 4 includes non-preferred brand drugs and non-preferred generic drugs.
- **Cost-Sharing Tier 5: Specialty Tier**

Tier 5 is the highest tier. It contains very high cost brand and generic drugs, which may require special handling and/or close monitoring.

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

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the "Drug List"?

You have four ways to find out:

1. Check the most recent "Drug List" we provided electronically.

2. Visit the plan's website (www.hmsa.com/advantage). The "Drug List" on the website is always the most current.

3. Call Customer Relations to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.

4. Use the plan's "Real-Time Benefit Tool" (through your HMSA MyAccount or by calling Customer Relations). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition. To get to the "Real-Time Benefit Tool", log into your HMSA MyAccount and go to Manage My Drugs Online. Then, click on "Plan & Benefits", "Rx Savings" from the drop down menu, and select "Check Drug Cost & Coverage".

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the "Drug List". If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Relations to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9)

Restricting brand name drugs or original biological products when a generic or interchangeable biosimilar version is available

Generally, a **generic** drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. **In most cases, when a generic or interchangeable biosimilar version of a brand name drug or original biological product is available, our network pharmacies will provide you the generic or interchangeable biosimilar version instead of the brand name drug or original biological product.** However, if your provider has told us the medical reason that neither the generic drug or interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug or original biological product. (Your share of the cost may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

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

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- **The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be.**
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the "Drug List" or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the "Drug List" or if the drug is restricted in some way

If your drug is not on the "Drug List" or is restricted, here are options:

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

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

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

- **If you are a new member,** we will cover a temporary supply of your drug **during the first 90 days of your membership in the plan.**
- **If you were in the plan last year,** we will cover a temporary supply of your drug **during the first 90 days of the calendar year**.

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

For questions about a temporary supply, call Customer Relations.

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

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Relations to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

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

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

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

You can change to another drug

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

You can ask for an exception

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 (Specialty Tier) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The "Drug List" can change during the year

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

- **Add or remove drugs from the "Drug List".**
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

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

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the "Drug List" occur, we post information on our website about those changes. We also update our online "Drug List" on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the plan year

- **A new generic drug replaces a brand name drug on the "Drug List" (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
  - We may immediately remove a brand name drug on our "Drug List" if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our "Drug List", but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
  - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.
- **Unsafe drugs and other drugs on the "Drug List" that are withdrawn from the market**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the "Drug List". If you are taking that drug, we will tell you right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the "Drug List"**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the "Drug List" or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - For these changes, we must give you at least 30 days' advance notice of change or give you a notice of change and a 30-day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should work with your provider to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
  - You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

Changes to the "Drug List" that do not affect you during this plan year

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

In general, changes that will not affect you during the current plan year are:

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

If any of these changes happen for a drug you are taking (except for a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your

use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug.

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

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are excluded. This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

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

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

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

If you are receiving "Extra Help" to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

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

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

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

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

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

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

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

Check your *Provider Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Relations. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our "Drug List" or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

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

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

Special note about creditable coverage:

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

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

Keep this notice about creditable coverage, because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

All medically necessary and appropriate drugs are covered by our plan. If you are enrolled in Medicare hospice and require a drug, such as an anti-nausea, laxative, pain medication, or anti-anxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

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

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

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

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

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

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the

right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end of life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

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

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

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Customer Relations.

CHAPTER 6:
What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Customer Relations and ask for the LIS Rider.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use *drug* in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 5, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real Time Benefit Tool" by calling Customer Relations.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called **cost-sharing**, and there are three ways you may be asked to pay.

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

Section 1.3 How Medicare calculates your out-of-pocket costs

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

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

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

- The amount you pay for drugs when you are in any of the following drug payment stages:

  - The Deductible Stage
  - The Initial Coverage Stage
  - The Coverage Gap Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included in your out-of-pocket costs. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $8,000 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments <u>are not included</u> in your out-of-pocket costs

Your out-of-pocket costs **<u>do not include</u>** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Relations.

How can you keep track of your out-of-pocket total?

- **We will help you**. The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $8,000, this report will tell

you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for *HMSA Akamai Advantage Complete* members?

There are four **drug payment stages** for your prescription drug coverage under *HMSA Akamai Advantage Complete*. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the Part D EOB)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**.
- We keep track of your **Total Drug Costs**. This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month we will send you a Part D EOB. The Part D EOB includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called year-to-date information. It shows the total drug costs and total payments for your drug since the year began.

- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost-sharing for each prescription claim.

Section 3.2 Help us keep our information about your drug payments up to date

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

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

SECTION 4 During the Deductible Stage, you pay the full cost of your Tiers 2, 3, 4 and 5 drugs

The Deductible Stage is the first payment stage for your drug coverage. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines. You will pay a yearly deductible of $380 on Tiers 2, 3, 4 and 5 drugs. **You must pay the full cost of your Tiers 2, 3, 4 and 5 drugs** until you reach the plan's deductible amount. For all other drugs you will not have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid $380 for your Tiers 2, 3, 4 and 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

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

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

The plan has five cost-sharing tiers

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

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

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

Your pharmacy choices

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

- A network retail pharmacy.
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Provider Directory.*

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

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

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

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

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Mail-order cost-sharing (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (*Preferred Generic*)	$4.50 copayment	$4.50 copayment	$4.50 copayment	$4.50 copayment
Cost-Sharing Tier 2 (*Generic*)	$12 copayment	$12 copayment	$12 copayment	$12 copayment
Cost-Sharing Tier 3 (*Preferred Brand*)	$47 copayment	$47 copayment	$47 copayment	$47 copayment
Cost-Sharing Tier 4 (*Non-Preferred Drug*)	$100 copayment	$100 copayment	$100 copayment	$100 copayment
Cost-Sharing Tier 5 (*Specialty Tier*)	27% of the cost	27% of the cost	27% of the cost	27% of the cost

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

Please see Section 8 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

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

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

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

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

Section 5.4 A table that shows your costs for a *long-term* (100-day) supply of a drug

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

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

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

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard retail cost-sharing (in-network) (100-day supply)	Mail-order cost-sharing (100-day supply)
Cost-Sharing Tier 1 (*Preferred Generic*)	$13.50 copayment	$4.50 copayment
Cost-Sharing Tier 2 (*Generic*)	$36 copayment	$12 copayment
Cost-Sharing Tier 3 (*Preferred Brand*)	$141 copayment	$94 copayment
Cost-Sharing Tier 4 (*Non-Preferred Drug*)	$300 copayment	$200 copayment
Cost-Sharing Tier 5 (*Specialty Tier*)	27% of the cost	27% of the cost

You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply at retail for each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

At Mail-order, you will pay no more than $70 for up to a two-month supply of covered insulin products on Tier 3, Tier 4, or Tier 5. For a three-month supply at Mail-order, you will pay no more than $70 for Tier 3 and Tier 4 and up to $105 for Tier 5 for each covered insulin product.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $5,030

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$5,030 limit for the Initial Coverage Stage**.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $5,030 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. Only the amount you pay counts and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount $8,000, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs (Section 1.3).

Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

You won’t pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 8 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List." Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Refer to your plan's "Drug List" or contact Customer Relations for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

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

Your costs for a Part D vaccination depends on three things:

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

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

2. Where you get the vaccine.

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

3. Who gives you the vaccine.

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

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

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

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

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

- For most adult Part D vaccines, you will pay nothing.

- For other Part D vaccines, you will pay the pharmacy your coinsurance or copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

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

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

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

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

CHAPTER 7:

Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. Or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called **reimbursing** you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

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

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received medical care from a provider who is not in our plan's network

When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. When a network provider sends you a bill you think you should not pay

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

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's "Drug List"; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

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

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

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

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

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

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

Part D Prescription drugs:

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

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

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

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

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

Please include a cover letter with:

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

- The charge for each service
- Your signature

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

Hospital, Physician, Lab, etc.:

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

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

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

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

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

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

Routine vision items and services:

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

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

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

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

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

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

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

CHAPTER 8:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Relations.

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with HMSA's Civil Rights Coordinator,
818 Ke'eaumoku St., Honolulu, HI 96814, 1-800-776-4672, TTY users call 711, Fax: (808) 948-6414, Email: Compliance_Ethics@hmsa.com. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

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

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

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

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

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Relations.

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

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

If you want any of the following kinds of information, please call Customer Relations:

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

Section 1.5 We must support your right to make decisions about your care

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

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

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

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

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

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

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

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an **advance directive** to give your instructions, here is what to do:

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

Island	Advance Directive Forms – Contact Information
OAHU	For information about advance directive, printing the form, or if you want to talk to an operator, contact Kōkua Mau. Phone: (808) 585-9977 (Please leave a voice message and Kōkua Mau will call you back). Write: Kōkua Mau P.O. Box 62155 Honolulu, HI 96839 Email: Go to https://kokuamau.org/contact-kokua-mau/ to send an email. Website: www.kokuamau.org For legal assistance if you are over 60 years old, on behalf of anyone over 60 years or older, or in need of economic assistance, contact University of Hawai‘i Elder Law Program. Phone: (808) 956-6544. This number is available 8:30 am - 4:30 pm, Monday through Friday. For legal assistance or information about your rights, which includes advance directive, contact Legal Aid Society of Hawai‘i. Phone: (808) 536-4302. This number is available 9:00 am - 11:30 am and 1:00 pm - 3:30 pm, Monday through Friday.
HAWAII AND MAUI	On Hawaii and Maui, contact Legal Aid Society of Hawai‘i. Phone: 1-800-499-4302. This number is available 9:00 am - 11:30 am and 1:00 pm - 3:30 pm, Monday through Friday.
KAUAI	On Kauai, you may contact University of Hawai‘i Elder Law Program. Phone: (808) 956-6544. This number is available 8:30 am - 4:30 pm, Monday through Friday.
LANAI	On Lanai, contact Legal Aid Society of Hawai‘i. Phone: 1-800-499-4302. This number is available 9:00 am - 11:30 am and 1:00 pm - 3:30 pm, Monday through Friday.
MOLOKAI	On Molokai, contact Legal Aid Society of Hawai‘i. Phone: 1-800-499-4302. This number is available 9:00 am - 11:30 am and 1:00 pm - 3:30 pm, Monday through Friday.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can’t. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

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

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

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

However, if you have a problem or concern about a health care facility (including hospitals, nursing homes, home health agencies, end-stage renal disease (ESRD) facilities, and other facilities serving Medicare and Medicaid members), contact Office of Health Care Assurance (OHCA) through any of the methods listed below.

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

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

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

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Relations**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.

- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

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

There are several places where you can get more information about your rights:

- You can **call Customer Relations**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Relations.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay your Medicare Part B premiums to remain a member of the plan.
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.

  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9:

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints;** also called grievances.

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

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

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says making a complaint rather than filing a grievance, coverage decision rather than organization determination or coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which

process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

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

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 10** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as **medical care**. You use the

coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied with this decision, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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

- You **can call us at Customer Relations**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Relations and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
  - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Customer Relations and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.hmsa.com/help-center/forms/medicare-appoint-representative/.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: Your medical care: How to ask for a coverage decision or make an appeal
- **Section 6** of this chapter: Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

- **Section 7** of this chapter: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon
- **Section 8** of this chapter: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, hospice care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Relations. You can also get help or information from government organizations such as your SHIP.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay*). In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this is covered by our plan. **Ask for a coverage decision. Section 5.2.**

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**

3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**

4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **organization determination.** A *fast coverage decision* is called an **expedited determination**.

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

A standard coverage decision is usually made within 14 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

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

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

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service.** If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

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

- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe.

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

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

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

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

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

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

- If you are appealing a decision, we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.

- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We are allowed to charge a fee for copying and sending this information to you.

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

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 10 of this chapter for information on complaints.)

- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

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

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

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

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

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

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

- For the standard appeal if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization**.**
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.). In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Level 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this coverage decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request**: If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5, Section 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term *Drug List* instead of *List of Covered Drugs* or *Formulary*.

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Terms
An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 6.2 What is an exception?

Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our "Drug List".** If we agree to cover a drug not on the "Drug List", you will need to pay the cost-sharing amount that applies to drugs in Tier 5 (Specialty Tier). You cannot ask for an exception to the cost sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our "Drug List". If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our "Drug List" is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

- If our "Drug List" contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
- If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (Specialty Tier).
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our "Drug List" includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Terms
A fast coverage decision is called an **expedited coverage determination.**

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

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the supporting statement,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

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

Section 6.5 Step-by-step: How to make a Level 1 appeal

Legal Terms

An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.**

A fast appeal is also called an **expedited redetermination.**

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

A standard appeal is usually made within 7 days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal.**

- For standard appeals, submit a written request or call us. Chapter 2 has contact information.
- For fast appeals either submit your appeal in writing or call us at (808) 948-6000. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.

- If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within **30 calendar days** after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 Step-by-step: How to make a Level 2 appeal

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a "fast appeal."
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no **to part or all of** your appeal**,** it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It is also called **turning down your appeal**.). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.

- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Customer Relations or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. Read this notice carefully and ask questions if you don’t understand it. It tells you:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. You will be asked to sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. Keep your copy of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Relations or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Relations. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or, find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge date.**
  - **If you meet this deadline,** you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Relations or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to Level 2 of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal to change your hospital discharge date?

Legal Terms
A fast review (or fast appeal) is also called an **expedited appeal.**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review**. This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.

- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

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

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

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must (pay you back) for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
  - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is about three services only:* Home health care, skilled nursing facility care, hospice care, and Comprehensive Outpatient Rehabilitation Facility (CORF) service

When you are getting covered **home health services, skilled nursing care, hospice care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.2 We will tell you in advance when your coverage will be ending

Legal Terms

Notice of Medicare Non-Coverage. It tells you how you can request a **fast-track appeal.** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. You receive a notice in writing at least two days before our plan is going to stop covering your care. The notice tells you:

- The date when we will stop covering the care for you.
- How to request a fast track appeal to request us to keep covering your care for a longer period of time.

2. You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it. Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

Section 8.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**

- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Relations. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you received (Notice of Medicare Non-Coverage) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

Legal Terms
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (*the reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you**.
- If you decide to keep getting the home health care, or skilled nursing facility care, or hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 8.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You could ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter talks more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Legal Terms
A *fast review* (or *fast appeal*) is also called an **expedited appeal.**

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review**. This means you are asking us to give you an answer using the *fast* deadlines rather than the *standard* deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

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

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your fast appeal. This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.

- The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal	A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Relations? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Relations or other staff at the plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast appeal, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

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

Section 10.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Relations is the first step.** If there is anything else you need to do, Customer Relations will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- If you call us or send us your complaint in writing, we will file your complaint for you. To process your complaint, we will need the following information:
  - Your full name.
  - Your member ID number.
  - A daytime telephone number where we can reach you.
  - A description of the complaint, including the date it occurred.
  - Address of office location, and name of practitioners, providers, or their staff who were involved, if applicable.
  - Any documents you would like us to consider when resolving your complaint.
  - Your signature or the signature of your representative, if the complaint is sent to us in writing. (Addresses are printed on the back cover of this document).

  If you want a friend, relative, your doctor or other provider, or other person to be your representative, then you will need to submit an "Appointment of Representative" form. The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. To obtain the form you can do the following:

  - Download the form on our website at www.hmsa.com/help-center/forms/medicare-appoint-representative/
  - Call Customer Relations (phone numbers are printed on the back cover of this document) and ask for the "Appointment of Representative" form.
  - Download the form on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf

  Reminder: A representative form is valid for one year from the date it has signatures for both the enrollee and the appointee, unless revoked. For example, if the enrollee signs the form on January 1, 2024 and the representative signs on January 3, 2024 (or vice versa), the form is effective for one year starting on January 3, 2024.

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

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization.**
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about *HMSA Akamai Advantage Complete* directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

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

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the **Annual Open Enrollment Period**). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open** E**nrollment Period**, you can:

- Switch to another Medicare Advantage Plan with or without prescription drug coverage.
- Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.

- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

In certain situations, members of *HMSA Akamai Advantage Complete* may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have QUEST Integration (Medicaid).
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.
- - *or* - Original Medicare *without* a separate Medicare prescription drug plan.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Your membership will usually end on the first day of the month after your request to change your plan is received.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Customer Relations**.
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from *HMSA Akamai Advantage Complete* when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from *HMSA Akamai Advantage Complete* when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Customer Relations if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from *HMSA Akamai Advantage Complete* when your coverage in Original Medicare begins.

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

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

- **Continue to use our network providers to receive medical care.**

- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 *HMSA Akamai Advantage Complete* must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

***HMSA Akamai Advantage Complete* must end your membership in the plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Customer Relations to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for two calendar months.
  - We must notify you in writing that you have two calendar months to pay the plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Customer Relations.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

HMSA Akamai Advantage Complete is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11:
Legal Notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at Customer Relations. If you have a complaint, such as a problem with wheelchair access, Customer Relations can help.

Hawai‘i Medical Service Association ("HMSA") complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

HMSA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 1-800-776-4672 toll-free. TTY 711.

Filing a Grievance with HMSA
If you believe that HMSA has discriminated in any way on the basis of race, color, national origin, age,

disability, sex, gender identity, or sexual orientation, you can file a grievance with HMSA's Civil Rights Coordinator in a number of ways as listed below:

Mail: 818 Keʻeaumoku St., Honolulu, HI 96814

Phone: 1-800-776-4672 toll-free; TTY users, call 711.

Fax: (808) 948-6414

Email: Compliance_Ethics@hmsa.com

You can also file a grievance in person. If you need help filing a grievance, HMSA's Civil Rights Coordinator is available to help you.

Such grievances must be submitted to HMSA's Civil Rights Coordinator within 60 days from the date you become aware of the alleged discriminatory action(s).

Filing a Complaint with the Federal Government
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

Mail: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201,

Phone: 1-800-368-1019 toll-free; TDD users, call 1-800-537-7697 toll-free.

You can review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Such complaints must be filed within 180 days of the date of the alleged discrimination.

SECTION 3 Notice about member non-liability

In the event HMSA fails to reimburse a Network provider's charge for covered services, you will not be liable for any sums owed by HMSA.

SECTION 4 Notice about when others are responsible for injuries

We do not pay medical expenses which are covered by workers' compensation insurance or automobile insurance coverage required by Hawaii state law. When others may be responsible for payment of your medical expenses or prescription drugs (due to tort liability, insurance or otherwise), our third-party liability rules apply and you should request a copy of these rules from us. You must give us prompt written notice of your injuries, claims, and demands for recovery and recoveries received, and must promptly fill out and return to us all papers we require to determine coverage and to secure our reimbursement rights for any

amounts we pay. Medicare and HMSA have liens and rights of reimbursement to the full extent of any expenses paid.

SECTION 5 Notice about our privacy policies and practices for personal financial information required by law

(Privacy of Consumer Financial Information, H.R.S. Chapter 431, Article 3A, eff. July 1, 2002) HMSA is required by state law to provide an annual notice of our privacy policies and practices for personal financial information to members who are enrolled in our individual health plans. This section contains information regarding how we collect and disclose personal financial information about our members to our affiliates and to nonaffiliated third parties. This applies to former as well as current HMSA members.

HMSA and our affiliated organizations throughout the state of Hawaii have established the following policies and practices:

- Maintain physical, technical and administrative safeguards to protect the privacy, confidentiality, and integrity of personal information.
- Ensure that those in our workforce who have access to or use your personal information need that information to perform their jobs and have been trained to properly handle personal information. Our employees are fully accountable to management for following our policies and practices.
- Require that third parties who access your personal information on our behalf comply with applicable laws and agree to HMSA's strict standards of confidentiality and security.

Collection of personal financial information
HMSA collects personal financial information about you that is necessary to administer your health plan. We may collect personal financial information about you from sources such as applications or other forms that you complete and your transactions with us, our affiliates, or others.

Sharing of personal financial information
HMSA may share with our affiliates and with nonaffiliated third parties any of the personal financial information that is necessary to administer your health plan as permitted by law. Nonaffiliated third parties are those entities that are not part of HMSA and its affiliates. We do not otherwise share your personal financial information with anyone without your permission.

SECTION 6 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, *HMSA Akamai Advantage Complete,* as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

In some situations, other parties should pay for your medical care before your Medicare Advantage health plan. In those situations, your Medicare Advantage plan may pay, but have the right to get the payments back from these other parties. Medicare Advantage plans may not be the primary payer for medical care you receive. These situations include those in which the Federal Medicare Program is considered a secondary

payer under the Medicare Secondary Payer laws. For information on the Federal Medicare Secondary Payer program, Medicare has written a document with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First (publication number 02179).* You can get a copy by calling 1-800-MEDICARE, 24 hours a day, 7 days a week, or by visiting the www.medicare.gov web site.

Our rights to recover in these situations are based on the terms of this health plan contract, as well as the provisions of the Federal statutes governing the Medicare Program. Your Medicare Advantage plan coverage is always secondary to any payment made or reasonably expected to be made under:

- A workers compensation law or plan of the United States or a State,
- Any non-fault based insurance, including automobile and non-automobile no-fault and medical payments insurance,
- Any liability insurance policy or plan (including a self-insured plan) issued under an automobile or other type of policy or coverage, and
- Any automobile insurance policy or plan (including a self-insured plan), including, but not limited to, uninsured and underinsured motorist coverages.

Since your Medicare Advantage plan is always secondary to any automobile no-fault (Personal Injury Protection) or medical payments coverage, you should review your automobile insurance policies to ensure that appropriate policy provisions have been selected to make your automobile coverage primary for your medical treatment arising from an automobile accident.

SECTION 7 Notice about Subrogation and Third Party Liability

We do not pay any medical expenses which are covered by workers' compensation insurance or automobile insurance coverage required by Hawaii state law.

If you suffer an injury or illness for which a third party is responsible due to a negligent or intentional act, you must promptly notify us. If we make any payment on your behalf for covered services when others are responsible for the illness or injury, we have the right to be repaid the full cost of benefits provided or paid by us. You are required to cooperate with us in pursuing such recoveries.

You must also notify us of any claims or demands for recoveries and recoveries received. HMSA has a right to restitution or reimbursement from any recovery obtained by you or on your behalf from any third party responsible for your injury or illness.

As outlined herein, in these situations, we may make payments on your behalf for this medical care, subject to the conditions set forth in this provision for us to recover these payments from you or from other parties. Immediately upon making any conditional payment, we shall be subrogated to (stand in the place of) all rights of recovery you have against any person, entity or insurer responsible for causing your injury, illness or condition or against any person, entity or insurer listed as a primary payer above.

In addition, if you receive payment from any person, entity or insurer responsible for causing your injury, illness or condition or you receive payment from any person, entity or insurer listed as a primary payer above, we have the right to recover from, and be reimbursed by you for all conditional payments we have made or will make as a result of that injury, illness or condition.

We will automatically have a lien to the extent of benefits it paid for the treatment of the injury, illness or condition, upon any recovery whether by settlement, judgment or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits we have paid including, but not limited to, you, your representatives or agents, any person, entity or insurer responsible for causing your injury, illness or condition or any person, entity or insurer listed as a primary payer above. By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds.

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any health care provider) from your Medicare Advantage plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be paid to the plan before any other claim for your damages. We shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery to you which is insufficient to make you whole or to compensate you in part or in whole for the damages you sustained. We are not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

We are entitled to full recovery regardless of whether any liability for payment is admitted by any person, entity or insurer responsible for causing your injury, illness or condition or by any person, entity or insurer listed as a primary payer above. We are entitled to full recovery regardless of whether the settlement or judgment received by you identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. We are entitled to recover from any and all settlements or judgments, even those designated as for pain and suffering, non-economic damages and/or general damages only.

You, and your legal representatives, shall fully cooperate with our efforts to recover the benefits that we paid. It is your duty to notify us within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by us or our representatives. You shall do nothing to prejudice our subrogation or recovery interest or to prejudice our ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

Failure to provide requested information or failure to assist us in pursuit of its subrogation or recovery rights may result in you being personally responsible for reimbursing us for benefits paid relating to the injury, illness or condition as well as for our reasonable attorney fees and costs incurred in obtaining reimbursement from you. For more information, see 42 U.S.C. § 1395y(b)(2)(A)(ii) and the Medicare statutes.

SECTION 8 Notice about Reporting Fraud, Waste, and Abuse

HMSA is committed to identifying and preventing fraud, waste and abuse under Medicare. You can assist us by reporting any potential cases of health care fraud to us. This includes instances in which a health care provider bills for services you never got or for equipment different from what you got. If you are concerned about any of the charges, items or services appearing on a bill or Explanation of Benefits, or if you suspect fraudulent activity, please call our fraud hotline at (808) 948-5166 or toll-free at 1-888-398-6445. This hotline allows you to report cases confidentially.

CHAPTER 12:
Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

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

Benefit Period – The way that your use of skilled nursing facility (SNF) services is measured. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service drug is received.

Cost-sharing Tier – Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Relations – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Relations.

Daily Cost-sharing Rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your daily cost-sharing rate is $1 per day.

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

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are: (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

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

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. For more information on the Hospice care benefit, see *Hospice care in* Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $5,030.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

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

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Lifetime Reserve Days – You are eligible for an additional 60 Medicare-covered inpatient hospital days after the first 90 days of your Medicare-covered hospital stay. These 60 reserve days can be used only once during your lifetime.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

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

Medicare-approved Provider – A Medicare-approved provider is a Medicare-enrolled DMEPOS supplier or any eligible professional or practitioner eligible to bill for Medicare services and supplies. Certain durable equipment, prosthetics, orthotics, and supplies are dispensed by these Medicare-approved providers. To find a Medicare-approved provider near you, go to www.medicare.gov/medical-equipment-suppliers/.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – **Provider** is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Observation Care – A stay in a hospital for less than 48 hours if: (1) You have not been admitted for an inpatient stay; (2) you are physically detained in an emergency room, treatment room, observation room, or other such area; or (3) you are being observed to determine whether an inpatient confinement will be required.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (**Traditional Medicare or Fee-for-service Medicare**) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

Palliative Care – Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care involves addressing physical, intellectual, emotional, social, and spiritual needs to facilitate patient autonomy, access to information, and choice.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Real Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Rebatable drugs – The Inflation Reduction Act of 2022 requires drug companies to pay a rebate if they raise their prices for certain drugs faster than the rate of inflation. If you receive any of these Part B medications, you may pay a lower coinsurance. If you pay more on the date of services, our plan must issue you a refund.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Form Approved
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hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1 (800) 660-4672 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1 (800) 660-4672 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1 (800) 660-4672 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1 (800) 660-4672 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1 (800) 660-4672 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1 (800) 660-4672 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1 (800) 660-4672 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1 (800) 660-4672 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1 (800) 660-4672 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1 (800) 660-4672 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إنني أقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديني. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1 (800) 660-4672 (TTY: 711). هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1 (800) 660-4672 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1 (800) 660-4672 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1 (800) 660-4672 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1 (800) 660-4672 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1 (800) 660-4672 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1 (800) 660-4672 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

HMSA Medicare Advantage Customer Relations

CALL	(808) 948-6000 or 1 (800) 660-4672 daily, 8 a.m.-8 p.m. Calls to these numbers are free. Customer Relations also has free language interpreter services available for non-English speakers.
TTY	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	(808) 948-6433
WRITE	HMSA Medicare Advantage Customer Relations P.O. Box 860 Honolulu, HI 96808-0860
WEBSITE	hmsa.com/advantage
VISIT	Hours of operation may change. Please go to hmsa.com/contact before your visit. HMSA Centers with extended evening and weekend hours **Honolulu, Oahu** | 818 Keeaumoku St. Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m. **Pearl City, Oahu** | Pearl City Gateway, 1132 Kuala St., Suite 400 Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m. **Hilo, Hawaii Island** | Waiakea Center, 303A E. Makaala St. Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m. **Kahului, Maui** | Puunene Shopping Center, 70 Hookele St. Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m. **Lihue, Kauai** | Kuhio Medical Center, 3-3295 Kuhio Highway, Suite 202 Monday–Friday, 8 a.m.–4 p.m.

Hawai'i SHIP

Hawai'i SHIP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

CALL	(808) 586-7299 or 1 (888) 875-9229 Monday-Sunday. This is a prerecorded helpline. Calls will be returned within five business days.
TTY	1 (866) 810-4379. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Hawai'i SHIP Executive Office on Aging Hawaii State Department of Health No. 1 Capitol District 250 S. Hotel St., Suite 406 Honolulu, HI 96813-2831
WEBSITE	hawaiiship.org

8700-841402 8.23

Evidence of Coverage

HMSA Akamai Advantage
Complete Plus (PPO)

2024

MedicareRx Prescription Drug Coverage

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

H3832_1150_8700_837147_AA_Complete_Plus_24_C

January 1 – December 31, 2024

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of *HMSA Akamai Advantage Complete Plus (PPO)*.

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2024. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

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

This plan, *HMSA Akamai Advantage Complete Plus*, is offered by Hawai‘i Medical Service Association (HMSA) (HMSA Akamai Advantage®). (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means **Hawai‘i** Medical Service Association (HMSA). When it says “plan” or “our plan,” it means *HMSA Akamai Advantage Complete Plus.*)

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

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

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2025.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

OMB Approval 0938-1051 (Expires: February 29, 2024)

2024 Evidence of Coverage

Table of Contents

CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in *HMSA Akamai Advantage Complete Plus*, which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, *HMSA Akamai Advantage Complete Plus*. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

HMSA Akamai Advantage Complete Plus is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/affordable-care-act/individuals-and-families for more information.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care and services and the prescription drugs available to you as a member of *HMSA Akamai Advantage Complete Plus*.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned or just have a question, please contact Customer Relations.

Section 1.3 Legal information about the *Evidence of Coverage*

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

The contract is in effect for months in which you are enrolled in *HMSA Akamai Advantage Complete Plus* between January 1, 2024, and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of *HMSA Akamai Advantage Complete Plus* after December 31, 2024. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve *HMSA Akamai Advantage Complete Plus* each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States

Section 2.2 Here is the plan service area for *HMSA Akamai Advantage Complete Plus*

HMSA Akamai Advantage Complete Plus is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes the City & County of Honolulu (island of Oahu).

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Relations to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

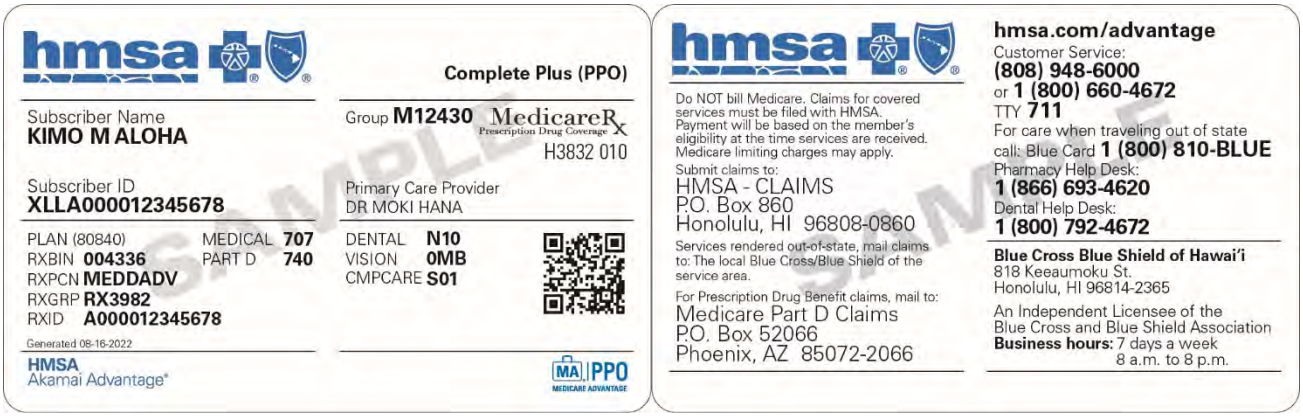
Section 2.3 U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify *HMSA Akamai Advantage Complete Plus* if you are not eligible to remain a member on this basis. *HMSA Akamai Advantage Complete Plus* must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



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

If your plan membership card is damaged, lost, or stolen, call Customer Relations right away and we will send you a new card.

Section 3.2 *Provider Directory*

The *Provider Directory* lists our current network providers, durable medical equipment suppliers, and pharmacies.

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

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

The most recent list of providers is available on our website at www.hmsa.com/advantage. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have your copy of the *Provider Directory*, you can request a copy (electronically or in hardcopy form) from Customer Relations. Requests for hard copy Provider Directories will be mailed to you within three business days.

Section 3.3 The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in *HMSA Akamai Advantage Complete Plus*. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the *HMSA Akamai Advantage Complete Plus* Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.hmsa.com/advantage) or call Customer Relations.

SECTION 4 Your monthly costs for *HMSA Akamai Advantage Complete Plus*

Your costs may include the following:

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

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

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

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

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2024* handbook, the section called 2024 *Medicare Costs*. If you need a copy you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. For 2024, the monthly premium for *HMSA Akamai Advantage Complete Plus* is $120.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly or quarterly premium. When you first enroll in *HMSA Akamai Advantage Complete Plus,* we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
  - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
  - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount is $34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $34.70, which equals $4.858. This rounds to $4.86. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

There are three important things to note about this monthly Part D late enrollment penalty:

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

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

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

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

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

SECTION 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium

There are four ways you can pay your plan premium.

Option 1: Paying by check, in person or by phone

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

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

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

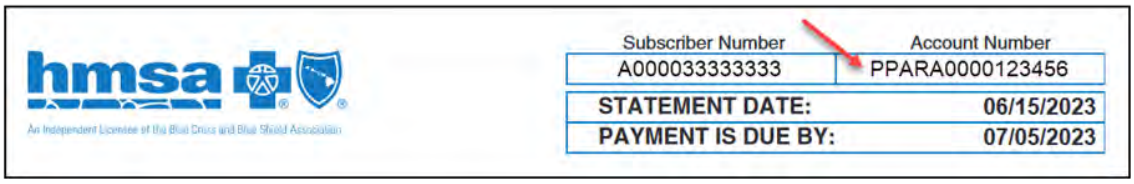
If you are submitting a payment for multiple accounts, please include either both bill stubs or both member ID numbers and Account Numbers which is located on the upper right hand of your premium billing statement with the check and clear instructions on how much you would like credited to each account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

You can also pay your bill by calling the toll-free IVR payment system phone number on your bill (1-855-613-9221). You will be able to pay using your checking or savings account or using a credit or debit card. To pay by phone, you will need the Account Number on your bill, and the routing and account number of your bank account or the credit or debit card you plan to use.

When paying by phone:

- Call toll free at 1-855-613-9221: it’s available 24 hours, 7 days a week.
- Only enter the last portion of the account number beginning with PPARA which appears at the top of your bill, ignoring the letter and all leading zeroes.

Example:



There are no additional fees to use our Pay by Phone services!

Option 2: You can have the premium paid directly from your bank account

You can have your monthly plan premium automatically withdrawn from your bank checking or savings account each month. If you don't currently have your monthly plan premium automatically withdrawn from your bank account but you want to, call Membership Services and ask about HMSA's Automatic Payment Service. This Automatic Payment Service is available only through banks located within the state of Hawaii.

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

Option 3: You can set up online bill pay

You can sign up for My Account using your HMSA membership card. In My Account, you can set up VueBill to make a one-time payment or recurring payments. Please visit our website at www.hmsa.com/Media/Default/documents/2500-50067-Vuebill-Guide-for-Individual-Members(F)(S-F).pdf for more information.

Register on www.HMSA.com:

Your My Account allows you to view claims, update personal information, and manage your health plan with ease. To sign up:

- Go to www.hmsa.com and click Member Login.
- Click Create an Account and follow the instructions.
- You will need your subscriber ID number from your HMSA membership card and a valid email address to complete registration. For an example of the HMSA membership card, see Section 3.1.

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

To sign up for automatic payments:

- Log into you're my Account using your Email Address and Password
- Click on Profile and select Pay My Bill. This will show a PDF copy of your bills and payment history.
- Add a form of payment on Payment Accounts using a Debit Card, Credit Card, US Checking Account, or US Savings Account.

- Then go to Automatic Payments to schedule the payment method to pay your bill every 1st of the month.
- You can watch this video to see all the things you can do online: https://www.youtube.com/watch?v=_adJPXP-ZYc

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

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

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

HMSA
ATTN: Membership Services
P.O. Box 860
Honolulu, HI 96808-0860

Or you may call HMSA's Membership Services at (808) 948-6174 on Oahu or 1-800-782-4672 toll-free on the Neighbor Islands or U.S. Mainland. TTY users should call 711.

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

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the fifth day of the month. If we have not received your payment by the fifth day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your plan premium within 30 days. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your premium on time, please contact Customer Relations to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your plan premium, you will have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual Medicare open enrollment period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 9 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your plan premium within our grace period, you can

make a complaint. For complaints, we will review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint or you can call us at (808) 948-6174 or 1-800-782-4672, 8:00 am to 5:00 pm, Hawaii Standard Time, Monday through Friday. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

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

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

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

If any of this information changes, please let us know by calling Customer Relations.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Relations. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2:
Important phone numbers and resources

SECTION 1 *HMSA Akamai Advantage Complete Plus* contacts (how to contact us, including how to reach Customer Relations)

Section 1.1 How to contact our plan's Customer Relations

For assistance with claims, billing, or member card questions, please call or write to *HMSA Akamai Advantage Complete Plus* Customer Relations. We will be happy to help you.

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

Section 1.2 How to contact us when you are asking for a coverage decision or appeal about your medical care or Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

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

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

Section 1.3 How to contact us when you are making a complaint about your medical care or Part D prescription drugs

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

Section 1.4 Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)) for more information.

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

Method	Payment Requests about Routine Vision Items and Services – Contact Information
CALL	From Oahu: (808) 948-6000 From the Neighbor Islands and U.S. Mainland: 1-800-660-4672 Calls to these numbers are free. These numbers are available 8:00 am - 8:00 pm, 7 days a week.
TTY	711 Calls to this number are free. This number is available 8:00 am - 8:00 pm, 7 days a week.
WRITE	First American Administrators, Inc. Attn: OON Claims PO Box 8504 Mason, OH 45040-7111
WEBSITE	You can download the payment request form at www.eyemedonline.com/managed-vision-care/member-forms/out-of-network-claim#/.

Section 1.5 How to contact case management if you are experiencing multiple or complex conditions

Case management is available to help members and their families experiencing multiple or complex conditions.

The goal of case management is to provide members with access to care, services, and coordination of care to reach optimum health or improved capabilities. Through a collaborative process, a case manager works with providers, family members, community case managers, and facilities (including nursing homes, skilled nursing facilities, hospices, and foster homes) to coordinate health care services and health plan benefits. Coordinating services and providing individualized case management ensures that members understand their options and have access to the best possible care.

Your PCP can refer you to case management. For more information about the case management program, please call 1-855-329-5461, Monday through Friday, 8 am to 5 pm TTY users call 711.

Method	Case management – Contact Information
CALL	1-855-329-5461
TTY	711

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

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

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool**: Provides Medicare eligibility status information. • **Medicare Plan Finder**: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

Method	Medicare – Contact Information
WEBSITE (continued)	You can also use the website to tell Medicare about any complaints you have about *HMSA Akamai Advantage Complete Plus:* • **Tell Medicare about your complaint:** You can submit a complaint about *HMSA Akamai Advantage Complete Plus* directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

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

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://www.shiphelp.org (Click on SHIP LOCATOR in middle of page)
- Select your STATE from the list. This will take you to a page with phone numbers and resources specific to your state.

Method	Hawaii SHIP – Contact Information
CALL	From Oahu: (808) 586-7299 From the Neighbor Islands: 1-888-875-9229 Calls to these numbers are free.
TTY	1-866-810-4379 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Hawaii SHIP Executive Office on Aging Hawaii State Department of Health No. 1 Capitol District 250 South Hotel St. Suite 406 Honolulu, HI 96813-2831
WEBSITE	www.hawaiiship.org

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare members in each state. For Hawaii, the Quality Improvement Organization is called Livanta.

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

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta (Hawaii's Quality Improvement Organization) – Contact Information
CALL	1-877-588-1123 Calls to this number are free. This number is available 9:00 am – 5:00 pm, Monday through Friday. 11:00 am – 3:00 pm, Saturday through Sunday. 24-hour voicemail service is available..
TTY	1-855-887-6668 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-855-694-2929
WEBSITE	www.livantaqio.com/en/states/hawaii

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

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

SECTION 6 Medicaid

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

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

To find out more about Medicaid and its programs, contact State of Hawai‘i Department of Human Services Med-QUEST Division.

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

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8:00 am to 7:00 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- You can contact Customer Relations. Please have the following information available: Member name, member ID number, "Extra Help" information (such as the subsidy level), and any written documentation you have concerning the "Extra Help" you are eligible to receive. Customer Relations phone numbers are on the back cover of this document.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Relations if you have questions.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP

formulary qualify for prescription cost-sharing assistance through the HIV Drug Assistance Program (HDAP).

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

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

SECTION 8 How to contact the Railroad Retirement Board

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

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	www.rrb.gov/

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

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

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

CHAPTER 3:
Using the plan for your medical services

SECTION 1 Things to know about getting your medical care as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are network providers and covered services?

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

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, *HMSA Akamai Advantage Complete Plus* must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

HMSA Akamai Advantage Complete Plus will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
  - The providers in our network are listed in the *Provider Directory.*
  - If you use an out-of-network provider, your share of the costs for your covered services may be higher.

- Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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

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

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

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

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

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

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

Usually, these providers practice in the areas of:

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

What can my PCP do for me?

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

Services your PCP will help coordinate:

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

How do you choose your PCP?

There are several ways you can choose a PCP:

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

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

Changing your PCP

You may change your PCP for any reason at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan or you will pay more for covered services.

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

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

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

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

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

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

Who will coordinate my care?

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

What's prior authorization?

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

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

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you access for continued care.
- If you are undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. An in-network provider, such as your PCP, can request prior authorization so that we can cover the service at in-network cost sharing.
- If you find out that your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

How do I access palliative care?

As a member of our plan, you may access palliative care, which is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering, through the *Supportive Care* benefit or the *Hospice care* benefit, depending on your eligibility and election. You should work with your primary care provider, specialists, and palliative care/hospice care provider to discuss how palliative care can integrate with your treatment plan. Transitional concurrent care may be available while you receive

palliative care. For more information on the *Supportive Care* and *Hospice care* benefits, see Chapter 4, Section 2.1 (*Medical Benefits Chart, what is covered and what you pay*).

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

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive non-emergent care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a medical emergency and what should you do if you have one?

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

If you have a medical emergency:

- **Get help as quickly as possible**. Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network. You are covered for emergency medical services or urgently needed care (not scheduled or elective care) in a foreign country. For more information, see the Medical Benefits Chart in Chapter 4 of this document. When you receive emergency/urgent care outside the country, you will need to pay the bill and ask for an itemized bill for your services. When you return to the United States, send the itemized bill and proof of payment to us along with a note describing your emergency/urgent care. If you did not pay your bill in U.S. dollars, the plan will reimburse you in U.S. dollars at the current exchange rate. See Chapter 7, Section 2 for more information on how to submit a bill for reimbursement, and the Medical Benefits Chart in Chapter 4 for more information.

What is covered if you have a medical emergency?

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

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

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. If your care requires prior authorization, your PCP will work with us and submit a prior authorization request. Your follow-up care will be covered by our plan. If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost-sharing.

What if it wasn’t a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, the amount of cost-sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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

What are urgently needed services?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

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

You are covered for emergency medical services or urgently needed care (not scheduled or elective care) in a foreign country. For more information, see the Medical Benefits Chart in Chapter 4 of this document.

Section 3.3 Getting care during a disaster

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

Please visit the following website: www.hmsa.com/advantage for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

SECTION 4 What if you are billed directly for the full cost of your services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

HMSA Akamai Advantage Complete Plus covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

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

SECTION 5 How are your medical services covered when you are in a clinical research study?

Section 5.1 What is a clinical research study?

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Section 5.2 When you participate in a clinical research study, who pays for what?

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

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

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

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

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

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies*. (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1 What is a religious non-medical health care institution?

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

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

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

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

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

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

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

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion

pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of *HMSA Akamai Advantage Complete Plus*, however, you may not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Ownership of DME will be at HMSA's discretion. Examples include, but are not limited to the following:

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

- Prosthetics and Orthotics
- Walkers
- Supply items

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

- Wheelchairs
- Hospital beds
- Insulin pumps
- PAP devices

Durable medical equipment items which will never have ownership transferred:

- Continuous Passive Motion (CPM) devices
- Ventilators

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

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

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage *HMSA Akamai Advantage Complete Plus* will cover:

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

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

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

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

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

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

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of *HMSA Akamai Advantage Complete Plus*. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- **Copayment** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

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

- Your **in-network maximum out-of-pocket amount** is $3,850. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, Part D prescription drugs, and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $3,850 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is $5,750. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan

premiums and for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $5,750 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to balance bill you

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

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has balance billed you, call Customer Relations.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

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

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from *HMSA Akamai Advantage Complete Plus.*
  - Covered services that need approval in advance to be covered as in-network services are marked by an endnote. In addition, Medicare Part A and Part B services that are rendered by out-of-network providers as a result of a referral from a network provider are covered at the lesser of the in-network or out-of-network cost-sharing only if prior authorization was approved by HMSA.
  - You never need approval in advance for out-of-network services from out-of-network providers.
- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

Important Benefit Information for all Enrollees Participating in Wellness and Health Care Planning (WHP) Services:

- Because *HMSA Akamai Advantage Complete Plus* participates in Medicare Advantage VBID Hospice Component program, you will be eligible for the following WHP services, including advance care planning (ACP) services:

- Your PCP or other physician may explain or discuss advance care directives with you, your family, or caregiver. You may access these services during a physician office visit or as part of your Annual Wellness Visit. Advance care planning discussion is voluntary and you may decline the offer of these services if you choose.

Note: Medicare approved *HMSA Akamai Advantage Complete Plus* to provide WHP and the Medicare Advantage VBID Hospice Component as part of the Value-Based Insurance Design (VBID) program. This program lets Medicare try new ways to improve Medicare Advantage plans.

 You will see this apple next to the preventive services in the benefits chart.

* You will see this asterisk next to services that do not count toward your maximum out-of-pocket amount in the benefits chart. See Chapter 4, Section 1.2 for more information about the maximum out-of-pocket amount.

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

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In-Network and Out-of-network** There is no coinsurance or copayment for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for the patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.	**In-Network** $0 copayment for each Medicare-covered acupuncture for chronic low back pain visit with a primary care provider in the primary care provider's office, or from an advanced practice registered nurse, nurse practitioner, or physician assistant. $30 copayment for each Medicare-covered acupuncture for chronic low back pain visit from a specialist. 20% of the cost for each Medicare-covered acupuncture for chronic low back pain visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic. **Out-of-network** $30 copayment for each Medicare-covered acupuncture for chronic low back pain visit with a primary care provider in the primary care provider's office, or from an advanced practice registered nurse, nurse practitioner, or physician assistant. $40 copayment for each Medicare-covered acupuncture for chronic low back pain visit from a specialist. 40% of the cost for each Medicare-covered acupuncture for chronic low back pain visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain (continued) Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Transportation starts where an injury or illness took place or first needed emergency care. Transportation ends at the nearest appropriate facility that can provide care. Non-emergency air ambulance transportation between Hawaii and the Mainland U.S. requires prior authorization by the plan.	**In-Network and Out-of-network** $225 copayment per one-way trip per ambulance provider per day for Medicare-covered ambulance benefits. Air ambulance is covered only in emergency situations based on Medicare guidelines. (1)
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every calendar year. **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In-Network and Out-of-network** There is no coinsurance or copayment for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In-Network and Out-of-network** There is no coinsurance or copayment for Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you get these services
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every calendar year for women age 40 and older • Clinical breast exams once every 24 months	**In-Network and Out-of-network** There is no coinsurance or copayment for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Cardiac rehabilitation is covered for a limited number of sessions when medically necessary.	**In-Network** $30 copayment for each Medicare-covered cardiac rehabilitation service ordered by your physician. $30 copayment for each Medicare-covered intensive cardiac rehabilitation service ordered by your physician. **Out-of-network** 40% of the cost for each Medicare-covered cardiac rehabilitation service ordered by your physician. 40% of the cost for each Medicare-covered intensive cardiac rehabilitation service ordered by your physician.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In-Network and Out-of-network** There is no coinsurance or copayment for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In-Network and Out-of-network** There is no coinsurance or copayment for cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test and pelvic exam every 12 months • We cover an HPV test once every five years for asymptomatic members aged 30 to 65 years in conjunction with the Pap smear test	**In-Network and Out-of-network** There is no coinsurance or copayment for Medicare-covered preventive Pap and pelvic exams. There is no coinsurance or copayment for a Medicare-covered preventive HPV test.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	**In-Network** $15 copayment for each visit for Medicare-covered services. **Out-of-network** 40% of the cost for each visit for Medicare-covered services.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	**In-Network and Out-of-network** There is no coinsurance or copayment for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay $0 for each Medicare-covered colorectal cancer screening exam for your doctors' services. In a hospital outpatient setting, you also pay the hospital $0 for each Medicare-covered colorectal cancer screening exam. The Part B deductible doesn't apply. $0 copayment for each Medicare-covered barium enema.

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening (continued) • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: **Preventive Dental Services: *** • Oral exams: 2 per calendar year • Cleanings: 2 per calendar year • Full mouth X-rays or Panoramic X-ray: 1 set per 5 calendar years • Bitewing X-rays: 1 set per calendar year except when performed within 12 months of full mouth x-rays or panoramic x-ray • Fluoride: 2 treatments per calendar year • Silver Diamine Fluoride: 2 treatments per calendar year **Additional Comprehensive Dental Services: *** • Fillings: 2 per calendar year • Extractions: 4 per calendar year • Root canals: 1 per calendar year • Crowns: 1 per calendar year following root canal procedure on the same tooth	**In-Network** $30 copayment for each visit for Medicare-covered dental benefits. $0 copayment for preventive and additional comprehensive dental services.* (2) **Out-of-network** 40% of the cost for each visit for Medicare-covered dental benefits. 40% of the cost for preventive and additional comprehensive dental services.* (2)

Services that are covered for you	What you must pay when you get these services
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In-Network and Out-of-network** There is no coinsurance or copayment for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**In-Network and Out-of-network** There is no coinsurance or copayment for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. There are quantity limits for diabetic test strips. If your doctor believes you require a higher number of test strips, they can request an exception. We cover the following preferred brands and manufacturers of supplies to monitor your blood glucose: • FreeStyle • FreeStyle InsuLinx • FreeStyle Lite • FreeStyle Precision Neo • OneTouch Ultra 2 • OneTouch Verio • Precision Xtra You can also ask your pharmacist to tell you which brands and manufacturers we cover.	**In-Network** $0 copayment for Medicare-covered blood glucose monitors, including continuous glucose monitors, and other diabetes monitoring supplies. 20% of the cost for Medicare-covered therapeutic shoes or inserts. **Out-of-network** 40% of the cost for Medicare-covered blood glucose monitors, including continuous glucose monitors, and other diabetes monitoring supplies. 40% of the cost for Medicare-covered therapeutic shoes or inserts. **In-Network and Out-of-network** There is no coinsurance or copayment for members eligible for the diabetes self-management training preventive benefit.

Services that are covered for you	What you must pay when you get these services
Diabetes self-management training, diabetic services and supplies (continued) Generally, we will not cover other brands and manufacturers of diabetic supplies unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to *HMSA Akamai Advantage Complete Plus* and are using a brand of diabetic supplies that is not preferred, we will continue to cover this brand for up to 100 days. During this time, you should talk with your doctor to decide the preferred brand that is medically appropriate for you after this 100-day period. • Other supplies to monitor your blood glucose: Medicare-covered Continuous Glucose Monitoring System (CGMS), and related supplies • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.hmsa.com/advantage.	**In-Network** 20% of the cost for Medicare-covered durable medical equipment and related supplies. Your cost sharing for Medicare oxygen equipment coverage is 20% of the cost, every rental payment. Your cost sharing will not change after being enrolled for 36 months. If prior to enrolling in *HMSA Akamai Advantage Complete Plus* you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in *HMSA Akamai Advantage Complete Plus* is 20% of the cost. Authorization rules may apply. (1) **Out-of-network**

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies (continued)	40% of the cost for Medicare-covered durable medical equipment and related supplies. Your cost sharing for Medicare oxygen equipment coverage is 40% of the cost, every rental payment. Your cost sharing will not change after being enrolled for 36 months. If prior to enrolling in *HMSA Akamai Advantage Complete Plus* you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in *HMSA Akamai Advantage Complete Plus* is 40% of the cost. For cost-sharing for home infusion therapy services (if billed separately), see *Home infusion therapy*.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	**In-Network and Out-of-network** $100 copayment for each Medicare-covered emergency room visit. If you are admitted to the hospital within 24 hours for the same condition, you pay $0 for the emergency room visit. If you get additional services at an out-of-network facility as part of your emergency room visit, your cost is the cost-sharing you would pay to a network provider. For cost-sharing for additional services received at the emergency room, see the following: • Inpatient care that began in an emergency room admission, see *Inpatient hospital care.* • Physician services (if billed separately), see *Physician/Practitioner services, including doctor's office visits*. • Services in an outpatient clinic, including same-day surgery, see

Services that are covered for you	What you must pay when you get these services
Emergency care (continued)	*Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*. (1) • Laboratory tests, X-rays and other radiology services, and medical supplies such as splints and casts, see *Outpatient diagnostic tests and therapeutic services and supplies*. (1) • Certain drugs and biologicals that you can't give yourself, see *Medicare Part B prescription drugs*. (1)
For emergency services in a foreign country (**Worldwide coverage***): • Physician services • Outpatient services • Room, board and ancillaries • Emergency transportation	**In-Network and Out-of-network** **Worldwide coverage*** 100% for any amounts above the plan's eligible charges for physician services. (2) 100% for any amounts above the plan's eligible charges for outpatient services. (2) 10% of the cost of the plan's eligible charge for hospital room, board and ancillaries. (2) 10% of the cost for emergency transportation. (2)
Fitness Program – The Silver&Fit® Healthy Aging and Exercise Program The Silver&Fit Healthy Aging and Exercise program provides you access to a Fitness Center Membership, Home Fitness Kit, and Healthy Aging Coaching, plus other features. • Fitness Center Membership: You can access a no-cost Standard Fitness Network membership at one of thousands of participating fitness centers or select YMCAs nationally. (Non-standard services at participating fitness centers/YMCAs are not included in the Silver&Fit program.) If you choose a Standard Fitness Network membership, you may change your fitness center once per month. You can also access the Premium Fitness Network, which includes	**In-Network and Out-of-network** The Silver&Fit Program Fitness Center Membership $0 monthly fee for Standard Network fitness centers $30-$200 monthly fee for Premium Network fitness centers.* (2) Home Fitness Kits $0 copayment for one Home Fitness Kit per calendar year.* (2)

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

Services that are covered for you	What you must pay when you get these services
Health and wellness education programs HMSA Health Education Workshops are fun and interactive workshops to teach members about fitness, nutrition, stress management, and other aspects of health and well-being that can impact physical, emotional and social health. To learn more about HMSA Health Education Workshops, go to www.hmsa.com/healtheducation.	**In-Network and Out-of-network** $0 copayment for covered supplemental health education workshops.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. See Section 3.1 of this chapter for services we do not cover.	**In-Network** $30 copayment for each Medicare-covered diagnostic hearing and balance exam. **Out-of-network** 40% of the cost for each Medicare-covered diagnostic hearing and balance exam.

Services that are covered for you	What you must pay when you get these services
Help with Certain Chronic Conditions **Dental services – Oral Health for Total Health** This program focuses on health conditions such as diabetes, coronary artery disease, pregnancy, stroke, chronic obstructive pulmonary disease, end stage renal disease, metabolic syndrome, head and neck cancer, oral cancer and Sjögren's syndrome that affect oral health. Programs include additional dental benefits for members identified with specific health conditions and outreach activities to support members and promote oral health. For more information on this program, please visit www.hmsadental.com/members/oral-health-for-total-health/enroll or call Customer Relations (phone numbers are listed on the back cover of this document). Members diagnosed with diabetes, coronary artery disease, stroke, pregnancy, chronic obstructive pulmonary disease, end stage renal disease or metabolic syndrome are eligible for the following services in addition to the plan's dental benefits: **Dental Services: *** • Cleanings: 2 additional per calendar year • Dental deep cleaning: 1 per 2 calendar years Members diagnosed with head and neck cancer, oral cancer or Sjögren's syndrome are eligible for the following services in addition to the plan's dental benefits: **Dental Services: *** • Cleanings: 2 additional per calendar year • Dental deep cleaning: 1 per 2 calendar years • Fluoride: 2 additional treatments per calendar year at least 3 months apart • Oral exams: 2 additional exams per calendar year	**In-Network** $0 copayment for additional dental benefits for members identified with specific health conditions.* (2) **Out-of-network** 40% of the cost for additional dental benefits for members identified with specific health conditions.* (2) For cost-sharing for the plan's dental benefits, see *Dental services*.

Services that are covered for you	What you must pay when you get these services
Help with Certain Chronic Conditions **In-home Health Assessments Program** This program provides an in-home health assessment once per calendar year. A nurse practitioner will conduct the visit, and may also provide health screening recommendations, health prevention tips, and care resource assistance. After the visit, the assessment summary will be shared with the member and the member's PCP or care team, as appropriate. Members who have been diagnosed with chronic conditions including diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, coronary artery disease (CAD), mood disorders, rheumatoid arthritis, dementia, cancer, vascular disease, chronic kidney disease (CKD), nutrition-related disorders, including obesity, or hematological disorders and who either do not have a PCP or need assistance managing their chronic condition with their PCP may be contacted to arrange an in-home health assessment.	**In-Network and Out-of-Network** There is no coinsurance or copayment for the In-home Health Assessments Program.*
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	**In-Network and Out-of-network** There is no coinsurance or copayment for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**In-Network** $0 copayment for Medicare-covered home health agency services. Authorization rules may apply. (1) **Out-of-network** 40% of the cost for Medicare-covered home health agency services.

Services that are covered for you	What you must pay when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	**In-Network** 20% of the cost for Medicare-covered home infusion therapy services furnished by a qualified home infusion therapy supplier if billed separately. **Out-of-network** 40% of the cost for Medicare-covered home infusion therapy services furnished by a qualified home infusion therapy supplier if billed separately. For cost-sharing for durable medical equipment (DME) (if billed separately), see *Durable medical equipment (DME) and related supplies.* For cost-sharing for Medicare Part B prescription drugs (if billed separately), see *Medicare Part B prescription drugs.*
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan. If you choose to remain in your plan you must continue to pay plan premiums. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> *HMSA Akamai Advantage Complete Plus* will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. The plan also covers transitional concurrent care for members enrolled in a network Medicare-certified hospice program for up to 30 days after election. You will get comfort-directed palliative care while continuing to receive outpatient curative treatment	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by *HMSA Akamai Advantage Complete Plus*. **In-Network and Out-of-network** There is no coinsurance or copayment for Medicare-covered hospice services. $0 copayment for prescription drugs and biologics. $0 copayment for inpatient respite care. For cost-sharing for hospice consultation services (one time only) for a member who hasn't elected the hospice benefit but may be considering and be eligible for the hospice benefit, along with their family or caregiver, see *Physician/Practitioner services, including doctor's office visits.*

Services that are covered for you	What you must pay when you get these services
Hospice care (continued) from an interdisciplinary team of practitioners. Transitional concurrent care is not available to members transitioning from the *Supportive Care* benefit into the Medicare hospice benefit. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay cost-sharing according to the plan's rules described in Chapter 3, Section 1.2, "Basic rules for getting your medical care covered by the plan." For services that are covered by *HMSA Akamai Advantage Complete Plus* but are not covered by Medicare Part A or B: *HMSA Akamai Advantage Complete Plus* will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a member who hasn't elected the hospice benefit but may be considering and be eligible for the hospice benefit, along with their family or caregiver.	

Services that are covered for you	What you must pay when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	**In-Network and Out-of-network** There is no coinsurance or copayment for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. For coverage of other vaccines (if you are at risk and the vaccine(s) meet Medicare Part B coverage rules), see *Medicare Part B prescription drugs.* (1)
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. The plan covers the following hospital days per stay: • The plan covers 90 hospital days. • The plan covers 60 Lifetime Reserve Days. • The plan covers unlimited additional hospital days.* Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	**In-Network** For Medicare-covered hospital stays: Days 1-5: $350 copayment per day Days 6-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. $0 copayment for additional hospital days.* (2) Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Authorization rules may apply. (1) **Out-of-network** For Medicare-covered hospital stays: Days 1-11: $375 copayment per day Days 12-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. $0 copayment for additional hospital days.* (2) **In-Network and Out-of-network** No limit to the number of days covered by the plan for each Medicare-covered inpatient hospital stay. Per day copayments are applied per hospital stay. If you are transferred but

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If *HMSA Akamai Advantage Complete Plus* provides transplant services at a location outside the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Additionally, we will cover transplant at a distant location, as well as lodging and transportation costs for you and a companion if the transplant is not available in Hawaii or if the distant location is deemed more medically favorable, per HMSA's policy. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	not discharged, it counts as the same hospital stay. If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. The plan covers the following hospital days per stay: • The plan covers 90 hospital days. • The plan covers 60 Lifetime Reserve Days. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to mental health care services provided in a psychiatric unit of a general hospital.	**In-Network** For Medicare-covered hospital stays: Days 1-5: $320 copayment per day Days 6-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. Authorization rules may apply. (1) **Out-of-network** For Medicare-covered hospital stays: Days 1-11: $375 copayment per day Days 12-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. **In-Network and Out-of-network** After you exhaust your Medicare 190-day lifetime limit, for coverage of all other inpatient services, see *Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay*. Per day copayments are applied per hospital stay. If you are transferred but not discharged, it counts as the same hospital stay.

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	For cost-sharing for physician services, see *Physician/Practitioner services, including doctor's office visits*. For cost-sharing for diagnostic tests (like lab tests), x-ray, radium and isotope therapy including technician materials and services, surgical dressings, splints, casts and other devices used to reduce fractures and dislocations, see *Outpatient diagnostic tests and therapeutic services and supplies.* (1) For cost-sharing for prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (or contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices, and for cost-sharing for leg, back, arm, back and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition, see *Prosthetic devices and related supplies*. (1) For cost-sharing for physical therapy, speech therapy, and occupational therapy, see *Outpatient rehabilitation services*. (1)

Services that are covered for you	What you must pay when you get these services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**In-Network and Out-of-network** There is no coinsurance or copayment for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare members under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In-Network and Out-of-network** There is no coinsurance or copayment for the MDPP benefit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers or insulin pumps) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant	**In-Network** 20% of the cost for Medicare-approved charges for prescription drugs covered under Part B of Original Medicare. You won't pay more than $35 for a one-month supply of insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). Authorization rules may apply. (1) **Out-of-network** 40% of the cost for Medicare-approved charges for prescription drugs covered under Part B of Original Medicare. Some drugs may be subject to step therapy.

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs (continued) • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Procrit®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.hmsa.com/part-b-step/. We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	For cost-sharing for home infusion therapy services (if billed separately), see *Home infusion therapy*. You may pay a lower coinsurance for rebatable drugs. For a definition of "rebatable drugs," see Chapter 12 of this document.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In-Network and Out-of-network** There is no coinsurance or copayment for preventive obesity screening and therapy.

Services that are covered for you	What you must pay when you get these services
Online Care With HMSA's Online Care, you can see a doctor or other health care provider from the comfort and privacy of home, work, or anywhere you can go online. Medical doctors are available 24 hours a day, 7 days a week and can diagnose conditions, recommend treatment and prescribe medications if necessary. Online therapy and counseling sessions are available by appointment.* To get started, download the free Online Care mobile app or for more information, go to www.hmsaonlinecare.com from a computer. Sessions and eligibility are subject to the HMSA's Online Care Consumer User Agreement.	**In-Network and Out-of-network** **Non-Behavioral Health Visits:** $0 copayment. Maximum 15 minutes.* (2) **Behavioral Health Visits:** $0 copayment. Maximum 60 minutes.* (2)
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of service to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessment Also covered via telehealth from eligible network providers.	**In-Network** $30 copayment for Medicare-approved Opioid Treatment Program services. **Out-of-network** 40% of the cost for Medicare-approved Opioid Treatment Program services.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Advanced Imaging tests. Advanced imaging studies include MRI, MRA, CT, PET and nuclear cardiology services • Other Medicare-covered diagnostic radiology services (not including X-rays or Advanced Imaging) • Radiation (radium and isotope) therapy including technician materials and supplies	**In-Network** 20% of the cost for Medicare-covered X-rays. $50 copayment for Advanced Imaging tests. (1) 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays or Advanced Imaging).

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued) • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests, therapeutic services and supplies	$50 copayment for Medicare-covered radiation therapy services. (1) 20% of the cost for Medicare-covered surgical supplies such as dressings, and splints, casts and other devices used to reduce fractures and dislocations. 20% of the cost for Medicare-covered lab services. $0 copayment for Medicare-covered blood. 20% of the cost for other Medicare-covered diagnostic tests, therapeutic services and supplies. (1) Authorization rules may apply. (1) **Out-of-network** 40% of the cost for Medicare-covered X-rays. 40% of the cost for Advanced Imaging tests. 40% of the cost for Medicare-covered diagnostic radiology services (not including X-rays or Advanced Imaging). 40% of the cost for Medicare-covered radiation therapy services. 40% of the cost for Medicare-covered surgical supplies such as dressings, and splints, casts and other devices used to reduce fractures and dislocations. 40% of the cost for Medicare-covered lab services. $0 copayment for Medicare-covered blood. 40% of the cost for other Medicare-covered diagnostic tests, therapeutic services and supplies.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-Network** $100 copayment for Medicare-covered observation care. **Out-of-network** 40% of the cost for Medicare-covered observation care.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-Network and Out-of-network** For cost-sharing for services in an emergency department, see *Emergency care.* For cost-sharing for services in an outpatient clinic, including same-day surgery, see *Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers.* (1) For cost-sharing for outpatient hospital observation services, see *Outpatient Hospital Observation.* For cost-sharing for laboratory tests, X-rays and other radiology services, and medical supplies such as splints and casts, see *Outpatient diagnostic tests and therapeutic services and supplies.* (1) For cost-sharing for mental health care, see *Outpatient mental health care*. For cost-sharing for partial hospitalization services, see *Partial hospitalization services*. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. For cost-sharing for certain drugs and biologicals that you can't give yourself, see *Medicare Part B prescription drugs*. (1)

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. Also covered via telehealth from eligible network providers.	(3) **In-Network** $30 copayment for each Medicare-covered individual or group therapy visit. **Out-of-network** 40% of the cost for each Medicare-covered individual or group therapy visit.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-Network** $30 copayment for each Medicare-covered physical and/or speech and language therapy visit ordered by your physician. $30 copayment for each Medicare-covered occupational therapy visit ordered by your physician. Authorization rules may apply. (1) **Out-of-network** 40% of the cost for each Medicare-covered physical and/or speech and language therapy visit ordered by your physician. 40% of the cost for each Medicare-covered occupational therapy visit ordered by your physician.
Outpatient substance abuse services Our plan covers certain treatment services for substance abuse which are covered by Original Medicare. Also covered via telehealth from eligible network providers.	(3) **In-Network** $30 copayment for each Medicare-covered individual or group visit. **Out-of-network** 40% of the cost for each Medicare-covered individual or group visit.

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**In-Network** 20% of the cost for each Medicare-covered visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic. Authorization rules may apply. (1) **Out-of-network** 40% of the cost for each Medicare-covered visit to an outpatient hospital facility, certified ambulatory surgical center, or clinic. **In-Network and Out-of-network** For cost-sharing for physician services (if billed separately), see *Physician/Practitioner services, including doctor's office visits*. For cost-sharing for other outpatient hospital services (if billed separately), see *Outpatient hospital services*.
Over-the-Counter (OTC) Health Products You are eligible for a $95 quarterly benefit to be used in-store or online shopping for over-the-counter (OTC) health and wellness products available through our mail order service and at select retail stores. The benefit renews at the beginning of each quarter of the calendar year (January, April, July, and October), and unused benefit balances do not carry over between quarters. You will receive your HMSA Extra Benefits carrier card with your HMSA Extra Benefits Debit Card in the mail to use towards the purchase of OTC health and wellness products available through United Medco, or at select retail stores. If you order OTC items online, by phone, or by mail, your items will be delivered to your door at no additional cost. Visit https://HMSAExtraBenefits.com to shop online or manage your Extra Benefits account, or call 1-800-790-6019 from 8:00 am - 8:00 pm Hawaii Standard Time, Monday through Friday.	**In-Network** $0 copayment for up to $95 quarterly of over-the-counter (OTC) health and wellness products available through our mail order service and at select retail stores.

Services that are covered for you	What you must pay when you get these services
Partial hospitalization services and Intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	**In-Network** $30 copayment for Medicare-covered partial hospitalization program services. $30 copayment for Medicare-covered intensive outpatient program services. **Out-of-network** 40% of the cost for Medicare-covered partial hospitalization program services. 40% of the cost for Medicare-covered intensive outpatient program services.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including for: primary care provider visits, specialist visits, mental health therapy or substance abuse therapy visits, visits with an advanced practice registered nurse, nurse practitioner, or physician assistant, or Opioid Treatment Program services o You have the option of receiving these services either through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, then you must use a network provider that currently offers the service by telehealth • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other locations approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate or treat symptoms of a stroke regardless of their location	(3) **In-Network** $0 copayment for each primary care provider visit in the primary care provider's office or in the member's home for Medicare-covered benefits. $0 copayment for each visit with an advanced practice registered nurse, nurse practitioner, or physician assistant in the provider's office or in the member's home for Medicare-covered benefits. $30 copayment for each specialist visit for Medicare-covered benefits. $0 copayment for certain telehealth services from eligible network providers. For a list of primary care providers, please refer to the *Provider Directory*. **Out-of-network** $30 copayment for each primary care provider visit for Medicare-covered benefits. $30 copayment for each visit with an advanced practice registered nurse, nurse practitioner, or physician assistant for Medicare-covered benefits.

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	$40 copayment for each specialist visit for Medicare-covered benefits. **In-Network and Out-of-network** For cost-sharing for hearing and balance exams, see *Hearing services*. For cost-sharing for non-routine dental care covered by Medicare, see *Dental services*.

Services that are covered for you	What you must pay when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	**In-Network** $30 copayment for each visit for Medicare-covered services. **Out-of-network** 40% of the cost for each visit for Medicare-covered services.
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In-Network and Out-of-network** There is no coinsurance or copayment for an annual PSA test. $0 copayment for an annual digital rectal exam.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see *Vision Care* later in this section for more detail.	**In-Network** 20% of the cost for Medicare-covered prosthetic devices and related supplies. Authorization rules may apply. (1) **Out-of-network** 40% of the cost for Medicare-covered prosthetic devices and related supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Pulmonary rehabilitation is covered for a limited number of sessions when medically necessary.	**In-Network** $15 copayment for each Medicare-covered pulmonary rehabilitation service ordered by your physician. Authorization rules may apply. (1) **Out-of-network** 40% of the cost for each Medicare-covered pulmonary rehabilitation service ordered by your physician.

Services that are covered for you	What you must pay when you get these services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In-Network and Out-of-network** There is no coinsurance or copayment for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months **Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening*: the member must receive a order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In-Network and Out-of-network** There is no coinsurance or copayment for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In-Network and Out-of-network** There is no coinsurance or copayment for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, *Medicare Part B prescription drugs.*	**In-Network and Out-of-network** 20% of the cost for Medicare-covered renal dialysis services which includes but is not limited to: • Outpatient dialysis treatments • Self-dialysis training • Home dialysis equipment and supplies • Certain home support services $0 copayment for Medicare-covered kidney disease education services. $0 copayment for Medicare-covered inpatient dialysis. For cost-sharing for physician services (if billed separately), see *Physician/Practitioner services, including doctor's office visits*.

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.) Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	**In-Network** For Medicare-covered SNF stays: Days 1-20: $20 copayment per day Days 21-40: $190 copayment per day Days 41-100: $0 copayment per day Authorization rules may apply. (1) **Out-of-network** For Medicare-covered SNF stays: Days 1-30: $200 copayment per day Days 31-100: $0 copayment per day **In-Network and Out-of-network** After you exhaust your Medicare SNF benefit, for coverage of other inpatient services, see *Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay*. No prior Medicare-covered acute level of care hospital stay is required. Cost-sharing for a SNF stay is based on a benefit period. For more information, see definition of a *Benefit Period* in Chapter 12.

Services that are covered for you	What you must pay when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	**In-Network and Out-of-network** There is no coinsurance or copayment for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**In-Network** $25 copayment for each Medicare-covered SET for PAD service ordered by your physician. **Out-of-network** 40% of the cost for each Medicare-covered SET for PAD service ordered by your physician.

Services that are covered for you	What you must pay when you get these services
Supportive Care services A comprehensive approach to care if you have a serious or advanced illness including Stage 3 or 4 cancer, advanced Congestive Heart Failure (CHF), advanced Chronic Obstructive Pulmonary Disease (COPD), or any advanced illness that meets the requirements of the Supportive Care policy. You will get comfort-directed care, while continuing to receive curative treatment from an interdisciplinary team of practitioners. Supportive Care is only available when you are referred by your physician. • We cover Supportive Care referral visits during which you are advised of Supportive Care options, regardless if you are later admitted to Supportive Care • Coverage is limited to 90 calendar days of services in a 12 month period that begins the first day Supportive Care services are provided* To receive Supportive Care, you must not be enrolled in a Medicare-certified hospice program. (For more information about the Medicare-certified hospice program, see *Hospice care*.)	**In-Network** Authorization rules may apply. (1) **In-Network and Out-of-network** $0 copayment for Supportive Care services*. (2)

Services that are covered for you	What you must pay when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. For emergency services or urgently needed care (not scheduled or elective care) in a foreign country (**Worldwide coverage***): • Physician services • Outpatient services • Room, board, and ancillaries • Emergency transportation	**In-Network and Out-of-network** $30 copayment to the facility for each covered urgently needed care visit. If you get additional services at an out-of-network facility as part of your urgently needed care visit, your cost is the cost-sharing you would pay to a network provider. For cost-sharing for physician services (if billed separately), see In-Network *Physician/Practitioner services, including doctor's office visits*. **Worldwide coverage*** 100% for amounts above the plan's eligible charges for physician services. (2) 100% for any amounts above the plan's eligible charges for outpatient services. (2) 10% of the cost of the plan's eligible charge for hospital room, board and ancillaries. (2) 10% of the cost for emergency transportation. (2)

Services that are covered for you	What you must pay when you get these services
Vision care Medicare-covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each calendar year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant	**In-Network** $0 copayment for Medicare-covered eye exams to diagnose and treat diseases and injuries of the eye. **Out-of-network** 40% of the cost for Medicare-covered eye exams to diagnose and treat diseases and injuries of the eye. **In-Network and Out-of-network** $0 copayment for Medicare-covered glaucoma screening once per calendar year. $0 copayment for one Medicare-covered pair of eyeglasses with standard frames or contact lenses from a Medicare-approved provider after each Medicare-covered cataract surgery. See Chapter 12 for a definition of *Medicare-approved provider*. If you receive consultation, diagnosis, or treatment by a specialist, see *Physician/Practitioner services, including doctor's office visits* for cost-sharing.
Supplemental covered services include: • One routine eye exam every calendar year* • The plan will pay up to $300 every calendar year for any combination of eyeglasses with standard frames, contact lenses, and contact lens fitting* • International travel solution: We cover the following services when you travel abroad*: o Receive a temporary pair of glasses in case of an emergency o Get help to find an eye doctor (Out-of-network benefits apply) (See Section 3.1 of this chapter for a list of exclusions)	**In-Network** $0 copayment for one routine eye exam every calendar year.* **Out-of-network** 40% of the cost for one routine eye exam every calendar year.* **In-Network and Out-of-network** 100% for any amounts above the plan coverage limit for routine eyewear. Plan pays up to $300 every calendar year, for any combination of frames, lenses, contact lenses, or contact lens fitting.*

Services that are covered for you	What you must pay when you get these services
Welcome to Medicare preventive visit The plan covers the one-time **Welcome to Medicare** preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the **Welcome to Medicare** preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your **Welcome to Medicare** preventive visit.	**In-Network and Out-of-network** There is no coinsurance or copayment for the **Welcome to Medicare** preventive visit or EKG service performed as a screening as part of the **Welcome to Medicare** preventive visit.

Notes to the Benefits Chart

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

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

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

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

Section 2.2 Getting care using our plan's optional visitor/traveler benefit

If you do not permanently move, but you are continuously away from our plan's service area for more than six months, we usually must disenroll you from our plan. However, we offer a visitor/traveler program, which will allow you to remain enrolled when you are outside of our service area for less than 12 months. Under our visitor/traveler program you may receive all plan covered services at in-network cost-sharing. Please contact the plan for assistance in locating a provider when using the visitor/traveler benefit.

If you are in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you have not returned to the plan's service area within 12 months, you will be disenrolled from the plan.

The visitor/traveler program includes Blue Medicare Advantage PPO network coverage of all Part A, Part B and supplemental benefits offered by your plan outside your service area in 48 states, the District of Columbia, and 1 territory: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and West Virginia. For some of the states listed, MA PPO networks are only available in portions of the state.

(This list is current as of September 2023 and may change. For an updated list of states and to learn more, visit www.hmsa.com/health-plans/medicare/travel-program/.)

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

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

Your Liability Calculation

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

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

Nonparticipating Healthcare Providers Outside Our Service Area

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

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

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

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		• Available for people with chronic low back pain under certain circumstances
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	**Not covered under any condition**	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition**	
Full-time nursing care in your home.	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Home-delivered meals	**Not covered under any condition**	
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	**Not covered under any condition**	
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	
Non-routine dental care.		• Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Outpatient prescription drugs received in a foreign country	**Not covered under any condition**	
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition**	
Private room in a hospital.		• Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	**Not covered under any condition**	
Routine chiropractic care		• Manual manipulation of the spine to correct a subluxation is covered.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.	No payment will be made for: broken, lost or stolen lenses, contact lenses or frames; sunglasses; prescription inserts for diving masks and any protective eyewear; non-prescription industrial or safety glasses; non-standard items for lenses including tinting, blending, oversized lenses and invisible bifocal and trifocals, repair and replacement of frame parts and accessories.	• Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Routine eye exam and any combination of eyeglasses with standard frames, contact lenses, and contact lens fitting are covered as supplemental benefit. See *Vision care* for more information about the services we cover.
Routine foot care		• Some limited coverage provided according to Medicare guidelines, (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids.	**Not covered under any condition**	
Services considered not reasonable and necessary, according to Original Medicare standards.	**Not covered under any condition**	

CHAPTER 5:
Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Section 1.1 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*).
- Your drug must be used for a medically accepted indication. A medically accepted indication is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider Directory*, visit our website (www.hmsa.com/advantage), and/or call Customer Relations.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Customer Relations or use the *Provider Directory*. You can also find information on our website at www.hmsa.com/advantage.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy. Home infusion pharmacies service all islands even though they may not be physically located on each island.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Relations.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (*Note*: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider Directory* or call Customer Relations.

Section 2.3 Using the plan's mail-order service

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

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

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

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

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

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

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

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

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

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

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

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

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4 How can you get a long-term supply of drugs?

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

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Provider Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Relations for more information.

2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Customer Relations** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

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

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

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

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

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

The plan has a *List of Covered Drugs (Formulary).* In this *Evidence of Coverage*, **we call it the "Drug List" for short**.

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

The drugs on the "Drug List" are only those covered under Medicare Part D.

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

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- -- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The "Drug List" includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the "Drug List", when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Customer Relations. See Chapter 4, Section 2.1 for information about our over-the-counter benefit.

What is *not* on the "Drug List"?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the "Drug List". In some cases, you may be able to obtain a drug that is not on the "Drug List". For more information, please see Chapter 9.

Section 3.2 There are five cost-sharing tiers for drugs on the "Drug List"

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

- **Cost-Sharing Tier 1: Preferred Generic**
  Tier 1 is the lowest tier and includes preferred generic drugs and may include some brand drugs.
- **Cost-Sharing Tier 2: Generic**
  Tier 2 includes generic drugs and may include some brand drugs.
- **Cost-Sharing Tier 3: Preferred Brand**
  Tier 3 includes preferred brand drugs and non-preferred generic drugs.
- **Cost-Sharing Tier 4: Non-Preferred Drug**
  Tier 4 includes non-preferred brand drugs and non-preferred generic drugs.
- **Cost-Sharing Tier 5: Specialty Tier**

Tier 5 is the highest tier. It contains very high cost brand and generic drugs, which may require special handling and/or close monitoring.

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

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the "Drug List"?

You have four ways to find out:

1. Check the most recent "Drug List" we provided electronically.

2. Visit the plan's website (www.hmsa.com/advantage). The "Drug List" on the website is always the most current.

3. Call Customer Relations to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.

4. Use the plan's "Real-Time Benefit Tool" (through your HMSA MyAccount or by calling Customer Relations). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition. To get to the "Real-Time Benefit Tool", log into your HMSA MyAccount and go to Manage My Drugs Online. Then, click on "Plan & Benefits", "Rx Savings" from the drop down menu, and select "Check Drug Cost & Coverage".

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the "Drug List". If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Relations to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9)

Restricting brand name drugs or original biological products when a generic or interchangeable biosimilar version is available

Generally, a **generic** drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. **In most cases, when a generic or interchangeable biosimilar version of a brand name drug or original biological product is available, our network pharmacies will provide you the generic or interchangeable biosimilar version instead of the brand name drug or original biological product.** However, if your provider has told us the medical reason that neither the generic drug or interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug or original biological product. (Your share of the cost may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

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

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- **The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be.**
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the "Drug List" or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the "Drug List" or if the drug is restricted in some way

If your drug is not on the "Drug List" or is restricted, here are options:

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

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

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

- **If you are a new member,** we will cover a temporary supply of your drug **during the first 90 days of your membership in the plan.**
- **If you were in the plan last year,** we will cover a temporary supply of your drug **during the first 90 days of the calendar year**.

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

For questions about a temporary supply, call Customer Relations.

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

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Relations to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

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

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

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

You can change to another drug

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

You can ask for an exception

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 (Specialty Tier) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The "Drug List" can change during the year

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

- **Add or remove drugs from the "Drug List".**
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

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

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the "Drug List" occur, we post information on our website about those changes. We also update our online "Drug List" on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the plan year

- **A new generic drug replaces a brand name drug on the "Drug List" (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
  - We may immediately remove a brand name drug on our "Drug List" if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our "Drug List", but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
  - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.
- **Unsafe drugs and other drugs on the "Drug List" that are withdrawn from the market**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the "Drug List". If you are taking that drug, we will tell you right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the "Drug List"**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the "Drug List" or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - For these changes, we must give you at least 30 days' advance notice of change or give you a notice of change and a 30-day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should work with your provider to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
  - You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

Changes to the "Drug List" that do not affect you during this plan year

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

In general, changes that will not affect you during the current plan year are:

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

If any of these changes happen for a drug you are taking (except for a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug.

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

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are excluded. This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

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

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs).
- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.
- Drugs used for cosmetic purposes or to promote hair growth.

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs used for the treatment of sexual or erectile dysfunction.
- Drugs used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

If you are receiving "Extra Help" to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

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

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

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

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

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

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

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

Check your *Provider Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Relations. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our "Drug List" or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

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

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

Special note about creditable coverage:

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

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

Keep this notice about creditable coverage, because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

All medically necessary and appropriate drugs are covered by our plan. If you are enrolled in Medicare hospice and require a drug, such as an anti-nausea, laxative, pain medication, or anti-anxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our

plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

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

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

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

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

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

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

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

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end of life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

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

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

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Customer Relations.

CHAPTER 6:
What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Customer Relations and ask for the LIS Rider.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use *drug* in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 5, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real Time Benefit Tool" by calling Customer Relations.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called **cost-sharing**, and there are three ways you may be asked to pay.

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

Section 1.3 How Medicare calculates your out-of-pocket costs

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

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

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

- The amount you pay for drugs when you are in any of the following drug payment stages:

  - The Initial Coverage Stage
  - The Coverage Gap Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included in your out-of-pocket costs. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $8,000 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments <u>are not included</u> in your out-of-pocket costs

Your out-of-pocket costs **<u>do not include</u>** any of these types of payments:

- Your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Relations.

How can you keep track of your out-of-pocket total?

- **We will help you**. The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $8,000, this report will tell

you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for *HMSA Akamai Advantage Complete Plus* members?

There are four **drug payment stages** for your prescription drug coverage under *HMSA Akamai Advantage Complete Plus*. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the Part D EOB)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**.
- We keep track of your **Total Drug Costs**. This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month we will send you a Part D EOB. The Part D EOB includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called year-to-date information. It shows the total drug costs and total payments for your drug since the year began.

- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost-sharing for each prescription claim.

Section 3.2 Help us keep our information about your drug payments up to date

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

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

SECTION 4 There is no deductible for *HMSA Akamai Advantage Complete Plus*

There is no deductible for *HMSA Akamai Advantage Complete Plus*. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

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

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

The plan has five cost-sharing tiers

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

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

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

Your pharmacy choices

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

- A network retail pharmacy.
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Provider Directory.*

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

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

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

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

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Mail-order cost-sharing (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (*Preferred Generic*)	$4 copayment	$4 copayment	$4 copayment	$4 copayment
Cost-Sharing Tier 2 (*Generic*)	$11 copayment	$11 copayment	$11 copayment	$11 copayment
Cost-Sharing Tier 3 (*Preferred Brand*)	$45 copayment	$45 copayment	$45 copayment	$45 copayment
Cost-Sharing Tier 4 (*Non-Preferred Drug*)	$95 copayment	$95 copayment	$95 copayment	$95 copayment
Cost-Sharing Tier 5 (*Specialty Tier*)	33% of the cost	33% of the cost	33% of the cost	33% of the cost

You won’t pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 8 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

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

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

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

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

Section 5.4 A table that shows your costs for a *long-term* (100-day) supply of a drug

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

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

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

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard retail cost-sharing (in-network) (100-day supply)	Mail-order cost-sharing (100-day supply)
Cost-Sharing Tier 1 (*Preferred Generic*)	$12 copayment	$4 copayment
Cost-Sharing Tier 2 (*Generic*)	$33 copayment	$11 copayment
Cost-Sharing Tier 3 (*Preferred Brand*)	$135 copayment	$90 copayment
Cost-Sharing Tier 4 (*Non-Preferred Drug*)	$285 copayment	$190 copayment
Cost-Sharing Tier 5 (*Specialty Tier*)	33% of the cost	33% of the cost

You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply at retail for each covered insulin product regardless of the cost-sharing tier.

At Mail-order, you will pay no more than $70 for up to a two-month supply of covered insulin products on Tier 3, Tier 4, or Tier 5. For a three-month supply at Mail-order, you will pay no more than $70 for Tier 3 and Tier 4 and up to $105 for Tier 5 for each covered insulin product.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $5,030

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$5,030 limit for the Initial Coverage Stage**.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $5,030 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

The plan covers Tier 1 drugs in the Coverage Gap Stage. For these drugs, you pay the same copayment that you would pay in the Initial Coverage Stage (see Section 5 of this chapter). Tier 1 drugs are marked in our Drug List.

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. Only the amount you pay counts and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount $8,000, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs (Section 1.3).

Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

You won’t pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 8 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List." Our plan covers most adult Part D vaccines at no cost to you. Refer to your plan's "Drug List" or contact Customer Relations for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

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

Your costs for a Part D vaccination depends on three things:

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

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

2. Where you get the vaccine.

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

3. Who gives you the vaccine.

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

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

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

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

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

- For most adult Part D vaccines, you will pay nothing.

- For other Part D vaccines, you will pay the pharmacy your coinsurance or copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

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

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

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

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

CHAPTER 7:

Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. Or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called **reimbursing** you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

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

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received medical care from a provider who is not in our plan's network

When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. When a network provider sends you a bill you think you should not pay

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

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's "Drug List"; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

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

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

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

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

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

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

Part D Prescription drugs:

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

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

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

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

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

Please include a cover letter with:

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

- The charge for each service
- Your signature

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

Hospital, Physician, Lab, etc.:

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

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

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

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

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

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

Routine vision items and services:

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

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

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

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

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

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

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

CHAPTER 8:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Relations.

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with HMSA's Civil Rights Coordinator,
818 Ke'eaumoku St., Honolulu, HI 96814, 1-800-776-4672, TTY users call 711, Fax: (808) 948-6414,
Email: Compliance_Ethics@hmsa.com. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

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

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

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

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

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Relations.

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

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

If you want any of the following kinds of information, please call Customer Relations:

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

Section 1.5 We must support your right to make decisions about your care

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

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

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

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

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

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

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

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an **advance directive** to give your instructions, here is what to do:

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

Island	Advance Directive Forms – Contact Information
OAHU	For information about advance directive, printing the form, or if you want to talk to an operator, contact Kōkua Mau. Phone: (808) 585-9977 (Please leave a voice message and Kōkua Mau will call you back). Write: Kōkua Mau P.O. Box 62155 Honolulu, HI 96839 Email: Go to https://kokuamau.org/contact-kokua-mau/ to send an email. Website: www.kokuamau.org For legal assistance if you are over 60 years old, on behalf of anyone over 60 years or older, or in need of economic assistance, contact University of Hawai‘i Elder Law Program. Phone: (808) 956-6544. This number is available 8:30 am - 4:30 pm, Monday through Friday. For legal assistance or information about your rights, which includes advance directive, contact Legal Aid Society of Hawai‘i. Phone: (808) 536-4302. This number is available 9:00 am - 11:30 am and 1:00 pm - 3:30 pm, Monday through Friday.
HAWAII AND MAUI	On Hawaii and Maui, contact Legal Aid Society of Hawai‘i. Phone: 1-800-499-4302. This number is available 9:00 am - 11:30 am and 1:00 pm - 3:30 pm, Monday through Friday.
KAUAI	On Kauai, you may contact University of Hawai‘i Elder Law Program. Phone: (808) 956-6544. This number is available 8:30 am - 4:30 pm, Monday through Friday.
LANAI	On Lanai, contact Legal Aid Society of Hawai‘i. Phone: 1-800-499-4302. This number is available 9:00 am - 11:30 am and 1:00 pm - 3:30 pm, Monday through Friday.
MOLOKAI	On Molokai, contact Legal Aid Society of Hawai‘i. Phone: 1-800-499-4302. This number is available 9:00 am - 11:30 am and 1:00 pm - 3:30 pm, Monday through Friday.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can’t. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

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

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

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

However, if you have a problem or concern about a health care facility (including hospitals, nursing homes, home health agencies, end-stage renal disease (ESRD) facilities, and other facilities serving Medicare and Medicaid members), contact Office of Health Care Assurance (OHCA) through any of the methods listed below.

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

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

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

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Relations**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

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

There are several places where you can get more information about your rights:

- You can **call Customer Relations**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Relations.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums.
  - You must continue to pay your Medicare Part B premiums to remain a member of the plan.
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

  - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9:

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints;** also called grievances.

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

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

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says making a complaint rather than filing a grievance, coverage decision rather than organization determination or coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which

process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

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

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 10** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as **medical care**. You use the

coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied with this decision, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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

- You **can call us at Customer Relations**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Relations and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
  - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Customer Relations and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.hmsa.com/help-center/forms/medicare-appoint-representative/.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: Your medical care: How to ask for a coverage decision or make an appeal
- **Section 6** of this chapter: Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

- **Section 7** of this chapter: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon
- **Section 8** of this chapter: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, hospice care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Relations. You can also get help or information from government organizations such as your SHIP.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay*). In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this is covered by our plan. **Ask for a coverage decision. Section 5.2.**

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**

3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**

4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **organization determination.** A *fast coverage decision* is called an **expedited determination**.

<u>Step 1:</u> Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 14 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

<u>Step 2:</u> Ask our plan to make a coverage decision or fast coverage decision.

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

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

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service.** If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

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

- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe.

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

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

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

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

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

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

- If you are appealing a decision, we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.

- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We are allowed to charge a fee for copying and sending this information to you.

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

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 10 of this chapter for information on complaints.)

- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

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

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

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

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

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

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

- For the standard appeal if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization**.**
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.). In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Level 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this coverage decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request**: If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5, Section 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term *Drug List* instead of *List of Covered Drugs* or *Formulary*.

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Terms
An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 6.2 What is an exception?

Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our "Drug List".** If we agree to cover a drug not on the "Drug List", you will need to pay the cost-sharing amount that applies to drugs in Tier 5 (Specialty Tier). You cannot ask for an exception to the cost sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our "Drug List". If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our "Drug List" is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

- If our "Drug List" contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
- If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (Specialty Tier).
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our "Drug List" includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Terms
A fast coverage decision is called an **expedited coverage determination.**

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

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the supporting statement,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

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

Section 6.5 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.** A fast appeal is also called an **expedited redetermination.**

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

A standard appeal is usually made within 7 days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal.**

- For standard appeals, submit a written request or call us. Chapter 2 has contact information.
- For fast appeals either submit your appeal in writing or call us at (808) 948-6000. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.

- If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within **30 calendar days** after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 Step-by-step: How to make a Level 2 appeal

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a "fast appeal."
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no **to part or all of** your appeal**,** it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It is also called **turning down your appeal**.). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.

- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Customer Relations or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. Read this notice carefully and ask questions if you don’t understand it. It tells you:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. You will be asked to sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. Keep your copy of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Relations or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Relations. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or, find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge date.**
  - **If you meet this deadline,** you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Relations or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to Level 2 of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal to change your hospital discharge date?

Legal Terms
A fast review (or fast appeal) is also called an **expedited appeal.**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review**. This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.

- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

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

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

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must (pay you back) for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
  - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is about three services only:* Home health care, skilled nursing facility care, hospice care, and Comprehensive Outpatient Rehabilitation Facility (CORF) service

When you are getting covered **home health services, skilled nursing care, hospice care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.2 We will tell you in advance when your coverage will be ending

Legal Terms

Notice of Medicare Non-Coverage. It tells you how you can request a **fast-track appeal.** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. You receive a notice in writing at least two days before our plan is going to stop covering your care. The notice tells you:

- The date when we will stop covering the care for you.
- How to request a fast track appeal to request us to keep covering your care for a longer period of time.

2. You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it. Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

Section 8.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**

- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Relations. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you received (Notice of Medicare Non-Coverage) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

Legal Terms
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (*the reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you**.
- If you decide to keep getting the home health care, or skilled nursing facility care, or hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 8.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You could ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter talks more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Legal Terms
A *fast review* (or *fast appeal*) is also called an **expedited appeal.**

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review**. This means you are asking us to give you an answer using the *fast* deadlines rather than the *standard* deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

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

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your fast appeal. This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.

- The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal	A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal	A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Relations? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Relations or other staff at the plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast appeal, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

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

Section 10.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Relations is the first step.** If there is anything else you need to do, Customer Relations will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- If you call us or send us your complaint in writing, we will file your complaint for you. To process your complaint, we will need the following information:
  - Your full name.
  - Your member ID number.
  - A daytime telephone number where we can reach you.
  - A description of the complaint, including the date it occurred.
  - Address of office location, and name of practitioners, providers, or their staff who were involved, if applicable.
  - Any documents you would like us to consider when resolving your complaint.
  - Your signature or the signature of your representative, if the complaint is sent to us in writing. (Addresses are printed on the back cover of this document).

  If you want a friend, relative, your doctor or other provider, or other person to be your representative, then you will need to submit an "Appointment of Representative" form. The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. To obtain the form you can do the following:

  - Download the form on our website at www.hmsa.com/help-center/forms/medicare-appoint-representative/
  - Call Customer Relations (phone numbers are printed on the back cover of this document) and ask for the "Appointment of Representative" form.
  - Download the form on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf

  Reminder: A representative form is valid for one year from the date it has signatures for both the enrollee and the appointee, unless revoked. For example, if the enrollee signs the form on January 1, 2024 and the representative signs on January 3, 2024 (or vice versa), the form is effective for one year starting on January 3, 2024.

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

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization.**
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about *HMSA Akamai Advantage Complete Plus* directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

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

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the **Annual Open Enrollment Period**). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open** E**nrollment Period**, you can:

  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

In certain situations, members of *HMSA Akamai Advantage Complete Plus* may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have QUEST Integration (Medicaid).
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.
- - *or* - Original Medicare *without* a separate Medicare prescription drug plan.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Your membership will usually end on the first day of the month after your request to change your plan is received.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Customer Relations**.
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from *HMSA Akamai Advantage Complete Plus* when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from *HMSA Akamai Advantage Complete Plus* when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Customer Relations if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from *HMSA Akamai Advantage Complete Plus* when your coverage in Original Medicare begins.

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

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

- **Continue to use our network providers to receive medical care.**

- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 *HMSA Akamai Advantage Complete Plus* must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

***HMSA Akamai Advantage Complete Plus* must end your membership in the plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Customer Relations to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for two calendar months.
  - We must notify you in writing that you have two calendar months to pay the plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Customer Relations.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

HMSA Akamai Advantage Complete Plus is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11:
Legal Notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at Customer Relations. If you have a complaint, such as a problem with wheelchair access, Customer Relations can help.

Hawai‘i Medical Service Association ("HMSA") complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

HMSA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 1-800-776-4672 toll-free. TTY 711.

Filing a Grievance with HMSA
If you believe that HMSA has discriminated in any way on the basis of race, color, national origin, age,

disability, sex, gender identity, or sexual orientation, you can file a grievance with HMSA's Civil Rights Coordinator in a number of ways as listed below:

Mail: 818 Keʻeaumoku St., Honolulu, HI 96814

Phone: 1-800-776-4672 toll-free; TTY users, call 711.

Fax: (808) 948-6414

Email: Compliance_Ethics@hmsa.com

You can also file a grievance in person. If you need help filing a grievance, HMSA's Civil Rights Coordinator is available to help you.

Such grievances must be submitted to HMSA's Civil Rights Coordinator within 60 days from the date you become aware of the alleged discriminatory action(s).

Filing a Complaint with the Federal Government
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

Mail: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201,

Phone: 1-800-368-1019 toll-free; TDD users, call 1-800-537-7697 toll-free.

You can review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Such complaints must be filed within 180 days of the date of the alleged discrimination.

SECTION 3 Notice about member non-liability

In the event HMSA fails to reimburse a Network provider's charge for covered services, you will not be liable for any sums owed by HMSA.

SECTION 4 Notice about when others are responsible for injuries

We do not pay medical expenses which are covered by workers' compensation insurance or automobile insurance coverage required by Hawaii state law. When others may be responsible for payment of your medical expenses or prescription drugs (due to tort liability, insurance or otherwise), our third-party liability rules apply and you should request a copy of these rules from us. You must give us prompt written notice of your injuries, claims, and demands for recovery and recoveries received, and must promptly fill out and return to us all papers we require to determine coverage and to secure our reimbursement rights for any

amounts we pay. Medicare and HMSA have liens and rights of reimbursement to the full extent of any expenses paid.

SECTION 5 Notice about our privacy policies and practices for personal financial information required by law

(Privacy of Consumer Financial Information, H.R.S. Chapter 431, Article 3A, eff. July 1, 2002) HMSA is required by state law to provide an annual notice of our privacy policies and practices for personal financial information to members who are enrolled in our individual health plans. This section contains information regarding how we collect and disclose personal financial information about our members to our affiliates and to nonaffiliated third parties. This applies to former as well as current HMSA members.

HMSA and our affiliated organizations throughout the state of Hawaii have established the following policies and practices:

- Maintain physical, technical and administrative safeguards to protect the privacy, confidentiality, and integrity of personal information.
- Ensure that those in our workforce who have access to or use your personal information need that information to perform their jobs and have been trained to properly handle personal information. Our employees are fully accountable to management for following our policies and practices.
- Require that third parties who access your personal information on our behalf comply with applicable laws and agree to HMSA's strict standards of confidentiality and security.

Collection of personal financial information
HMSA collects personal financial information about you that is necessary to administer your health plan. We may collect personal financial information about you from sources such as applications or other forms that you complete and your transactions with us, our affiliates, or others.

Sharing of personal financial information
HMSA may share with our affiliates and with nonaffiliated third parties any of the personal financial information that is necessary to administer your health plan as permitted by law. Nonaffiliated third parties are those entities that are not part of HMSA and its affiliates. We do not otherwise share your personal financial information with anyone without your permission.

SECTION 6 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, *HMSA Akamai Advantage Complete Plus,* as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

In some situations, other parties should pay for your medical care before your Medicare Advantage health plan. In those situations, your Medicare Advantage plan may pay, but have the right to get the payments back from these other parties. Medicare Advantage plans may not be the primary payer for medical care you receive. These situations include those in which the Federal Medicare Program is considered a secondary

payer under the Medicare Secondary Payer laws. For information on the Federal Medicare Secondary Payer program, Medicare has written a document with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First (publication number 02179).* You can get a copy by calling 1-800-MEDICARE, 24 hours a day, 7 days a week, or by visiting the www.medicare.gov web site.

Our rights to recover in these situations are based on the terms of this health plan contract, as well as the provisions of the Federal statutes governing the Medicare Program. Your Medicare Advantage plan coverage is always secondary to any payment made or reasonably expected to be made under:

- A workers compensation law or plan of the United States or a State,
- Any non-fault based insurance, including automobile and non-automobile no-fault and medical payments insurance,
- Any liability insurance policy or plan (including a self-insured plan) issued under an automobile or other type of policy or coverage, and
- Any automobile insurance policy or plan (including a self-insured plan), including, but not limited to, uninsured and underinsured motorist coverages.

Since your Medicare Advantage plan is always secondary to any automobile no-fault (Personal Injury Protection) or medical payments coverage, you should review your automobile insurance policies to ensure that appropriate policy provisions have been selected to make your automobile coverage primary for your medical treatment arising from an automobile accident.

SECTION 7 Notice about Subrogation and Third Party Liability

We do not pay any medical expenses which are covered by workers' compensation insurance or automobile insurance coverage required by Hawaii state law.

If you suffer an injury or illness for which a third party is responsible due to a negligent or intentional act, you must promptly notify us. If we make any payment on your behalf for covered services when others are responsible for the illness or injury, we have the right to be repaid the full cost of benefits provided or paid by us. You are required to cooperate with us in pursuing such recoveries.

You must also notify us of any claims or demands for recoveries and recoveries received. HMSA has a right to restitution or reimbursement from any recovery obtained by you or on your behalf from any third party responsible for your injury or illness.

As outlined herein, in these situations, we may make payments on your behalf for this medical care, subject to the conditions set forth in this provision for us to recover these payments from you or from other parties. Immediately upon making any conditional payment, we shall be subrogated to (stand in the place of) all rights of recovery you have against any person, entity or insurer responsible for causing your injury, illness or condition or against any person, entity or insurer listed as a primary payer above.

In addition, if you receive payment from any person, entity or insurer responsible for causing your injury, illness or condition or you receive payment from any person, entity or insurer listed as a primary payer above, we have the right to recover from, and be reimbursed by you for all conditional payments we have made or will make as a result of that injury, illness or condition.

We will automatically have a lien to the extent of benefits it paid for the treatment of the injury, illness or condition, upon any recovery whether by settlement, judgment or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits we have paid including, but not limited to, you, your representatives or agents, any person, entity or insurer responsible for causing your injury, illness or condition or any person, entity or insurer listed as a primary payer above. By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds.

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any health care provider) from your Medicare Advantage plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be paid to the plan before any other claim for your damages. We shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery to you which is insufficient to make you whole or to compensate you in part or in whole for the damages you sustained. We are not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

We are entitled to full recovery regardless of whether any liability for payment is admitted by any person, entity or insurer responsible for causing your injury, illness or condition or by any person, entity or insurer listed as a primary payer above. We are entitled to full recovery regardless of whether the settlement or judgment received by you identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. We are entitled to recover from any and all settlements or judgments, even those designated as for pain and suffering, non-economic damages and/or general damages only.

You, and your legal representatives, shall fully cooperate with our efforts to recover the benefits that we paid. It is your duty to notify us within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by us or our representatives. You shall do nothing to prejudice our subrogation or recovery interest or to prejudice our ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

Failure to provide requested information or failure to assist us in pursuit of its subrogation or recovery rights may result in you being personally responsible for reimbursing us for benefits paid relating to the injury, illness or condition as well as for our reasonable attorney fees and costs incurred in obtaining reimbursement from you. For more information, see 42 U.S.C. § 1395y(b)(2)(A)(ii) and the Medicare statutes.

SECTION 8 Notice about Reporting Fraud, Waste, and Abuse

HMSA is committed to identifying and preventing fraud, waste and abuse under Medicare. You can assist us by reporting any potential cases of health care fraud to us. This includes instances in which a health care provider bills for services you never got or for equipment different from what you got. If you are concerned about any of the charges, items or services appearing on a bill or Explanation of Benefits, or if you suspect fraudulent activity, please call our fraud hotline at (808) 948-5166 or toll-free at 1-888-398-6445. This hotline allows you to report cases confidentially.

CHAPTER 12:
Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

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

Benefit Period – The way that your use of skilled nursing facility (SNF) services is measured. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service drug is received.

Cost-sharing Tier – Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Relations – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Relations.

Daily Cost-sharing Rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your daily cost-sharing rate is $1 per day.

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

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are: (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

"Extra Help" – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

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

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. For more information on the Hospice care benefit, see *Hospice care in* Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $5,030.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

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

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Lifetime Reserve Days – You are eligible for an additional 60 Medicare-covered inpatient hospital days after the first 90 days of your Medicare-covered hospital stay. These 60 reserve days can be used only once during your lifetime.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

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

Medicare-approved Provider – A Medicare-approved provider is a Medicare-enrolled DMEPOS supplier or any eligible professional or practitioner eligible to bill for Medicare services and supplies. Certain durable equipment, prosthetics, orthotics, and supplies are dispensed by these Medicare-approved providers. To find a Medicare-approved provider near you, go to www.medicare.gov/medical-equipment-suppliers/.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – **Provider** is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Observation Care – A stay in a hospital for less than 48 hours if: (1) You have not been admitted for an inpatient stay; (2) you are physically detained in an emergency room, treatment room, observation room, or other such area; or (3) you are being observed to determine whether an inpatient confinement will be required.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (**Traditional Medicare or Fee-for-service Medicare**) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

Palliative Care – Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care involves addressing physical, intellectual, emotional, social, and spiritual needs to facilitate patient autonomy, access to information, and choice.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Real Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Rebatable drugs – The Inflation Reduction Act of 2022 requires drug companies to pay a rebate if they raise their prices for certain drugs faster than the rate of inflation. If you receive any of these Part B medications, you may pay a lower coinsurance. If you pay more on the date of services, our plan must issue you a refund.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Form Approved
OMB# 0938-1421

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An Independent Licensee of the Blue Cross and Blue Shield Association

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1 (800) 660-4672 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1 (800) 660-4672 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1 (800) 660-4672 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1 (800) 660-4672 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1 (800) 660-4672 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1 (800) 660-4672 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1 (800) 660-4672 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1 (800) 660-4672 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1 (800) 660-4672 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1 (800) 660-4672 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إنني أقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديني. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1 (800) 660-4672 (TTY: 711). هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1 (800) 660-4672 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1 (800) 660-4672 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1 (800) 660-4672 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1 (800) 660-4672 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1 (800) 660-4672 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1 (800) 660-4672 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

HMSA Medicare Advantage Customer Relations

CALL	(808) 948-6000 or 1 (800) 660-4672 daily, 8 a.m.-8 p.m. Calls to these numbers are free. Customer Relations also has free language interpreter services available for non-English speakers.
TTY	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	(808) 948-6433
WRITE	HMSA Medicare Advantage Customer Relations P.O. Box 860 Honolulu, HI 96808-0860
WEBSITE	hmsa.com/advantage
VISIT	Hours of operation may change. Please go to hmsa.com/contact before your visit. HMSA Centers with extended evening and weekend hours **Honolulu, Oahu** | 818 Keeaumoku St. Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m. **Pearl City, Oahu** | Pearl City Gateway, 1132 Kuala St., Suite 400 Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m. **Hilo, Hawaii Island** | Waiakea Center, 303A E. Makaala St. Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m. **Kahului, Maui** | Puunene Shopping Center, 70 Hookele St. Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m. **Lihue, Kauai** | Kuhio Medical Center, 3-3295 Kuhio Highway, Suite 202 Monday–Friday, 8 a.m.–4 p.m.

Hawai'i SHIP

Hawai'i SHIP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

CALL	(808) 586-7299 or 1 (888) 875-9229 Monday-Sunday. This is a prerecorded helpline. Calls will be returned within five business days.
TTY	1 (866) 810-4379. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Hawai'i SHIP Executive Office on Aging Hawaii State Department of Health No. 1 Capitol District 250 S. Hotel St., Suite 406 Honolulu, HI 96813-2831
WEBSITE	hawaiiship.org

8700-841402 8.23

Active state, city, and county workers

We're here with you

April 2023

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Aloha,

Your health and well-being are our top priority. With HMSA, you have access to:

- **Your choice of doctors and top-rated hospitals.** Our network includes more than 7,500 doctors, specialists, and other health care providers, along with access to quality care from Hawaii's top-rated hospitals and clinics. See page 2 to learn more about our growing network.
- **Convenient after-hours care.** Need care but don't need the emergency room? You can see a doctor online, at an urgent care clinic, or at a MinuteClinic® in selected Longs Drugs stores on Oahu. To learn more about after-hours care options, see page 5.
- **Benefits that travel with you.** Go to doctors and hospitals on the Mainland and around the world with Blue Cross Blue Shield Global® Core. Your HMSA plans gives you access to more than 1.7 million doctors and hospitals nationwide and 170 countries and territories worldwide. If you need to travel to another island for medical treatment, you may be eligible for financial assistance. Learn more on page 6.
- **Support for your best health and well-being.** Our programs and services can help you maintain or improve your health and achieve your well-being goals. We also help you save with discounts on health-related products and services such as online fitness classes, gym memberships, and more.

Also, EUTF and HSTA VB plans will include the artificial insemination benefit at the plan's standard coinsurance starting July 1.

This year's open enrollment is April 3-28, 2023. If you have questions, we're happy to help. Call or visit us at an HMSA Center or office. Our phone numbers, locations, and hours are listed on the back cover of this guide.

Thank you for choosing HMSA. We look forward to supporting you in your good health.

Sincerely,

Mark M. Mugiishi, M.D., F.A.C.S.
President and Chief Executive Officer

Top-rated hospitals and clinics

With HMSA, you have access to top-rated hospitals. We're part of the Blue Cross and Blue Shield Association, which recognizes Hawaii hospitals for expertise in delivering high-quality, cost-effective specialty care.

Blue Distinction Centers are hospitals recognized for their expertise in delivering specialty care and Blue Distinction Centers+ are hospitals recognized for their expertise and efficiency in delivering specialty care.

- **Bariatric surgery**
  Adventist Health Castle (**adventisthealth.org**)
  The Queen's Medical Center **(queens.org)**
- **Knee and hip replacement**
  Adventist Health Castle+
  Straub Medical Center
  Wilcox Medical Center+ (**wilcoxhealth.org**)
- **Maternity care**
  Kapi'olani Medical Center for Women & Children+ **(kapiolani.org)**
  Wilcox Medical Center+
- **Spine surgery**
  Adventist Health Castle
  Pali Momi Medical Center+ (**palimomi.org**)
  The Queen's Medical Center+
  Straub Medical Center
- **Substance use treatment and recovery**
  The Queen's Medical Center

We're proud to work with these health care providers to offer you quality care:

Adventist Health Castle

HAWAIʻI PACIFIC HEALTH
KAPIʻOLANI
PALI MOMI
STRAUB
WILCOX
CREATING A HEALTHIER HAWAIʻI

THE QUEEN'S HEALTH SYSTEM

It's easy to get the care you need

The choice is yours

With HMSA, you can choose your primary care provider, the doctor at the center of your health care team. You can see your PCP for general and preventive care needs, including health concerns and questions.

If you're happy with your PCP, you don't have to do anything differently. You can continue to see the doctor you know, trust, and rely on in times of need.

Want to choose or change your PCP? Use Find a Doctor on **hmsa.com/eutf** to search for a doctor by location, specialty, or languages spoken. Just remember to choose your plan before starting your search.

You can also use Find a Doctor to search for other health care providers in HMSA's network.

Get after-hours care

An emergency room visit can be expensive and isn't necessary for minor illnesses and injuries. But where can you go if your doctor's office is closed and you need treatment? You can save money and get the care you need with these after-hours options.

- Connect with a doctor on your computer or mobile device from anywhere in Hawaii with HMSA's Online Care®. Online Care doctors are available 24 hours a day, seven days a week. This benefit is available at no cost for EUTF members. Download Online Care from the App Store or Google Play and register or visit **hmsaonlinecare.com**.
- See a doctor at the urgent care clinics in our network, which are listed on page 5. To search for urgent care providers, go to **hmsa.com/urgentcare**.
- See a doctor or nurse practitioner at MinuteClinic, the medical clinic in selected Longs Drugs stores on Oahu. To find a MinuteClinic, use Find a Doctor on **hmsa.com/eutf**.

Amwell® is an independent company providing hosting and software services for HMSA's Online Care platform on behalf of HMSA.

A Guide to Your Care Options

Save time and money

by choosing the right care. Remember that emergency room visits are expensive and aren't necessary for illnesses or injuries that aren't life threatening.

Use this guide to help you get the right care when you need it.

Primary care provider

See your PCP for routine and common medical issues like fever, minor symptoms of the flu or a cold, chronic condition management, medication refills, or general care.

HMSA's Online Care®

Connect with doctors and specialists online from anywhere in Hawaii, 24 hours a day, seven days a week. There's no copayment for Online Care visits.

Use Online Care when your PCP isn't available.

Urgent care providers

Go to an urgent care provider when you need care in person sooner than you can see your doctor.

For example, you need stitches or have a high fever or sprained ankle.

Emergency room

Go to the emergency room when you have life-threatening symptoms.

For example, you have difficulty breathing or chest pain.

More tips

- ✔ Use the directory on the next page to find an urgent care provider near you. Services vary at each location, so call ahead to make sure they can provide the services you need.
- ✔ Register for HMSA's Online Care now so it's easy to log in when you need it. Go to **hmsaonlinecare.com** to register and download the app on your smartphone.
- ✔ Follow up with your PCP after an urgent care or Online Care visit.

Amwell® is an independent company providing hosting and software services for HMSA's Online Care platform on behalf of HMSA.

Participating Urgent Care Clinics

Hawaii Island

Aloha Kona Urgent Care
75-5995 Kuakini Hwy., Suite 213
Kailua-Kona Ph. (808) 365-2297
Monday–Friday: 8 a.m.–4 p.m.
Saturday: 1–9 p.m.
Closed Sundays

Hilo Urgent Care
670 Kekuanaoa St.
Hilo Ph. (808) 969-3051
Monday–Friday: 8:30 a.m.–6:30 p.m
Saturday–Sunday: 8:30 a.m.–4:30 p.m.

Keaau Urgent Care
16-590 Old Volcano Rd.
Keaau Ph. (808) 966-7942
Monday–Friday: 8:30 a.m.–6:30 p.m.
Saturday–Sunday: 8:30 a.m.–4:30 p.m.

Waimea Urgent Care
65-1230 Mamalahoa Hwy.,
Suite A10
Kamuela Ph. (808) 885-0660
Monday–Friday: 8:30 a.m.–6:30 p.m.
Saturday–Sunday: 8:30 a.m.–4:30 p.m.

Kauai

Hale Lea Medicine and Urgent Care
2460 Oka St., Suite 101A
Kilauea Ph. (808) 828-2885
Monday–Friday: 8 a.m–5 p.m.
Saturday: 9 a.m.–5 p.m.
Sunday: 9 a.m.–4 p.m.

Kauai Urgent Care
4484 Pahee St.
Lihue Ph. (808) 245-1532
Daily: 8 a.m.–7 p.m.

Makana North Shore Urgent Care
4488 Hanalei Plantation Rd.
Princeville Ph. (808) 320-7300
Monday-Friday: 7 a.m.–7 p.m.
Saturday-Sunday: 8 a.m..–4 p.m.

Urgent Care at Poipu
2829 Ala Kalani Kaumaka St.,
Suite B-201
Koloa Ph. (808) 742-0999
Monday–Friday: 8:30 a.m.–7 p.m.
Saturday–Sunday: 8 a.m.–4:30 p.m.

Maui

Doctors On Call
3350 Lower Honoapiilani Rd.,
Suite 211
Lahaina Ph. (808) 667-7676
Monday–Friday: 8 a.m.–6 p.m.
Saturday: 8 a.m.–4 p.m.
Closed Sundays

Doctors On Call
3750 Wailea Alanui Drive., Suite B34
Wailea Ph. (808) 875-7676
Monday–Saturday: 8 a.m.–6 p.m.
Saturday: 8 a.m..–4 p.m.
Closed Sundays

Kihei-Wailea Medical Center
221 Piikea Ave., Suite A
Kihei Ph. (808) 874-8100
Monday–Friday: 8 a.m.–8 p.m.
Saturday–Sunday: 8 a.m.–5 p.m.

Minit Medical Urgent Care Clinic
270 Dairy Rd., Suite 239
Kahului Ph. (808) 667-6161
Monday–Friday: 8 a.m.–7 p.m.
Saturday: 8 a.m.–6 p.m
Sunday: 8 a.m.–4 p.m.

Minit Medical Urgent Care Clinic
305 Keawe St., Suite 507
Lahaina Ph. (808) 667-6161
Monday–Saturday: 8 a.m.–6 p.m.
Sunday: 8 a.m.–4 p.m.

Minit Medical Urgent Care Clinic
1325 S. Kihei Rd., Suite 103
Kihei Ph. (808) 667-6161
Monday–Saturday: 8 a.m.–6 p.m.
Sunday: 8 a.m.–4 p.m.

The Maui Medical Group Inc.
2180 Main St.
Wailuku Ph. (808) 249-8080
Monday–Friday: 8 a.m.–7 p.m.
Saturday–Sunday: 8 a.m.–4 p.m.

The Maui Medical Group Inc.
130 Prison St.
Lahaina Ph. (808) 249-8080
Monday–Friday: 8 a.m.–7 p.m.
Saturday: 8 a.m.-noon
Closed Sundays

Oahu

Adventist Health Castle Urgent Care Kailua
660 Kailua Rd.
Kailua Ph. (808) 263-2273
Daily: 8 a.m.–6 p.m.

Adventist Health Castle Urgent Care Kapolei
890 Kamokila Blvd., Suite 106
Kapolei Ph. (808) 521-2273
Monday–Friday: 7 a.m.–6 p.m.
Saturday–Sunday: 8 a.m.–6 p.m.

Adventist Health Castle Urgent Care Pearl City
1245 Kuala St., Suite 103
Pearl City Ph. (808) 456-2273
Monday–Friday: 7 a.m.–7 p.m.
Saturday–Sunday: 8:30 a.m.–6 p.m.

Adventist Health Castle Urgent Care Waikiki
1860 Ala Moana Blvd., Suite 101
Honolulu Ph. (808) 921-2273
Monday-Friday: 8 a.m.–6 p.m.

All Access Ortho
1401 S. Beretania St., Suite 102
Honolulu Ph. (808) 356-5699
Monday–Friday: 8 a.m.–8 p.m.
Saturday–Sunday: 9 a.m.–5 p.m.

All Access Ortho
4850 Kapolei Pkwy., Bldg. F
Kapolei Ph. (808) 356-5699
Monday–Friday: 8 a.m.–8 p.m.
Saturday–Sunday: 9 a.m.–5 p.m.

All Access Ortho
95-1830 Meheula Pkwy., Suite C10-11
Mililani Ph. (808) 356-5699
Monday–Friday: 8 a.m.–8 p.m.
Saturday–Sunday: 9 a.m.–5 p.m.

Braun Urgent Care Kailua
130 Kailua Rd., Suite 111
Kailua Ph. (808) 261-4411
Monday–Friday: 8 a.m.–8 p.m.
Saturday–Sunday: 8 a.m.–5 p.m.

Doctors of Waikiki
120 Kaiulani Ave., Wing 10 & 11
Honolulu Ph. (808) 922-2112
Daily: 8 a.m.–midnight

Kalihi Kai Urgent Care
2070 N. King St., Suite A1
Honolulu Ph. (808) 841-2273
Monday–Friday: 8 a.m.– 4 p.m
Saturday–Sunday: 9 a.m.–1 p.m.

Kunia Urgent Care
94-673 Kupuohi St., Suite C201
Waipahu Ph. (808) 983-1671
Thursday–Tuesday: 8:30 a.m.–7 p.m.Closed Wednesdays

NIU Health Ala Moana
1450 Ala Moana Blvd., Suite 2230 Honolulu Ph. (808) 888-4800
Daily: 8 a.m.–8 p.m.

NIU Health Hawaii Kai
6600 Kalanianaole Hwy., Suite 114A
Honolulu Ph. (808) 888–4800
Daily: 8 a.m..–6 p.m.

Queen's Island Urgent Care Ewa Kapolei
91-6390 Kapolei Pkwy.
Ewa Beach Ph. (808) 735-0007
Daily: 8 a.m.–8 p.m.

Queen's Island Urgent Care Kahala
1215 Hunakai St.
Honolulu Ph. (808) 735-0007
Daily: 8 a.m.–8 p.m.

Queen's Island Urgent Care Kakaako
400 Keawe St., Suite 100
Honolulu Ph. (808) 735-0007
Daily: 8 a.m.–8 p.m.

Queen's Island Urgent Care Kapahulu
449 Kapahulu Ave., Suite 104
Honolulu Ph. (808) 735-0007
Daily: 8 a.m.–8 p.m.

Queen's Island Urgent Care Pearl Kai
98-199 Kamehameha Hwy., Bldg. F
Aiea Ph. (808) 735-0007
Daily: 8 a.m.–8 p.m.

Straub Kapolei Clinic & Urgent Care
91-5431 Kapolei Pkwy., Suite 1706
Kapolei Ph. (808) 426-9300
Daily: 10 a.m.–8 p.m.

Straub Doctors On Call
2255 Kalakaua Ave., Manor Wing
Shop No. 1
Honolulu Ph. (808) 971-6000
Daily: 10 a.m.–8 p.m.

Straub Kahala Clinic & Urgent Care
4210 Waialae Ave., Suite 501
Honolulu Ph. (808) 462-5300
Daily: 10 a.m.–8 p.m

Straub Ward Village Clinic & Urgent Care
1001 Queen St., Suite 102
Honolulu Ph. (808) 462-5200
Daily: 10 a.m.–8 p.m.

Windward Urgent Care
46-001 Kamehameha Hwy., Suite 107
Kaneohe Ph. (808) 247-7596
Daily: 8 a.m.–7 p.m.

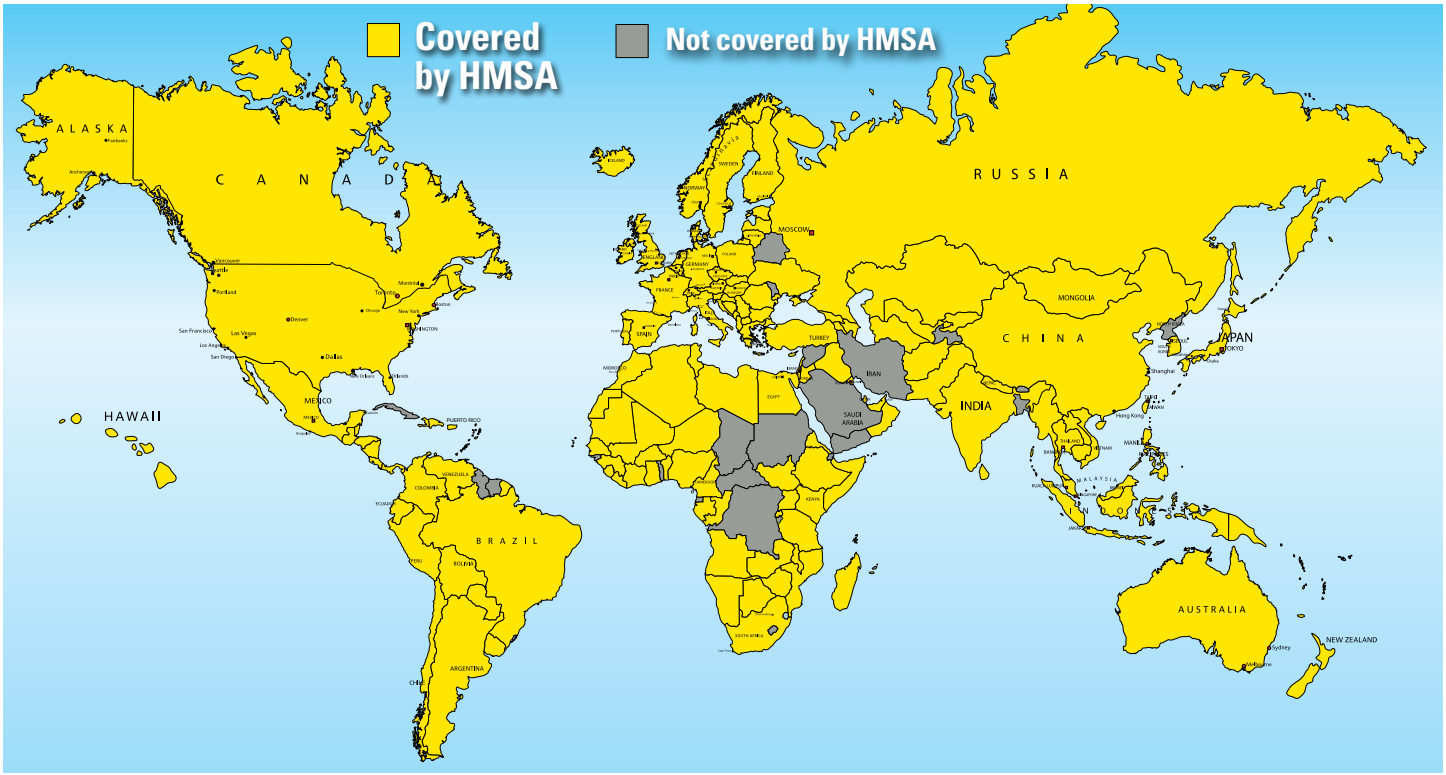
Hours and locations may change. Please call the clinic for the latest information.

For a current list of participating urgent care providers, visit **hmsa.com/urgentcare**.

These options aren't a substitute for emergency care. If you experience life-threatening conditions such as a stroke or difficulty breathing, call 911 or go to the emergency room immediately.

Most urgent care clinics are closed on Thanksgiving Day, Christmas Day, and New Year's Day. Services vary by location. Call the clinic to ask about specific services.

Get care around the world



With HMSA, you and your eligible dependents can get care on the Mainland and in many international locations.

How it works

HMSA is part of the Blue Cross and Blue Shield Association network, which includes access to more than 1.7 million doctors and hospitals nationwide and in 170 countries and territories worldwide.

Looking for a doctor or hospital on the Mainland? Go to **bcbs.com**.

Traveling internationally? Download the Blue Cross Blue Shield Global Core mobile app for Apple and Android devices. You can use the app to search for providers when you travel. To learn more, go to **bcbsglobalcore.com**.

Be prepared

- Before you go, make sure you have your current HMSA membership card with you. Your card will help providers file your claims.
- You can also call the phone number on the back of your card, 1 (800) 810-BLUE (2583), for the participating doctors and hospitals in the area you'll be visiting.

Care Access Assistance Program

If you need to travel to another island for medical treatment, you may be eligible for financial assistance if care isn't available from a participating provider on your home island or you can't get an appointment soon enough. Call us at 1 (844) 357-0726 for more information.

hmsa.com/eutf

You can use the EUTF portal to:

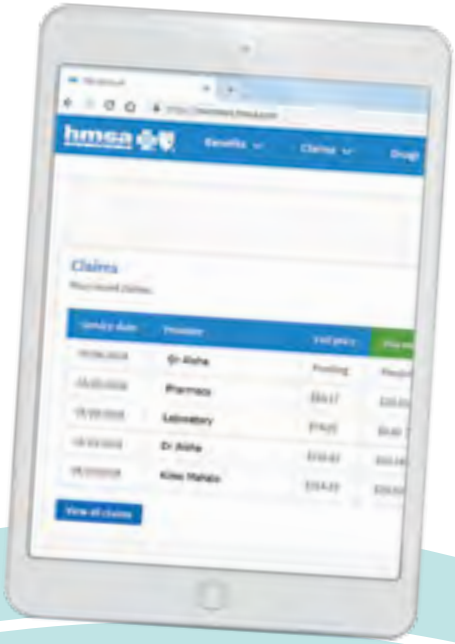
- Search for a doctor.
- Learn about well-being programs available to you and your family.
- View helpful videos specifically for EUTF and HSTA VB members.
- Request plan materials.

My Account

As an HMSA member, you can view all your health plan information and member benefits online on My Account at **hmsa.com/eutf**. On the homepage, click the blue Member Login button in the upper right corner.

Use My Account to:

- View your claims.
- Use an annual maximum out-of-pocket calculator to see the most you'll pay for benefits in a plan year.
- See where you are with reaching your deductible, if applicable.
- Download your plan's *Guide to Benefits* for details about your HMSA plan.
- Print or request another HMSA membership card.
- Find health and fitness discounts with HMSA365, the Active&FitDirect™ program, and the ChooseHealthy® program.



The Active&Fit Direct program is provided by American Specialty Health Fitness, Inc. and the ChooseHealthy program is provided by ChooseHealthy, Inc., both subsidiaries of American Specialty Health Incorporated, a national provider of fitness, health education, musculoskeletal provider networks and health management programs. Active&Fit Direct and ChooseHealthy are trademarks of ASH and used with permission herein.

EUTF health plan comparison

Use this chart to compare the plans and choose the one that fits your health and budget needs.

PLAN BENEFITS	EUTF	
	90/10 PPO PLAN	80/20 PPO PLAN
Annual Out-of-pocket Maximum (The most you pay out of pocket in a calendar year.)	$2,000 per person $4,000 per family	$2,500 per person $5,000 per family
Annual Deductible (The amount you pay out of pocket in a calendar year before your plan pays.)	In-network: None Out of network: $100 per person $300 per family	In-network: None Out of network: $250 per person $750 per family
In-network Services	YOU PAY	YOU PAY
Office Visits	10%	20%
Annual Preventive Health Evaluation	$0	$0
Physical Exams	N/A	N/A
Hospital Room and Board	10%	20%
Maternity Care	10%	20%
Surgical Procedures (outpatient surgery)	10%	20%
Diagnostic Tests	10%	20%
Outpatient Laboratory	10%	20%
Outpatient X-ray and Other Radiology	10%	20%
Emergency Room	10%	20%
Ambulance (ground)	10%	20%
Hearing aids One hearing aid per ear every 60 months	10%	20%
Chiropractic Services	$15 copayment per visit for up to 20 medically necessary visits per calendar year when you see an ASH in-network provider	$15 copayment per visit for up to 20 medically necessary visits per calendar year when you see an ASH in-network provider

* Annual deductible applies.

This is only a summary. For complete information, see your plan's *Guide to Benefits*, which can be found on **hmsa.com/eutf**. All benefits listed are for services from a participating provider.

		HSTA VB	
75/25 PPO PLAN	**HMO**	**90/10 PPO PLAN**	**80/20 PPO PLAN**
$5,000 per person $10,000 per family	$1,500 per person $3,000 per family	$2,000 per person $4,000 per family	$2,500 per person $5,000 per family
$300 per person $900 per family	None	In-network: None Out of network: $100 per person $300 per family	None
YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
25%	$15	10%	20%
$0	$0	N/A	N/A
N/A	N/A	$0	$0
25%*	$0	10%	20%
25%*	$0	10%	20%
25%*	$0 (outpatient surgical center) $15 (professional charges)	10%	20%
25%*	$0	10%	20%
25%	$0	10%	$0
25%*	$15 per X-ray	10%	20%
25%*	$100	10%	20%
25%*	20%	10%	20%
25%*	20%	10%	20%
$15 copayment per visit for up to 20 medically necessary visits per calendar year when you see an ASH in-network provider	$15 copayment per visit for up to 20 medically necessary visits per calendar year when you see an ASH in-network provider	$12 copayment per visit for up to 20 medically necessary visits per calendar year when you see an ASH in-network provider	$12 copayment per visit for up to 20 medically necessary visits per calendar year when you see an ASH in-network provider

Please note that HSTA VB plans are closed plans. Active HSTA VB employees with these plans can switch to another HMSA EUTF plan, but can't switch back if they do.

Preventive care services

Preventive care is the best way to stay healthy. Many preventive care services are available at no cost to HMSA members. Check your health plan benefits to be sure.

On this form, "Gender" refers to the gender HMSA has on file for you at this time. Transgender and nonbinary members with questions can call the number on the back of their HMSA membership card for more information.

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

Updated July 1, 2022

Preventive visits for adults

Adults: Age 22 and older except as noted			
Preventive visit	**Frequency**	**Gender**	
Annual Preventive Health Evaluation* May include: • Height, weight, blood pressure, and body mass index measurement • Screening for depression, unhealthy alcohol use (18 and older), unhealthy drug use (18 and older), tobacco use, and interpersonal and domestic violence	Once a year	M	F
Well-woman exam	Once a year		F

Screening and counseling for adults			
Screening and counseling	**Frequency**	**Gender**	
Abdominal aortic aneurysm screening	Ages 65 to 75 who have never smoked: One-time screening	M	
Anxiety screening	Once a year		F
BRCA screening and genetic counseling	Any woman with increased risk from family history: Once per lifetime		F
Blood pressure screening	Age 18 and older: Once every 12 months	M	F
Breast cancer screening	Age 40 and older: Once every 12 months. Ages 35 to 39: One baseline mammogram		F
Colorectal cancer screening • Stool-based tests • Sigmoidoscopy • Colonoscopy	Ages 45 to 75 at average risk for colorectal cancer	M	F
Cervical cancer screening • Pap smear	Ages 21 to 65: Once a year		F
Counseling: Healthy diet, physical activity, obesity, fall prevention, skin cancer and safety, sexually transmitted infections, contraceptive methods, tobacco use, and intimate partner violence	Consult your doctor	M	F
Cholesterol screening	Once every 12 months. For retirees: Men ages 35 to 65 and women ages 45 to 65: One every five years	M	F
Diabetes screening	Ages 35 to 70: Once every 12 months	M	F
Hepatitis B screening	Once a year	M	F
Hepatitis C screening	Ages 18 to 79: Once a year	M	F
Human papillomavirus screening	Age 30 and older: Once every three years		F
Lung cancer screening	Ages 50 to 80 with 20 pack-year** history. Once every 12 months for current smokers or former smokers who quit within past 15 years.	M	F
Osteoporosis screening	65 and older, younger if at increased risk		F
Sexually transmitted infection screenings • Chlamydia • Gonorrhea • HIV • Syphilis	Once every 12 months	M	F
Tuberculosis screening	Up to two tests a year. For retirees: One test a year	M	F

* Annual Preventive Health Evaluation for active members. Annual Physical Exam for HSTA VB members.

** Pack-year is calculated by multiplying the number of cigarettes smoked per day by the number of years a person has smoked. For example, a 30 pack-year history is a pack a day for 30 years or two packs a day for 15 years.

Preventive care for pregnant people

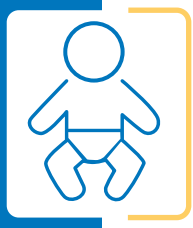
Preventive care	Gender	
Anxiety screening		F
Bacteriuria screening		F
Chalymdia screening		F
Comprehensive lactation support and counseling from a physician or midwife during pregnancy and or postpartum. Includes breastfeeding equipment.		F
Counseling for alcohol and tobacco use and depression		F
Gestational diabetes screening		F
Gonorrhea screening		F
Hepatitis B screening and immunization		F
HIV screening		F
Rh (D) incompatibility screening		F
Smoking cessation counseling		F
Syphilis screening		F
Prenatal and postpartum depression screening		F

Preventive drugs and treatments for adults

Preventive drugs and treatment		Gender	
Aspirin	- Ages 50 to 59 to reduce the risk of stroke and heart attack - Pregnant people at risk for preeclampsia	M	F
Breast cancer preventive medications	People who are at increased risk for breast cancer without a cancer diagnosis		F
Folic acid supplementation	People planning or capable of pregnancy: Daily supplement containing 0.4 to 0.8 mg folic acid		F
Preexposure prophylaxis	Treatment using preexposure prophylaxis (with effective antiretroviral therapy to persons who are at high risk of getting HIV	M	F
Statin preventive medication	Ages 40 to 75 years with one or more cardiovascular disease risk factors and have a calculated 10-year risk of a cardiovascular event of 10% or greater	M	F
Tobacco cessation	Adults who use tobacco products	M	F

Immunizations for adults

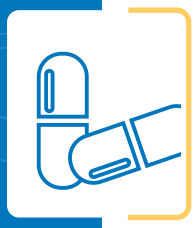
- Chicken pox
- Flu
- *Haemophilus influenzae* type B
- Hepatitis A
- Hepatitis B
- Human papillomavirus
- Measles, mumps, rubella
- Meningococcal meningitis
- Pneumonia
- Shingles
- Tetanus, diphtheria, pertussis (Tdap or Td)
- Travel immunizations



Preventive care for children

Birth to 21 Years

- Well-child visits
- Alcohol misuse screening
- Anxiety screening for adolescent girls
- Contraceptive methods and counseling for adolescent girls
- Depression screening
- Dyslipidemia screening
- Hearing loss screening
- Hepatitis B (HBV) screening
- Human immune-deficiency virus (HIV) screening
- Interpersonal and domestic violence screening for adolescent girls
- Newborn bilirubin screening
- Newborn blood screening
- Newborn screening for metabolic diseases and hemoglobinopathies
- Obesity screening
- Psychosocial and behavioral assessment
- Skin cancer screening
- Syphilis, chlamydia, and gonorrhea screening
- Tobacco use and tobacco-caused disease interventions and counseling
- Visual acuity screening



Preventive drugs and treatment for children

- Gonorrhea prophylactic medication
- HIV preexposure prophylactic medication
- Prevention of dental caries, oral fluoride

Immunizations for children

- Chicken pox
- Flu
- Haemophilus influenzae type B (Hib)
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Measles, mumps, rubella (MMR)
- Meningococcal meningitis
- Pneumonia
- Polio
- Rotavirus
- Tetanus, diphtheria, pertussis (Tdap or Td)
- Travel immunizations

If you don't have a primary care provider:
- Visit hmsa.com/eutf and click Find a Doctor.
- If you need help, call us at (808) 948-6499 or 1 (800) 776-4672, Monday through Friday, 7 a.m. to 7 p.m. or Saturday, 9 a.m. to 1 p.m.

This reference list isn't a substitute for your doctor's advice. Your doctor may recommend more or less screenings based on your individual needs. If you have questions about prior authorizations or your health plan benefits, please call the number on the back of your HMSA membership card.

Quick reference guide for preventive care

Blood pressure check
A blood pressure check is recommended for everyone. A blood pressure plan is recommended for people whose most recent blood pressure test was high.

Body mass index
BMI is a number calculated from your weight and height. It's an indicator of body fat and is used to screen for excess weight that may lead to health problems.

Breast cancer screening
A mammogram is recommended for women ages 50 to 74. The test looks for abnormal cells in breast tissue that could lead to cancer.

Cervical cancer screening
These tests are recommended for women ages 21 to 65. There are two tests. A Pap smear looks for abnormal changes in cells in the cervix that could lead to cancer. An HPV test looks for a virus that causes cervical cancer.

Colorectal cancer screening
A colorectal cancer screening is recommended for people ages 50 to 75. This screening looks for abnormal cells and polyps in the colon and rectum that could lead to cancer. Since there are different tests, your doctor can recommend which test is right for you.

Diabetes checkup: Blood sugar test
A blood sugar test is recommended for people with diabetes. High blood sugar can lead to heart attack, stroke, nerve damage, poor circulation, sexual dysfunction, kidney failure, and blindness.

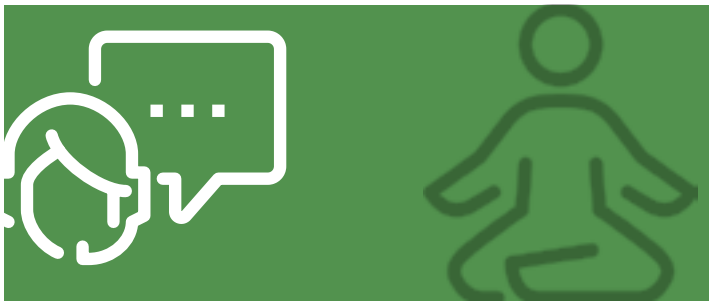
Diabetes checkup: Eye exam
A dilated retinal eye exam (which is different from a regular eye exam) is recommended for people with diabetes. This exam looks for damage to the eye caused by high blood sugar and high blood pressure.

Diabetes checkup: Kidney function test
A kidney function test is recommended for people with diabetes ages 18 to 75. This test looks at your kidneys' ability to filter blood.

Be well, be strong

With HMSA, there are many ways to take care of your health and well-being. Here are some of the benefits and programs available to you at little or no cost. Go to **hmsa.com/eutf** to learn more.

This is an overview of HMSA's well-being programs and services. Check your *Guide to Benefits* to confirm your plan's specific benefits.



Lifestyle Resources

American Specialty Health Group Inc. provides access to 20 medically necessary chiropractic visits per calendar year when you go to an ASH Group network chiropractic provider. Visit **ashlink.com/ash/hmsa** or call ASH Group Customer Service at 1 (888) 981-2746 to find a participating ASH Group chiropractor. See your *Guide to Benefits* to learn more.

Blue Zones Project® is a communitywide well-being improvement initiative that helps make healthy choices easier.

Health and fitness discounts

- **Active&Fit Direct** offers discounted fitness center memberships and more.
- **ChooseHealthy** gives members discounts on health and fitness products such as apparel, home exercise and gym equipment, smart-watches, and more.
- **HMSA365** is a member savings program for fitness, healthy living, and well-being products and services.

Go to **hmsa.com/eutf** and click Member Resources to learn more.

Island Scene is a health and well-being magazine for members. Read it at home or online at **islandscene.com**.

Health Resources

Blue Cross Blue Shield Global Core gives members access to care on the Mainland and in many places around the world.

Caregiver resources are offered to members who are caring for a loved one.

MinuteClinic is a medical clinic in selected Longs Drugs stores on Oahu.

Find a Doctor on **hmsa.com/eutf** helps members find a doctor or other health care provider.

Hawai'i Tobacco Quitline provides support for members who want to quit tobacco for good. Talk to your PCP and call 1 (800) QUIT-NOW (784-8669) to get started.

Health coaching is available to help members reach their health goals. Call 1 (855) 329-5461 to connect with an HMSA health coach.

HMSA's Online Care connects members to doctors and specialists from a computer, tablet, or smartphone from anywhere in Hawaii.

My Account is an online portal that members can use to view their claims, details about their health plan, and more.

Urgent care clinics are usually open after hours and on the weekends. They're recommended for treating minor illnesses and injuries that aren't an emergency but can't wait until the next day.

American Specialty Health Group Inc. is an independent company providing chiropractic, acupuncture, and/or massage therapy services on behalf of HMSA.

Medical Resources

AccordantCare™ is a CVS Caremark® program that offers personalized care for members with rare and complex conditions. The AccordantCare Rare Conditions program provides support for patients who have a rare and/or complex condition.

Advance care planning is a process that documents your health care wishes so that your doctors and family know how you want to be cared for if you can't make decisions for yourself.

Diabetes education provides information and resources for members living with diabetes.

Health and well-being support provides outreach and coaching for members with chronic health conditions.

HMSA Behavioral Health Program provides referrals to providers who can help members with their emotional health.

HMSA's Care Access Assistance Program provides financial assistance for eligible members who need to travel for specialty care that isn't available or isn't available soon enough on their home island.

HMSA Pregnancy and Postpartum Support Program provides eligible members with personalized prenatal care support for a healthy pregnancy and six months after delivery.

HMSA Supportive Care helps members manage the symptoms and stresses of serious illnesses.

Ornish Lifestyle Medicine™ is a nine-week program that helps eligible members reverse the effects of heart disease and reduce risk factors for health conditions like hypertension, prediabetes, diabetes, and early-stage prostate cancer.

Preventive Care

Annual visits with a PCP

- **An annual preventive health evaluation** is an annual health assessment for EUTF Active plan members.
- **A physical exam** is the annual health assessment for HSTA VB Active plan members.
- See the **personal screening checklist** on page 12 for recommended screenings and tests for adults ages 21 to 65.

Diabetes Prevention Program helps eligible members who are at risk for prediabetes prevent the onset of type 2 diabetes through lifestyle and diet changes, exercise, and group support.

Online health education workshops are fun, interactive ways for members to learn about health and well-being topics.

Worksite well-being programs encourage people to engage in healthy habits at work.

GET STARTED

Interested in health management programs or advance care planning? Talk to your PCP. For health and well-being discounts, go to **hmsa.com/eutf** and log in to your account.

Questions? Call us at (808) 948-6499 or 1 (800) 776-4672 or visit us at an HMSA Center or office.

To learn more, visit **hmsa.com/well-being**.

Serving you

hmsa.com/eutf

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

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

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

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

HMSA Office - Lihue, Kauai
4366 Kukui Grove St., Suite 103
Monday–Friday, 8 a.m.–4 p.m.

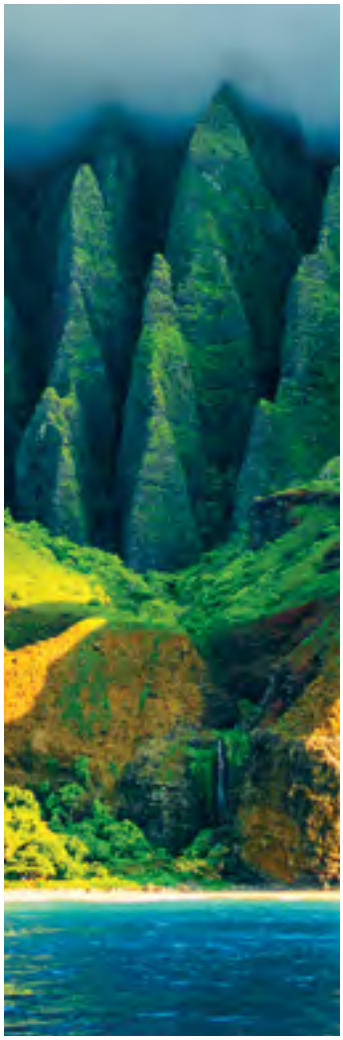
Scan the QR code for more information about HMSA EUTF Actives health plans.

Contact HMSA. We're here with you.

Call (808) 948-6079 or 1 (800) 776-4672.

hmsa.com

myhmsa @AskHMSA @askhmsa HMSA



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) 4000-691850 2:23 GO

Guide to Benefits

EUTF HMO (HMSA)

For Active EUTF State, City and County Employees

July 202.

An Independent Licensee of the Blue Cross and Blue Shield Association

Table of Contents

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CHAPTER 1

This Chapter Covers

About this Guide to Benefits

Your HMO Program

The Trust Fund has contracted with us to administer a health benefits plan as described in this Guide to Benefits.* The type of health coverage provided by the Plan is called a ***Health Maintenance Organization***. If you enroll in our ***Health Maintenance Organization***, you will have medical benefits for treatment of an illness or injury, prevention of illness and injury, and promotion of good health. The Health Plan Hawaii Member Handbook provides further information about this Plan including Member's Rights and Responsibilities, Well-Being Services and preventive health services. In the event the Handbook differs from this Guide to Benefits, the Guide takes precedence. You can get a copy of the Handbook by calling your nearest Customer Service office listed on the back cover of this Guide or visit our web site at www.hmsa.com.

HMSA's Pharmacy and Therapeutics Advisory Committee, composed of practicing physicians and pharmacists from the community, meet quarterly to assess drugs, including new drugs, for inclusion in HMSA's plans. Drugs that meet the Committee's standards for safety, efficacy, ease of use, and value are included in various plan formularies. For more details on coverage under this plan, see *Chapter 4: Description of* Benefits and *Chapter 6: Services Not* Covered.

***EUTF Administrative Rules**

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

Terminology

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

The term ***Health Plan Hawaii (HPH)*** means the HMSA plan that provides or arranges for benefits specified in this Guide to Benefits.

The term ***Provider*** means a physician or other practitioner recognized by us 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.

The term ***Health Center*** means a specified group of providers in the Health Plan Hawaii network that you designate as your primary center of care. Your designated health center is made up of your PCP and other providers.

The term ***Network*** means all providers represented in all health centers that have contracted with HMSA to care for Health Plan Hawaii members.

The term ***Primary Care Provider (PCP)*** means the provider you choose within your health center to act as your personal health care manager.

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.

Accessing Care

Your Member Card

You must present your member card whenever you get services. It identifies you as a Health Plan Hawaii member. If you misplace or lose your card, call Customer Service so that a new card can be sent to you. Our phone numbers are listed on the back cover of this Guide.

Your PCP

Benefits are available only for care you receive from or arranged by your PCP except for care for emergency services, annual vision exams, Online Care, breast pumps, covered immunizations mental health and substance abuse services and clinics located at pharmacies in Hawaii and approved by HMSA. To find a clinic near you go to www.hmsa.com. For more details on these services see *Chapter 4: Description of Benefits*.

You do not need a referral from your PCP to obtain access to obstetrical or gynecological care from a health care professional in your health center who specializes in obstetrics or gynecology. You may receive an annual gynecological exam from any Health Plan Hawaii participating gynecologist or nurse midwife without a referral.

Health Center and PCP

Health Center

Your health center is the group of providers from which all of your services are received. Your health center may be an actual clinic of providers or a group of providers who practice at various locations. Your health center is very important for two reasons:

- Your PCP works within your designated health center; and
- If your condition requires the skills of a specialist, your PCP will arrange for you to get care from a specialty provider within the health center.

PCP

Your PCP will act as your health manager. He or she will do all of the following:

- Advise you on personal health issues.
- Diagnose and treat medical problems.
- Coordinate and monitor any care you may require from appropriate specialists.
- Keep your medical records up-to-date.

Your PCP is the first point of contact whenever you require medical assistance. Maintaining an ongoing relationship with your PCP will help ensure that you are receiving optimal care.

Please check with your PCP for specific information about the requirements for receiving services at your health center.

Your Health Team

Choosing Your Health Team

Your health care team is made up of you and both of the following:
- Your designated health center
- Your designated PCP

To address individual health care needs, you and each covered dependent may choose his or her own PCP and health center within the Health Plan Hawaii Network.

When choosing a PCP and health center, you should consider the following information:
- Do you already have a Provider that you want to remain with? Read through the ***Health Plan Hawaii Directory of Health Centers and Providers*** to determine whether your current Provider is available as a PCP.
- Decide what type of Primary Care Provider specialty fits your needs (family practice, general practice, OB/GYN, internal medicine or pediatrics). For example, you may designate a pediatrician as the Primary Care Provider for your child.
- Select a health center that fits your needs (health centers are in different locations and may offer different providers and specialties).
- Consider your personal preferences (a male or female Provider, cultural issues and languages spoken).
- Call the Provider's office for more details (what are the office hours, what hospital can the Provider practice at, what is their experience with certain diseases).
- You may select any Primary Care Provider within the Health Plan Hawaii Network (the PCP you choose must be in your selected health center or you will be reassigned to the health center where your PCP works).

The Directory of Health Centers and Providers lists the names of each health center and the PCPs and other providers that belong to that health center. Copies of the directory are available by contacting Customer Service. Our phone numbers are listed on the back cover of this Guide.

Certain hospitals may leave HMSA's network of Providers but will remain available to you as if they were network Providers through the current term of your employer's agreement with HMSA. During this time you will continue to pay network hospital copayments and enjoy other in-network benefits even if the hospital leaves the network as to some or all HMSA plans. Network benefits will be available to you through the most current term of your employer's agreement with HMSA but no longer than 12 months from the time the hospital leaves the network.

Please note: To provide you with the best care possible, the total number of patients a PCP can care for is limited. If the PCP you select cannot accept new patients without adversely affecting the availability or quality of services provided, you will need to select someone else.

Changing Your Health Team

Your Primary Care Provider is responsible for providing and arranging all your medical care. Having a continuous relationship with your Primary Care Provider allows you the best possible care. If you need to change your Primary Care Provider, please call your nearest Customer Service office listed on the back cover of this Guide or visit our website at www.hmsa.com, or write Customer Service at:

Customer Service Department
Health Plan Hawaii
P.O. Box 860
Honolulu, Hawaii 96808-0860

If the request is received between the 1st and the 5th of the month, you may choose either the first of the current month or the 1st of the following month as the effective date. If the requested change is between the 6th – 31st, the earliest effective date is the first of the following month. You will get a new member card indicating the name of your new Primary Care Provider.

HMSA will review your request to change to a different health center on a case-by-case basis. We may postpone your request if:

- You are an inpatient in a hospital, an extended care facility or other medical institution at the time of your request;
- The change could have an adverse affect on the quality of your healthcare;
- You are an organ transplant candidate; or
- You have an unstable, acute medical condition for which you are receiving active medical care.

When We Must Assign a New PCP

If your Primary Care Provider's agreement with HMSA ends, we will notify you of the need to select a new Primary Care Provider from your health center. If you do not make a selection, you will be assigned a new Primary Care Provider. Your access to care will not be interrupted during the transition period.

Referrals

The Referral Process

When your PCP determines that your condition requires the services of a specialist or facility, he or she will refer you to an appropriate specialty physician or facility.

The referral process is as follows:

- First, your PCP will look for a physician or facility within your designated health center to treat you.
- If a specialty physician or facility is not available within your health center, your PCP will refer you to a physician or facility within the Health Plan Hawaii network of providers.
- If a specialty physician or facility is not available within your Health Plan Hawaii network of providers, your PCP will refer you to an HMSA participating physician or facility.

When you go to a specialty physician's office or a facility, you should do both of the following:

- Present your member card.
- Inform the physician or nurse that you have been referred by your PCP.

In rare circumstances, your PCP may need to refer you to a nonparticipating or out-of-state physician or facility. This should happen only when:

- a nonparticipating or out-of-state facility required to treat your condition is not available within the Health Plan Hawaii network or HMSA participating providers, or
- you are diagnosed with a condition or disease requiring specialty care, and a specialist within the Health Plan Hawaii network or HMSA participating providers who can provide the health care services for your condition or disease is either not available or access to these providers require unreasonable travel or delay.

Your PCP must submit an administrative review request to HMSA for authorization prior to services being rendered by a nonparticipating or out-of-state physician or facility. If authorization is received and approved prior to you getting services, HMSA will make payment using the nonparticipating or out-of-state provider's actual charge as the eligible charge and you will be responsible for the copayment/ coinsurance amount(s). If authorization is not received prior to receiving these services, you are responsible for the cost of the medical services.

HMSA will respond to this request within a reasonable time appropriate to the medical circumstances of your case but not later than 15 days after receipt of the request. We may extend the time once for 15 days if we cannot respond to the request within the initial 15 days and it is due to circumstances beyond our control. If this happens, we will let your PCP know before the end of the initial 15 days why we are extending the time and the date we expect to render our decision. If we need more details, we will let your PCP know and provide him or her with at least 45 days to provide the information.

Authorization of Services

Benefits are available only for care you receive from or arranged by your PCP except for care for emergency services, annual vision exams, Online Care, breast pumps, covered immunizations mental health and substance abuse services, and clinics located at pharmacies in Hawaii and approved by HMSA. To find a clinic near you go to www.hmsa.com. For more details on these services see *Chapter 4: Description of Benefits*.

You do not need prior authorization from us or from your PCP to obtain access to obstetrical or gynecological care from a health care professional in your health center who specializes in obstetrics or gynecology. Prior authorization may be required for certain services. For a list of participating health care professionals in your health center who specialize in obstetrics or gynecology, contact Customer Service. Our phone numbers are listed on the back cover of this Guide.

You may receive an annual gynecological exam from any Health Plan Hawaii participating gynecologist or nurse midwife without prior authorization from us or from your PCP.

If your PCP does not provide or arrange for your services, you are responsible for the cost of the medical services.

If the provider you are referred to asks you to return for more services, benefits are only available if both of the following are true:

- The provider you are referred to contacts your PCP; and
- Your PCP arranges for more services (that may include the submission of an administrative review to HMSA).

Referral Limitations

Benefits for referred care are limited to those covered services described in this Guide to Benefits. Should your provider recommend or perform services that are not covered or do not meet payment determination criteria, you are responsible for all charges related to the service. See the section *Questions We Ask When You Receive Care* later in this chapter.

Claim Filing and Copayments

Specialty physicians and facilities who provide care when you are referred by your PCP will forward all claims to us. We reserve the right to send benefit payments to you, to a provider, or if you have other coverage besides this Plan, to the other carrier. You are responsible for your copayment. For a summary of your copayments, see Chapter 3: Summary of Benefits and Your Payment Obligations.

Referrals to Another Island

If your PCP refers you to a specialist on another island you may be eligible for inter-island transportation. For more details, see the section *Miscellaneous Medical Treatments* in *Chapter 4: Description of Benefits.*

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 Plans and their Licensed Controlled Affiliates ("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 obtain healthcare services outside of Hawaii, the claims for those services may be processed through one of these Inter-Plan Arrangements.

When you receive Medical 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.

We cover only limited medical services received outside your plan service area. As used in this section, "Medical Care Outside of Hawaii" includes emergency care and urgent care only (and specifically not follow-up care, routine care, and elective care) obtained outside the geographic area we serve. Any other services will not be covered as Medical Care Outside of Hawaii when processed through any Inter-Plan Arrangements unless authorized by your PCP. This is described in more detail below.

- For emergency and urgent care services outside of Hawaii, benefits are available through the BlueCard program. You should follow these steps:
  - Carry your current member card for easy reference and access to service.
  - If you experience a Medical Emergency while traveling outside Hawaii, go to the nearest Emergency facility.
  - For urgent care, to find names and addresses of nearby providers, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard Access at 1-800-810-BLUE (2583). Call the provider to schedule an appointment.

When you arrive at the participating BlueCard provider, present your member card. You are responsible for paying the provider copayments for covered services. The provider will submit a claim for the services rendered.

Contact your PCP as soon as possible after receiving services so that he or she can update your file and assist/approve any added care you might require.

- For non-emergency and non-urgent care services outside of Hawaii, you must contact your PCP to make appropriate arrangements for your care. Your PCP must submit an administrative review request to HMSA for an authorization prior to services being rendered. If authorization is not received prior to you receiving these services, you are responsible for the cost of the medical services.

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 Providers

Under the BlueCard® Program, when you receive Medical Care Outside of Hawaii within the geographic area served by a Host Blue, we 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.

The BlueCard Program enables you to obtain Medical Care Outside of Hawaii, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for Medical Care Outside of Hawaii provided to you, so there are no claim forms for you to fill out. You will be responsible for the copayment amount, as stated in *Chapter 1: Important Information; Chapter 3: Summary of Benefits and Your Payment Obligations,* and *Chapter 4: Description of Benefits*.

Emergency Care Services

If you experience a Medical Emergency while traveling outside of Hawaii, go to the nearest Emergency or Urgent Care facility.

Whenever you receive Medical Care Outside of Hawaii and the claim is processed through the BlueCard Program, the amount you pay for Medical Care Outside of Hawaii, if not a flat dollar copayment, 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 of claims, 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.

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 Medical Providers Outside Hawaii

When Medical Care Outside of Hawaii is provided 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 responsible 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.

Exceptions

In certain situations, we may use other payment methods, such as billed covered charges we would make if the 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 make for covered medical services as set forth in the Guide to Benefits.

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 copayment amounts. 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.

Care on Neighbor Islands

For trips to the Neighbor Islands, urgent care benefits are available by contacting the Customer Service office on the island you are visiting. Our phone numbers are listed on the back cover of this Guide. A customer service representative will arrange your appointment and advise you of your copayment responsibility. Benefits include one visit to a provider's office. Contact your PCP as soon as possible after receiving services so that he or she can update your file and provide or arrange any added care you might require.

Guest Membership Program

If you will be living away from your plan service area for longer than 90 days, benefits are available through the Guest Membership program within the U.S. You will need to prearrange care in the new service area through us. We will advise you of the HMO host plans that are available to you.

- For members who are away from home, Guest Membership privileges are available for up to 180 days. If your absence from Hawaii exceeds 180 days, you may renew your Guest Membership privileges for up to an additional six months.
- For dependents who are away from home, Guest Membership privileges must be renewed annually.

Process for Establishing Guest Membership

How to Enroll in the Guest Membership Program. To enroll in the Guest Membership Program, call the HPH Away from Home Care Coordinator before you leave your plan service area. For a list of phone numbers by island, see the back cover of this Guide. The coordinator will research if a HMO host plan is available in the area you will be visiting.

- If a provider is available, you will need to fill out an enrollment form. Enrollment information can be taken by phone or through the mail.
- Once the enrollment is completed, the HPH coordinator will forward the enrollment form to the Away from Home Care Coordinator in the service area you will be visiting.
- Once the HMO host plan processes your enrollment form, you will become a guest member of the HMO host plan while you are living in their service area. As a guest member, you are eligible for those benefits offered by the HMO host plan and must abide by the provisions of that plan. Your HPH plan benefits will not apply until you return to your HPH service area.
- When you arrive at your destination, call the Away from Home Care Coordinator of the HMO host plan. The coordinator will provide you with a list of Providers (from which you can select a PCP) and a description of the host plan's benefits.

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 on the regarding 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.

Did You Receive Care from Your PCP?

Benefits are available only for care you receive from or arranged by your PCP except for care for emergency services, annual vision exams, Online Care, breast pumps, covered immunizations mental health and substance abuse services, and clinics located at pharmacies in Hawaii and approved by HMSA. To find a clinic near you go to www.hmsa.com. For more details on these services see *Chapter 4: Description of Benefits*.

You do not need a referral from your PCP to obtain access to obstetrical or gynecological care from a health care professional in your health center who specializes in obstetrics or gynecology. You may receive an annual gynecological exam from any Health Plan Hawaii participating gynecologist or nurse midwife without a referral.

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. 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 HPH network providers and some non-network providers are recognized. To find out if your provider is a network provider, refer to your Directory of Health Centers and 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 non-network 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.

Chapter 1: Important Information

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.

Routine and Preventive Services

Detecting conditions early is important. That's why HMSA is committed to providing you with benefits for routine and preventive health services. Many serious disorders can be prevented by healthier lifestyles, immunizations, and early detection and treatment. Routine and preventive care should always be performed by your PCP. ***PCP*** means the provider you choose within your health center to act as your personal health care manager.

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

Our Rights to Interpret this Document

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

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

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

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

CHAPTER 2

This Chapter Covers

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.

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.

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

Please note: If you get a noncovered service, you are responsible for the entire amount charged by your provider.

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.

Except as otherwise stated in this Guide:

- When you get multiple services from the same provider on the same day, you owe one fixed dollar copayment if fixed dollar copayments are applicable to the services you get. However, if the eligible charge for the service or supply you receive is less than the fixed dollar copayment amount listed in chapter 3, your actual copayment is the eligible charge and you may owe more than one copayment. The total copayment amount will not exceed the fixed dollar copayment amount listed in chapter 3 for the service or supply you receive.
- You owe all copayments that are a percentage of eligible charge if eligible charge percentage copayments are applicable to the services you get.

• If you get some services with fixed dollar copayments and some with copayments that are a percentage of eligible charge, you owe one fixed dollar copayment and all copayments based on a percentage of eligible charge. For services with fixed dollar copayments, if the eligible charge for such services is less than the fixed dollar copayment amount listed in chapter 3, your actual copayment is the eligible charge and you may owe more than one copayment. However, your copayment amount will not exceed the fixed dollar copayment amount listed in chapter 3 for the service or supply you receive.

If you get services from more than one provider on the same day, more than one copayment may apply.

Amount

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

Annual Copayment Maximum

Definition

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

Amount

$1,500 per person

$3,000 (maximum) per family

When You Pay More

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

• Payments for services subject to a maximum once you reach the maximum. See *Benefit Maximum* later in this chapter.
• 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 non-network 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 PPO and 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 *er 1: Important Information*.

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

Benefit and Payment Chart

About this Chart

This benefit and payment chart:

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

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

Remember, benefits are available only for care you receive from or arranged by your PCP except for care for emergency services, annual vision exams, Online Care, breast pumps, covered immunizations mental health and substance abuse services, and clinics located at pharmacies in Hawaii and approved by HMSA. To find a clinic near you go to www.hmsa.com. For more details on these services see *Chapter 4: Description of Benefits*.

You do not need a referral from your PCP to obtain access to obstetrical or gynecological care from a health care professional in your health center who specializes in obstetrics or gynecology. You may receive an annual gynecological exam from any Health Plan Hawaii participating gynecologist or nurse midwife without a referral.

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
Routine and Preventive		
Annual Preventive Health Evaluation (preventive visit)	24	None
Chlamydia (screening)	24	None
Diabetes Prevention Program	24	None when received from a provider that meets the requirements of the Diabetes Prevention Program as described in *Chapter 4: Description of Benefits* under *Special Benefits – Routine and Preventive.*
Disease Management and Preventive Services Programs	24	None
Gonorrhea (screening)	24	None
Gynecological Exam	24	None
Immunizations	24	None
Mammography (screening)	25	None
Prostate Specific Antigen (PSA) Screening Test	25	None
Screening Services, Preventive Counseling, and Preventive Services	25	None
Vision Exam	26	$15
Well-Being Services	26	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.
Well-Child Care	26	None
Online Care		
Online Care	26	None
Telehealth		
Telehealth	27	Your copayment amounts vary depending on the type of services or supply you receive. See copayment amounts listed in this chart for the service or supply you receive.
Physician Visits		
Away from Home Care	27	$15 for out of network urgent care in Hawaii $15 for urgent care from a BlueCard provider outside Hawaii Host plan copayments apply for services from BlueCard providers outside Hawaii if you are enrolled in the Guest Membership Program Please see *er 1: Important Information* under *Care While You are Away from Home* for more information
Emergency Room	27	None
Extended Care Facility	27	None

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
Home	27	$15
Inpatient Hospital	27	None
Office	27	$15
Outpatient Hospital	28	$15
Surgical Center	28	$15
Testing, Laboratory, and X-Rays		
Allergy Testing	28	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Diagnostic Testing	28	None (office visit) None (hospital outpatient) None (hospital inpatient)
Evaluations for the Use of Hearing Aids	28	None (office visit)
Genetic Testing and Counseling	28	None (office visit) None (hospital outpatient) None (hospital inpatient)
Laboratory and Pathology	28	None (office visit) None (hospital outpatient) None (hospital inpatient)
X-ray and Other Radiology	28	$15 per x-ray (office visit) $15 per x-ray (hospital outpatient) None (hospital inpatient)
Surgery		
Anesthesia	28	$15 (outpatient professional charges) None (inpatient professional charges)
Assistant Surgeon Services	28	$15 (outpatient professional charges) None (inpatient professional charges)
Bariatric Surgery	29	$15 (outpatient professional charges) None (inpatient professional charges)
Oral Surgery	29	$15 (outpatient professional charges) None (inpatient professional charges)
Surgical Procedures	29	None (outpatient surgical center) $15 (outpatient professional charges) None (hospital operating room) None (inpatient professional charges)
Tubal Ligation	29	None (outpatient professional charges) None (inpatient professional charges)

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
Maternity		
Artificial Insemination	29	$15
In Vitro Fertilization	29	20% of eligible charge
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	30	None
Pregnancy Termination	30	$15 (outpatient) None (inpatient)
Hospital and Facility Services		
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	30	None
Hospital Ancillary Services	31	None
Hospital Room and Board	31	None (You may owe amounts in addition to your copayment. Please see *Chapter 4: Description of Benefits* under *Hospital and Facility Services – Hospital Room and Board* for more information.)
Outpatient Facility	31	None
Private Duty Nursing	32	50% of eligible charge
Emergency Services		
Emergency Room Facility Services	32	$100
Rehabilitation Therapy Services		
Dr. Ornish's Program for Reversing Heart Disease (TM)	33	$15 when received from a provider that meets the requirements of the Dr. Ornish Program described in *Chapter 4: Description of Benefits* under *Rehabilitation Therapy Services.*
Physical and Occupational Therapy	33	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Pulmonary Rehabilitation	34	$15 (outpatient) None (inpatient)
Speech Therapy Services	34	$15 (outpatient) None (inpatient)
Home Health Care and Hospice		
Home Health Care	35	None
Hospice Services	35	None
Supportive Care	35	None

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
Chemotherapy and Radiation Therapy		
Chemotherapy – Infusion/Injections	36	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Radiation Therapy	36	$15 (outpatient) None (inpatient)
Miscellaneous Medical Treatments		
Advance Care Planning	36	None
Ambulance (air)	36	20% of eligible charge
Ambulance (ground)	36	20% of eligible charge
Applied Behavior Analysis rendered by a Behavior Analyst Recognized by Us	37	$15
Blood and Blood Products	37	20% of eligible charge
Breast Pump	37	None
Contraceptive IUD	37	None
Contraceptive Implants	37	None
Contraceptive Injectables	37	None
Dialysis and Supplies	37	$15 (hospital outpatient) None (hospital inpatient)
Durable Medical Equipment and Supplies	37	20% of eligible charge
Gender Identity Services	37	Your copayment amounts vary depending on the type of service or supply. See copayment amounts listed in this chart for the service or supply you receive.
Growth Hormone Therapy	38	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Implanted Internal Items/Implants - Outpatient	38	None
Inhalation Therapy	39	$15(office visit) $15 (hospital outpatient) None (hospital inpatient)
Injections – Other than Self-Administered	39	$15 (office visit) None (hospital outpatient) None (hospital inpatient)
Injections – Self Administered	39	None
Inter-island Transportation	39	None

	more info. on page:	Your Copayment Amount Is: (Copayments are based on eligible charges)
Medical Foods	39	20% of eligible charge
Medical Nutrition Therapy	39	$15
Orthodontic Services to Treat Orofacial Anomalies	39	None (You may owe amounts in addition to your copayment. Please see *Chapter 4: Description of Benefits* under *Miscellaneous Medical Treatments Orthodontic Services to Treat Orofacial Anomalies* for more information.)
Orthotics and External Prosthetics	40	20% of eligible charge
Outpatient IV Therapy	40	None
Vision and Hearing Appliances	40	20% of eligible charge
Behavioral Health - Mental Health and Substance Abuse		
Hospital/Facility Charges	41	None (hospital outpatient) None (hospital inpatient) (You may owe amounts in addition to your copayment. Please see *Chapter 4: Description of Benefits* under *Behavioral Health - Mental Health and Substance Abuse* for more details.)
Physician Visits	41	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Psychological Testing	41	None (office visit) None (hospital outpatient) None (hospital inpatient)
Organ and Tissue Transplants		
Organ and Tissue Transplants	41	None (outpatient surgical center) $15 (outpatient professional charges) None (hospital operating room) None (inpatient professional charges)
Organ Donations	42	None (outpatient surgical center) $15 (outpatient professional charges) None (hospital operating room) None (inpatient professional charges)
Case Management Services		
Case Management Services	42	Your copayment amounts vary depending on the type of service. See copayment amounts listed in this chart for the service you receive.

Chiropractic Services

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

	more info. on page:	**Your Copayment Amount Is** (Copayments are based on the ASH Group eligible charges)
Chiropractic Services		
Patient Exam (New or Established)	43	$15
Office Visit (Follow-up)	43	$15
X-rays/Radiological Consultations	43	None
Chiropractic – Supports and Supplies	43	Not Covered

CHAPTER 4

This Chapter Covers

Chapter 4: Description of Benefits describes covered services. Benefits are available only for care you receive from or arranged by your PCP except for care for emergency services, annual vision exams, Online Care, breast pumps, covered immunizations mental health and substance abuse services, and clinics located at pharmacies in Hawaii and approved by HMSA. To find a clinic near you go to www.hmsa.com. You do not need a referral from your PCP to obtain access to obstetrical or gynecological care from a health care professional in your health center who specializes in obstetrics or gynecology. You may get an annual gynecological exam from any Health Plan Hawaii participating gynecologist or nurse midwife without a referral. For more details on these exceptions, refer to the benefit descriptions for each of these services in this chapter. Be sure to read *Chapter 1: Important Information*. All information within *Chapter 1: Important Information* applies to accessing the services described in this chapter. This chapter is divided into the following categories:

Be Sure to Also Read:
- Chapter 1: Important Information
- Chapter 3: Summary of Benefits and Your Payment Obligations

About this Chapter

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

Additional Coverage Mandated by Law

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

Non-Assignment of Benefits

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

Routine and Preventive

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 *Screening Services, Preventive Counseling, and Preventive Services* for other screenings covered by this plan.

Please note: Similar services for members under age 22 are covered as set forth in other sections of this chapter. See *Well-Child Care.*

Chlamydia (screening)

Covered.

Diabetes Prevention Program

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

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

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

For more details on the program criteria and how to find a provider, please visit our Diabetes Prevention Program page at HMSA.com.

***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.

Gonorrhea (screening)

Covered.

Gynecological Exam

Covered, for an annual gynecological exam. You may receive an annual gynecological exam from a participating Health Plan Hawaii gynecologist or nurse midwife without a referral. Any services from a provider outside the Health Plan Hawaii network require an administrative review request by your PCP as described in *Chapter 1: Important Information*.

Covered, but only vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).

Please note: The list of ACIP recommended immunizations may change. If you would like information about the ACIP recommended immunizations, please visit our website at www.hmsa.com or call us at one of the phone numbers listed on the back cover of this Guide.

Mammography (Screening)

Covered, but only for screening mammography according to the following schedule:
- Age 35 - 39 years of age, one baseline mammogram.
- Age 40 years of age or older, one mammogram per calendar year.

Please note: Benefits for diagnostic mammography is described in other sections of this chapter under *X-rays and Other Radiology*.

Prostate Specific Antigen (PSA) Screening Test

Covered. For diagnostic PSA tests, see later in this chapter under *Testing, Laboratory, and X-Rays.*

Screening Services, Preventive Counseling, and Preventive Services

Covered for the following screenings:
- anemia and lead screening for children
- colorectal cancer screening
- fecal occult blood test
- lipid evaluation
- newborn metabolic screening
- cervical cancer screening
- osteoporosis screening
- diabetes screening

Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following:
- Preventive Counseling
- Preventive Services
- Screening Laboratory Services:
  - Screening for Lipid Disorders in Adults
  - Screening for Asymptomatic Bacteriuria in Adults
  - Screening for Hepatitis B Virus Infection
  - Screening for HIV
  - Screening for Syphilis Infection
  - Screening for Type 2 Diabetes Mellitus in Adults
  - Screening for Iron Deficiency Anemia
  - Screening for Rh (D) Incompatibility
  - Screening for Congenital Hypothyroidism
  - Screening for Phenylketonuria (PKU)
  - Screening for Sickle Cell Disease in Newborns
  - Screening for Tuberculosis
- Screening Radiology Services:
  - Screening for Abdominal Aortic Aneurysm
  - Screening for Osteoporosis in Postmenopausal Women

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

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

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

Covered for recommended preventive services for women developed by the Institute of Medicine (IOM) and supported by the Health Resources and Services Administration (HRSA), such as the following:
- Breastfeeding Support and Counseling – but only from a trained physician or midwife during pregnancy and/or in the postpartum period.
- Contraceptive Counseling.
- Gestational Diabetes Screening.

- Human Papillomavirus (HPV) DNA Testing.
- Interpersonal and Domestic Violence Screening and Counseling.

Please note: Benefits for other IOM recommended preventive services for women may be found in this section under *Gynecological Exam*, and in other sections of this chapter under *Surgery* and *Miscellaneous Medical Treatments.*

Vision Exam

Covered. Your HMO medical plan provides benefits for one routine vision exam per calendar year. A referral from your PCP is not necessary. You may get services from any provider who participates in the HMO vision network. However, follow-up care or care unrelated to the routine vision exam must be received from or arranged by your PCP.

Your plan does not provide benefits for vision exams by non-network vision providers. Copies of the HMO Vision Network directory are available by contacting Customer Service. Our phone numbers are listed on the back cover of this Guide.

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. Well-Child Care means routine and preventive care for children through age twenty-one. Well-Child Care includes:

- office visits for history,
- physical exams,
- sensory screenings,
- developmental/behavioral assessments,
- anticipatory guidance,
- laboratory tests, and
- immunizations as identified on the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care and in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP).

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.

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 Visits

Away from Home Care

Covered, for physician visits while you are away from home according to the Away From Home Care Program. Guidelines are explained in *Chapter 1: Important Information* in the section *Care While You are Away from Home.*

Emergency Room - Physician Visits

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 or a referral from your PCP 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 services benefits.

Extended Care Facility Physician Visits

Covered, when you are in an extended care facility, including physician consultations and visits by a specialty physician.

Home Physician Visits

Covered, including physician consultations and visits by a specialty physician.

Inpatient Hospital Physician Visits

Covered, when you are inpatient at a hospital including physician consultations and visits by a specialty physician. Newborn care is covered in accord with the time periods specified later in the chapter under *Maternity and Newborn Length of Stay*.

Office Physician Visits

Covered, at a physician's office including physician consultations and visits by a specialty physician.

Please note: A copayment will not be applied to outpatient miscarriage services.

Outpatient Hospital Physician Visits	Covered, when you are outpatient at a hospital including physician consultations and visits by a specialty physician
Surgical Center Physician Visits	Covered, when you are in a surgical center, including physician consultations and visits by a specialty physician.

Testing, Laboratory and X-Rays

Allergy Testing	Covered.
Diagnostic Testing	Covered, for tests to diagnose an illness or injury. Some examples of diagnostic testing include: • Electroencephalograms (EEG) • Electrocardiograms (EKG or ECG)
Evaluations for the Use of Hearing Aids	Covered.
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 *Routine and Preventive, Screening Services, Preventive Counseling, and Preventive Services.*
Laboratory Tests	Covered. Some examples of lab tests include: • Urinalysis • Blood tests • Throat cultures
X-rays and Other Radiology	Covered. Some examples of other radiology include: • Computerized Tomography Scan (CT Scan) • Nuclear Medicine • Ultrasound • Diagnostic mammography ***Please note:*** Some radiological procedures must have precertification. See *Chapter 5: Precertification.*

Surgery

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

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.
Assistant Surgeon Services	Covered, 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 and when:
- The facility is located in the state of Hawaii, has a contract with HMSA to perform bariatric surgery and has a comprehensive weight management program; or
- The facility is an approved Blue Distinction Center for bariatric surgery with an agreement for continuity of care in the state where the member primarily resides.

Oral Surgery

Covered. You have benefits for services of a dentist if you require oral surgery and the surgery (or emergency procedure) could be performed by either a physician or a dentist.

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, except treatment rendered by a Health Plan Hawaii Network physician for complications resulting from non-covered cosmetic services performed by a Health Plan Hawaii Network physician while you were enrolled in a Health Plan Hawaii group plan.

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

Surgical Procedures

Covered, for surgery including pre-and post-operative care.

Tubal Ligation

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

Maternity

Artificial Insemination

Covered.

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

In Vitro Fertilization

Covered, when provided or arranged by your PCP. But coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are an HPH or HMSA member. If you get benefits for in vitro fertilization services under an HPH or HMSA plan, you will not be eligible for in vitro fertilization benefits under any other HPH or HMSA plan. In vitro fertilization services are not covered when a surrogate is used. The in vitro procedures must be performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine's minimal standards for programs of in vitro fertilization.

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: In vitro fertilization not provided or approved by your PCP is not a covered benefit and you are responsible for payment. In vitro fertilization services include those services constituting the complete in vitro fertilization and embryo transfer process. Benefits for services in connection with, but not included in the complete in vitro fertilization process, are covered elsewhere in this Guide.

Please note: Exclusions or limitations that 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.

HMSA pays physicians a global fee related to a bundle of maternity care. If benefit payments are made separately before delivery, payments will be considered an advance and we will deduct the amount from the global benefit payment for maternity care.

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

You have inpatient benefits for maternity as follows:
- 48 hours from time of delivery for a vaginal labor and delivery; or
- 96 hours from time of delivery for a cesarean labor and delivery.

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.

Hospital and Facility Services

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 PCP.
- Care is ordered and certified by your PCP.
- Care is for skilled nursing care, sub-acute care, or long-term acute care rendered in an extended care facility.
- Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care.
- The confinement is not for custodial care.

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

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

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

Hospital Ancillary Services

Covered. Examples of ancillary services include:
- anesthesia,
- antibiotics and other drugs chemotherapy and radiation therapy,
- hemodialysis,
- lab tests,
- oxygen,
- surgical supplies and
- X-rays.

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. Your plan may include a copayment for hospital rooms. See *Chapter 3: Summary of Benefits and Your Payment Obligations*, under *Hospital and Facility* Services, to find out if you owe a copayment under this plan. Also, you may owe the difference between HMSA's payment and the hospital charge. See below for more information.

- Semi-Private Rooms. Your copayment (if any) is based on the facility's medical/surgical semi-private room rate.
- Private Rooms.
  - At Network Facilities:
    - If you are hospitalized in a network facility with private rooms only, your copayment (if any) is based on HMSA's maximum allowable fee for semi-private rooms.
    - If you are hospitalized in a network facility with semi-private and private rooms or a BlueCard facility, your copayment (if any) 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 (if any) is based on the facility's medical/surgical private room rate. You may call HMSA for a list of these conditions.
  - At Non-network Facilities:
    - If you are hospitalized in a non-network facility, your copayment (if any) 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 (if any) is based on the facility's medical/surgical private room rate. You may call HMSA for a list of these conditions.
- Intensive care or coronary units.
- Intermediate care units.
- Isolation units.
- Operating rooms.
- Newborn nursery care. Covered for the baby's nursery care after birth in accord with the time periods specified in this chapter under *Maternity and Newborn Length of Stay*.

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

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*.

Private Duty Nursing

Covered, when:
- Care is ordered and certified by your PCP or attending physician.
- You are inpatient at a hospital; and
- Services are rendered by a duly licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.)

Emergency Services

Covered, but only to stabilize a medical condition that is accompanied by acute symptoms or sufficient severity (including severe pain), including room and ancillary charges and physician visits, if 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 or a referral from your PCP is not needed.

Please note: If you are admitted to the hospital after your condition is no longer emergent, hospital inpatient benefits will apply and not emergency services benefits.

You will not receive benefits if you use emergency services for any of these reasons:
- For your convenience.
- During normal office hours for medical conditions that are treatable in a physician's office.

Contacting Your PCP

If you are unable to contact your PCP before you get emergency services, you (or someone acting on your behalf) should contact your PCP to:
- Advise him or her of your condition; and
- Get instructions about follow-up care.

Please note: You should contact your PCP within 48 hours after the illness or injury or as soon as reasonably possible.

Emergencies Outside of Hawaii

For emergencies in another state or country, these guidelines apply:
- If the provider participates with the Blue Cross and/or Blue Shield plan in that state (or foreign country), the provider will file a claim for you. We will reimburse the provider directly. ***Please note***: Remember to show the provider your member identification card.
- If the provider does not participate with the Blue Cross and/or Blue Shield plan in that state (or foreign country), you are responsible for paying the provider directly and filing a claim with us. For more details on filing claims, see *Chapter 7: Filing Claims.*

Please note: If you have guest membership and require emergency services, the benefits of guest membership applies. See *Chapter 1: Important Information* in section *Care While You are Away from Home.*

How to Access Emergency Services

For emergencies you should do one of the following:

- If possible, you should first contact your PCP for direction and guidance on the emergency situation. Your PCP (or a Provider acting on his or her behalf) is available for such calls 24 hours a day.
- If your illness or injury is so life-threatening that contacting your PCP is not realistic, go immediately to the nearest emergency center for care.

Once at the emergency room, you (or someone acting on your behalf) should do all of the following:

- Present your member card.
- Ask the physician or hospital to forward a copy of your medical care record to your PCP. Your PCP will review the emergency care, arrange for any necessary follow-up care, update your medical records, and be kept informed of your health status. Please tell your PCP about any specific emergency instructions given to you.
- Request the physician or hospital to file a claim with us.

Rehabilitation Therapy Services

Dr. Ornish's Program for Reversing Heart Disease™

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

- You received one or more of the following medical procedures:
  - An acute myocardial infarction within the preceding 12 months;
  - A coronary artery bypass surgery;
  - Current stable angina pectoris;
  - Heart valve repair or replacement;
  - Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;
  - A heart or heart-lung transplant; or
  - Stable, chronic heart failure.
- Program services are provided by practitioners who contract with HMSA to provide program services, and
- 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 from a physician, physician's assistant or advanced practice registered nurse under an individual treatment plan.

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

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.

Home Health Care and Hospice Services

Home Health Care

Covered, 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.
- The attending physician must approve a plan of treatment for the Beneficiary. If you need home health care visits for more than 30 days, the physician must recertify that more visits are required and provide an ongoing plan of treatment at the end of each 30-day period of care.
- Visits must be from the Health Center or a qualified home health agency.

Benefit Limitation: Home health care is limited to 365 visits per illness or injury.

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 patient is not eligible for benefits for the terminal condition except hospice services and attending physician office visits. The patient is eligible for all covered benefits unrelated to the terminal condition.

The attending physician must certify in writing that the patient 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.

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.*

Miscellaneous Medical Treatments

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.

Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us

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

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

Autism Spectrum Disorders – Diagnosis and Treatment

Covered, in accord with Hawaii law and HMSA's medical policies, for the following services:

- Behavioral health treatment. Benefits for Applied Behavior Analysis rendered by a Recognized Behavior Analyst as described more fully in the section labeled "Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us".
- Psychiatric care.
- Psychological care.
- Therapeutic care.

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

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

Blood and Blood Products

Covered, for blood, blood products, blood bank services, and blood processing including collection, processing and storage of autologous blood for a scheduled surgery when prescribed by a provider whether or not the units are used.

You are not covered for any of the following:

- Blood bank processing for blood transfused as an outpatient.
- Storage of or lab fees for blood or blood products.
- Peripheral stem cell transplants except as described in this chapter under Stem-Cell *Transplants (including Bone Marrow Transplants).*

Breast Pump

Covered, for purchase of one device including attachments per pregnancy when purchased from a Health Plan Hawaii Network Provider or Participating Medical Pharmacy that provides medical equipment and supplies. You do not need a referral from your PCP.

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.

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

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, for inpatient and outpatient inhalation therapy.

Injections – Other than Self-Administered

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

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

Injectable drugs must be FDA approved.

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

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

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

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

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

Injections – Self Administered

Covered, Injectable drugs must be FDA approved.

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

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

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

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

Inter-island Transportation

Covered, as follows:

- The transportation is for the covered person who requires treatment; and
- The transportation is necessary because treatment is not available at your health center but is available on another island in the state of Hawaii.

Benefit Limitation: Benefits for inter-island transportation is limited to one round-trip inter-island transportation required for one complete episode of treatment. You are not covered for ground transportation or fees charged by the airlines for cancellation or changes to your reservations. Reimbursement shall be made for the lowest appropriate fare on an inter-island or commercial airline and/ or ferry service. Payment will not be made for use of personally owned or privately chartered modes of transportation.

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 *Routine and Preventive, Screening Services, Preventive Counseling, and Preventive Services.*

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

Orthodontic Services to Treat Orofacial Anomalies

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

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

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

Orthotics and External Prosthetics

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

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

Examples of orthotics include:
- braces,
- orthopedic footwear, and
- shoe inserts.

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

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 orthotics/external prosthetics require 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.*

Behavioral Health - Mental Health and Substance Abuse

Covered, if:

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

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

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

Please note: Precertification is required for the admission and continued treatment at all residential treatment facilities. In addition, partial hospitalization and intensive outpatient treatment at non-contracted and out-of-state facilities require precertification. 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.

How to Access Services

You may get mental health or substance abuse services from any provider who practices at your designated health center or any provider listed under the HMO Behavioral Health Network in the Health Plan Hawaii Directory of Health Centers and Providers. A referral from your PCP is not necessary. However, any services from a provider outside your health center or the HMO Behavioral Health Network require an administrative review request by your PCP as described in *Chapter 1: Important Information*. Copies of the Health Plan Hawaii Directory of Health Centers and Providers are available by contacting Customer Service. Our phone numbers are listed on the back cover of this Guide.

Organ and Tissue Transplants

Covered, but only as described in this section 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.

Also, all transplants (with the exception of corneal and kidney transplant surgeries) must:

- Receive our approval. Without approval for the specified transplants, benefits are not available. Your PCP will get approval for you.
- Be from a facility that:
  - Accepts you as a transplant candidate, and
  - Is located in the State of Hawaii and has a contract with us to perform the transplant, or
  - Is an approved Blue Distinction Center for Transplants. You may call HMSA for a current list of providers.

	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 the 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.
Heart and Lung Transplants	Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification.*
Heart Transplants	Covered, but only if you meet HMSA's criteria and if we approve. See *Chapter 5: Precertification.*
Kidney Transplant Surgery	Covered, but only if you meet HMSA's criteria. Coverage for related services are described in other sections of this Guide.
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.*
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 and must be rendered either at a facility that is located in the State of Hawaii and has a contract with us to perform the transplant or is an approved Blue Distinction Center for Transplants. For details about donor screening benefits, see in this chapter under *Organ Donor Services*.

Organ Donations

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.

Case Management Services

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*.

Chiropractic Services

Covered, in accord with American Specialty Health Group, Inc. ("ASH") which has been contracted by HMSA to administer the benefit through a Complementary Care Rider for the following services. All Definitions, provisions, limitations, exclusions, and conditions of the Complementary Care Rider shall apply to the chiropractic services benefits described in this Guide to Benefits.

- Office Visit - New/Established patient exam
- Follow-up office visits (include manipulation of the spine, joints, and /or musculoskeletal soft tissue, a reevaluation, and/or other services in various combinations).
- Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies covered only when provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- X-rays/radiological consultations when provided by or referred by an in-state or out-of-state ASH In-Network provider to another in-state or out-of-state ASH In-Network provider.

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

Benefit Limitation and maximums

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

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

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

CHAPTER 5

This Chapter Covers

Definition

Precertification is a special approval process to make sure that certain medical treatments, procedures, or devices meet payment determination criteria before the service is rendered. HMSA requires pre-certification of various services before the services are given. Your physician is aware of the guidelines to follow and will submit the information and papers that are needed for consideration. When pre-certification is authorized, you should receive services at your selected health center unless the services are referred.

Services and Supplies Which Require Precertification

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

Lab, X-ray and Other Diagnostic Tests such as genetic testing, polysomnography and sleep studies, computed tomography (CT), and functional MRI.

Surgeries such as organ and tissue transplants and varicose veins treatment.

Treatment Therapies such as applied behavior analysis, physical, occupational and speech therapies, chiropractic services, in vitro fertilization, growth hormone therapy, home IV therapy, drugs such as oral chemotherapy agents, infusibles and injectables, new drug to market (specialty medical drugs), and off-label drug use.

Durable Medical Equipment and Orthotics and Prosthetic Devices such as wheelchairs, positive airway pressure and oral devices to treat obstructive sleep apnea.

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

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

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 Customer Service, 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 *Routine and Preventive – Screening 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 cover 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 services listed in *Chapter 4: Description of Benefits*. Included in this exclusion are dental services that are generally provided only by dentists and not by physicians. The following exclusions apply regardless of the symptoms or illnesses being treated:

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

Drugs

You are not covered for prescription drugs and supplies.

Eyeglasses and Contacts

Except as described in *Chapter 4: Description of Benefits* under *Miscellaneous Medical Treatments, 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 contraceptive services or contraceptives including diaphragms, cervical caps, oral contraceptives, and other contraceptive methods except as described in *Chapter 3: Summary of Benefits and Your Payment Obligations and Chapter 4: Description of Benefits* under *Miscellaneous Medical Treatments*.

Infertility Treatment

Except as described in *Chapter 4: Description of BenefitsChapter* 4: Description of Benefits under *Maternity*, 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 *Maternity*.

Sterilization Reversal

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

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 under Routine and Preventive, Screening Services, Preventive Counseling, Preventive Services and Miscellaneous Medical Treatments, Medical Nutrition Therapy*.

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, domestic partner, 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 Network Providers under this plan except as noted above. Services received from these providers will be subject to HMSA's Referral Process, see *Chapter 1: Important Information Referrals*.

Chapter 6: Services Not Covered

Transplants

Living Organ Donor Services
You are not covered for organ donor services if you are the organ donor.

Living Donor Transport
You are not covered for expenses of transporting a living 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.* ***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 or peripheral 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 diagnostic 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 *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, except treatment rendered by a Health Plan Hawaii Network physician for complications resulting from non-covered cosmetic services performed by a Health Plan Hawaii Network physician while you were enrolled in a Health Plan Hawaii group plan.

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 also not covered for complications of recent or past cosmetic surgeries, services or supplies, except treatment rendered by a Health Plan Hawaii Network physician for complications resulting from non-covered cosmetic services performed by a Health Plan Hawaii Network physician while you were enrolled in a Health Plan Hawaii group plan.

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

Refer to Sexual Dysfunction.

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 the trust fund 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 the trust fund are responsible for reimbursing us.

Foot Orthotics

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

- Foot orthotics for persons with specific diabetic conditions per Medicare guidelines;
- Foot orthotics for persons with partial foot amputations;
- Foot orthotics that are an integral part of a leg brace and are necessary for the proper functioning of the brace, and;
- Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.

Genetic Testing

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

Growth Hormone Therapy

You are not covered for growth hormone therapy except as stated in *Chapter 4: Description of Benefits.*

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, and devices 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.

Physical Exams

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.

Private Duty Nursing

You are not covered for outpatient private duty nursing services.

Prohibited by Law

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

Radiation (Nonionizing)

You are not covered for treatment with nonionizing radiation.

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)*.

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.

Sexual Dysfunction

You are not covered for services or supplies related to sexual dysfunction, except for erectile dysfunction as stated below.

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 *Miscellaneous Medical Treatments, 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 *Miscellaneous Medical Treatments, Gender Identity Services.*

Supplies

You are not covered for take home supplies or supplies billed separately by your provider when the supplies are integral to services 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, except as described in *Chapter 4: Description of Benefit* under *Miscellaneous Medical Treatments*, *Inter-island Transportation.*

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 Benefit* under *Miscellaneous Medical Treatments*.

Chapter 6: Services Not Covered

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

When to File

Most providers in Hawaii file claims for you. If your 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 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.

Proof of Payment

Make sure you enclose proof of payment.

Other Claim Filing Information

Where to Send Claim

For Physician claims, send to:
HPH – HCFA 1500 claims
P.O. Box 44500
Honolulu, Hawaii 96804-4500

For Facility claims, send to:
HPH – UB92 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

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 of our receipt of 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

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

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

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

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

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

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.

CHAPTER 9

This Chapter Covers

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.

If we need more details regarding your other coverage, we will contact you in writing. Your benefit payment may be delayed or denied if you do not provide the information we need to coordinate your benefits.

To help us coordinate your benefits, you should:

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

Chapter 9: Coordination of Benefits and Third Party Liability

What We Will Do

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

General Coordination Rules

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

No Coordination Rules

The coverage without coordination of benefits rules pays first.

Member Coverage

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

Active Employee Coverage

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

Earliest Effective Date

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

Dependent Children Coordination Rules

Birthday Rule

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

Court Decree Stipulates

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

Court Decree Does Not Stipulate

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

- Custodial parent.
- Spouse of custodial parent.
- Non-custodial parent.
- Spouse of non-custodial 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 any motor vehicle insurance coverage. We do not cover 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. For more information, contact your employer or the Centers for Medicare & Medicaid Services.

If You are Age 65 or Older

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 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 right to be reimbursed for any benefits we provide, from any recovery received from or on behalf of any third party or other source of recovery in connection with the injury or illness, including but not limited to, proceeds from any:

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

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

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

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

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

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

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

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

CHAPTER 10

This Chapter Covers

When Coverage Ends

Notifying Us When Your Child's Eligibility Ends

You must inform the Trust Fund, in writing, if a child no longer meets the eligibility requirements. You must notify the Trust Fund on or before the first day of the month following the month the child no longer meets the requirements. For example, your child turns 26 on June 1. You would need to notify the Trust Fund by July 1.

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

Notifying Us When Other Events Cause Coverage To End

You must inform the Trust Fund, in writing, if other events occur that terminate coverage, such as divorce or the dissolution of a domestic partnership.

Termination for Fraud

Your eligibility for coverage will end if you the thrust fund use this coverage fraudulently or intentionally misrepresent or conceal material facts.

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

If your coverage is terminated for fraud, intentional misrepresentation, or the concealment of material facts:

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

Continued Coverage

Other Continuation Coverage

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

Continued Coverage if Member Dies

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

Chapter 10: General Provisions

Continued Coverage if You have Medicare

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

Confidential Information

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

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

Terms of Coverage

Terms of Coverage

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

Authority to Terminate, Amend, or Modify Coverage

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

Governing Law

To the extent not superseded by the laws of the United States, 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:

HPH
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.

CHAPTER 11

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.

Administrative Review — Administrative review is an approval process that is required for services to be rendered by a provider who is located out of state or who does not participate with HMSA.

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

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

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

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

Ambulance Service — Air or ground emergency transport to a hospital.

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

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

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

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

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.

Chapter 11: Glossary

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.

Away from Home Care

A program sponsored by the Blue Cross and Blue Shield Association. The program offers medical benefits when you need medical care while you are away from your service area (but within the U.S.).

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 services or calendar year.

Benefits

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

Bereavement Services

Services that focus on healing from emotional loss.

Biofeedback

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

Biological Therapeutics and Biopharmaceuticals

Any biology-based therapeutics that structurally mimic compounds found in the body. This includes:

- recombinant proteins,
- monoclonal and polyclonal antibodies,
- peptides,
- antisense oligonucleotides,
- therapeutic genes, and
- certain therapeutic vaccines.

Birthing Center

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

Blood Transfusion

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

BlueCard Provider

A provider that participates with the Blue Cross and Blue Shield Association. BlueCard participating providers file claims for you and accept the eligible charge as payment in full.

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.

Chemotherapy

Treatment of infections or malignant diseases by drugs that act selectively on the cause of the disorder, but which may have substantial effects on normal tissue. Chemotherapy drugs must be FDA approved.

Child

Means any of the following: your son, daughter, stepson or stepdaughter, your legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian, or your eligible foster child (defined as an individual who is placed with you by an authorized placement agency or by judgment, decree, or other court order).

Chiropractor

A health care professional who practices the system of healing through spinal manipulation and specific adjustment of body structures.

Claim

A written request for payment of benefits for services covered by this coverage.

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.

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 either:
- Listed in this Guide in Chapter 4: Description of Benefits, or
- Not listed in this Guide in Chapter 6: Services Not Covered.

Custodial Care

Care that helps you meet your daily living activities. This type of care does not need the ongoing attention and help from licensed medical or trained paramedical personnel.

Chapter 11: Glossary

Custom-Fabricated

Items that are individually made for a specific patient (no other patient would be able to use it) starting with basic materials including, but not limited to:
- plastic,
- metal,
- leather, or
- cloth in the form of sheets, bars, etc.

It involves substantial work such as:
- vacuum forming,
- cutting,
- bending,
- molding,
- sewing, etc.

It may involve the incorporation of some prefabricated components but it involves more than:
- trimming,
- bending, or
- making other modifications to a substantially prefabricated item.

Deluxe/Upgraded Items

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

Dependent

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

Diagnosis

The medical description of the disease or condition.

Diagnostic Testing

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

Directory of Health Centers and Providers

A complete listing of HPH health centers and network providers.

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 HPH 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.

Emergency — A medical condition accompanied by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

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

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

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

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

False Statement — Any fraudulent or intentional misrepresentation you the trust fund made on your membership enrollment form or in any claims for benefits.

Family Member — The member's spouse or domestic partner and/or children who are eligible and enrolled in the Plan.

Foot Orthotics — Devices that are placed into shoes to assist in restoring or maintaining normal alignment of the foot, relieve stress from strained or injured soft tissues, bony prominences, deformed bones and joints and inflamed or chronic bursae.

Frame — An 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.

Group — Those members who share a common relationship such as employment or membership.

Guest Membership — Prearranged membership from an HMO Host Plan offered by the Blue Cross and/or Blue Shield plan in the service area where you require services.

Guide to Benefits — This document, along with any riders or amendments that provide a written description of your health care coverage.

Chapter 11: Glossary

HMSA

Hawai‘i Medical Service Association, an independent licensee of the Blue Cross and Blue Shield Association.

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 IV Therapy

Treatment in the home that involves giving nutrients, antibiotics and other drugs and fluids intravenously or through a feeding tube. Drugs must be FDA approved.

Hospice Program

A program that provides care in a comfortable setting for patients who are terminally ill and have a life expectancy of six months or less. Care is normally provided in the patient’s home.

Hospital

An institution that provides diagnostic and therapeutic services for surgical and medical diagnosis, treatment and care of injured or sick persons.

Illness or Injury

Any bodily disorder, injury, disease or condition, including pregnancy and its complications.

Immediate Family Member

Your child, spouse, domestic partner, parent, or yourself.

Immunization

An injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

Implanted Internal Items/Implants (Surgical/Orthopedic)

Internal prosthetic devices used during surgery that are necessary for anatomical repair or reconstructive purposes. These devices remain in the body and replace a missing biological structure or support or enhance a damaged biological structure.

Examples include, but are not limited to:

- cardiac pacemakers,
- defibrillators,
- heart valves and stents,
- breast implants for post-mastectomy reconstruction,
- hip and knee replacements,
- hardware necessary to anchor fractured bones,
- implanted cataract lenses,
- cochlear implants,
- adjustable gastric bands for bariatric surgery, and
- human tissue.

The device must be FDA-approved for the purpose it is being used.

In Vitro Fertilization

A method used to treat infertility in women.

Inhalation Therapy

Therapy to treat conditions of the cardiopulmonary system.

Injection — The introduction of a drug, biological therapeutic, biopharmaceutical, or vaccine into the body by using a syringe and needle. Injectable drugs must be FDA approved.

Inpatient Admission — A stay in an inpatient facility, usually involving overnight care.

Intravenous Administration — The administration of medication into the vein.

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.

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 person who meets the Trust Fund's eligibility requirements.

Member Card — Your member card issued to you by us. You must present this card to your provider at the time you get services.

Mental Health Outpatient Facility — A mental health clinic, institution, center, or community mental health center that provides for the diagnosis, treatment, care or rehabilitation of people who are mentally ill.

Chapter 11: Glossary

Mental Illness/Disorder	A syndrome of clinically significant psychological, biological, or behavioral abnormalities that result in personal distress or suffering, impairment of capacity to function, or both. Mental illness and disorder are used interchangeably in this Guide and as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or in the International Classification of Disease.
Microprocessor-Controlled Prosthetic Device	Prosthetic devices that use feedback from sensors to adjust joint movement on a real-time as-needed basis.
Myoelectric Prosthetic Device	Prosthetic devices powered by electric motors with an external power source. For example, the movement of an upper limb prosthesis (e.g., hand, wrist, and/or elbow) is driven by micro-chip-processed electrical activity in the muscles of the remaining limb stump.
Network Provider	All providers represented in all health centers that have contracted with Health Plan Hawaii to care for its members.
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-Network Provider	A provider that is not under contract with HMSA to treat Health Plan Hawaii members.
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.
Optometrist	One who specializes in the examination, diagnosis, treatment and management of diseases and disorders of the visual system, the eye and related structures.
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.
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 Medical Pharmacy	A participating retail pharmacy that also contracts with us to provide items that are covered under this plan such as medical equipment and supplies.
Primary Care Provider (PCP)	The provider you choose within your health center 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.
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 Services	Professional services necessarily and directly performed by a doctor to treat an injury or illness.
Physician Assistant	A practitioner who provides care under the supervision of a physician.
Plan	This health benefits plan, including hospital and medical coverage, as defined in this Guide to Benefits. The Plan is subject to Chapter 87A, Hawaii Revised Statutes, and the Trust Fund’s administrative rules, which may be amended from time to time. The Trust Fund may modify or amend the terms and conditions of the Plan from time to time.
Podiatrist	A health care professional who specializes in conditions of the feet.
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.
Postpartum	The period of time after childbirth.
Postoperative Care	Care given after a surgical operation.
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.
Preoperative Care	Care that occurs, is performed, or is administered before, and usually close to, a surgical operation.

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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 within your health center 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	A physician or other practitioner, facility, or other health care provider such as an agency or program, recognized by us.
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.
Radiology	The use of radiant energy to diagnose and treat disease.
Referral	When your PCP determines that your condition requires the services of a specialist, he or she will arrange for you to get treatment from the appropriate provider.
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.
Service Area	The island or islands of Hawaii where the health center operates its facilities (excluding Hana, Maui) and where you reside.
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.
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 for the diagnosis, assessment and treatment of communication impairments and swallowing disorders.
Spouse	Your husband or wife as the result of a marriage who is legally recognized in the State of Hawaii. For purposes of this Guide to Benefits, "spouse" also includes an Employee's domestic partner who is eligible to enroll in the Plan under the Trust Fund's administrative rules.
Subscriber Number	The number that appears on your HPH member card.
Substance Abuse Services	Providing medical, psychological, nursing, counseling, or therapeutic services as part of a treatment plan for alcohol or drug dependence or both. Services may include aftercare and individual, group and family counseling services.
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.
Trust Fund	Hawaii Employer-Union Health Benefits Trust Fund (EUTF). The trust fund has executed an Agreement with us to administer a health benefits plan covering eligible members.
Tubal Ligation	A sterilization procedure for women.
Urgent Care	When you require medical care for an unexpected illness or injury that is not life threatening but cannot be reasonably postponed until your return to your service area.
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.

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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 eligible for coverage under this Guide.

Serving you

Meet with knowledgeable, experienced health plan advisers. We'll answer questions about your health plan, give you general health and well-being information, and more. Hours of operation may change. Go to hmsa.com/contact before you visit.

HMSA Center @ Honolulu
818 Keeaumoku St.
Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center @ Pearl City
Pearl City Gateway | 1132 Kuala St., Suite 400
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center @ Hilo
Waiakea Center | 303A E. Makaala St.
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center @ Kahului
Puunene Shopping Center | 70 Hookele St.
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

Customer Relations representatives are also available in person at our Kauai office, Monday through Friday, 8 a.m. to 4 p.m.:

Lihue, Kauai
4366 Kukui Grove St., Suite 103

Contact HMSA. We're here with you.
Call (808) 948-6499 or 1 (800) 776-4672.

hmsa.com/EUTF myhmsa @askHMSA askhmsa

Together, we improve the lives of our members and the health of Hawaii.
Caring for our families, friends, and neighbors is our privilege.

hmsa

Utilization Review Matrix 2022 – HMSA

The matrix below contains all of the CPT 4 codes for which Magellan Healthcare[1] manages on behalf of HMSA. This matrix is designed to assist in the resolution of claims adjudication and claims questions related to those services authorized by Magellan Healthcare. The "Allowable Billed Groupings" is meant to outline that if a given procedure is authorized, that any one of the listed procedure codes could be submitted on a claim representing that service. This assumes that the member is eligible at the time of the service, that appropriate rebundling rules are applied, that the claim includes an appropriate diagnosis code for the CPT code and that the service is performed within the validity period.

If a family of CPT codes is not listed in this matrix, an exact match is required between the authorized CPT code and the billed CPT code. If the exact match does not occur, the charge should be adjudicated accordingly.

***Please note: Services rendered in an Emergency Room, Observation Room, Surgery Center or Hospital Inpatient Setting are not managed by Magellan Healthcare.**

[1]National Imaging Associates, Inc. is a subsidiary of Magellan Healthcare, Inc.

Authorized CPT Code	Description	Allowable Billed Groupings
33225	Cardiac Resynchronization Therapy (CRT)	33221, 33224, 33225, 33231
33249	Implantable Cardioverter Defibrillator (ICD)	33230, 33240, 33249
33208	Pacemaker Insertion	33206, 33207, 33208, 33212, 33213
70336	MRI Temporomandibular Joint	70336
70450	CT Head/Brain	70450, 70460, 70470
70480	CT Orbit	70480, 70481, 70482
70486	CT Maxillofacial/Sinus	70486, 70487, 70488, 76380
70490	CT Soft Tissue Neck	70490, 70491, 70492
70496	CT Angiography, Head	70496
70498	CT Angiography, Neck	70498
70540	MRI Orbit, Face, and/or Neck	70540, 70542, 70543, +0698T
70551	MRI Internal Auditory Canal	70551, 70552, 70553, 70540, 70542, 70543, +0698T
70544	MRA Head	70544, 70545, 70546
70547	MRA Neck	70547, 70548, 70549
70551	MRI Brain	70551, 70552, 70553, +0698T
70554	Functional MRI Brain	70554, 70555
71250	CT Chest	71250, 71260, 71270, 71271
71271	Low Dose CT for Lung Cancer Screening	71271
71275	CT Angiography, Chest (non coronary)	71275
71550	MRI Chest	71550, 71551, 71552, +0698T
71555	MRA Chest (excluding myocardium)	71555

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72125	CT Cervical Spine	72125, 72126, 72127
72128	CT Thoracic Spine	72128, 72129, 72130
72131	CT Lumbar Spine	72131, 72132, 72133
72141	MRI Cervical Spine	72141, 72142, 72156, +0698T
72146	MRI Thoracic Spine	72146, 72147, 72157, +0698T
72148	MRI Lumbar Spine	72148, 72149, 72158, +0698T
72159	MRA Spinal Canal	72159
72191	CT Angiography, Pelvis	72191
72192	CT Pelvis	72192, 72193, 72194
72196	MRI Pelvis	72195, 72196, 72197, +0698T
72198	MRA Pelvis	72198
73200	CT Upper Extremity	73200, 73201, 73202
73206	CT Angiography, Upper Extremity	73206
73220	MRI Upper Extremity, other than Joint	73218, 73219, 73220, +0698T
73221	MRI Upper Extremity Joint	73221, 73222, 73223, +0698T
73225	MRA Upper Extremity	73225
73700	CT Lower Extremity	73700, 73701, 73702
73706	CT Angiography, Lower Extremity	73706
73720	MRI Lower Extremity	73718, 73719, 73720, 73721, 73722, 73723, +0698T
73721	MRI Hip	72195, 72196, 72197, 73721, 73722, 73723, +0698T
73725	MRA Lower Extremity	73725
74150	CT Abdomen	74150, 74160, 74170
74174	CT Angiography, Abdomen and Pelvis	74174
74175	CT Angiography, Abdomen	74175
74176	CT Abdomen and Pelvis Combination	74176, 74177, 74178
74181	MRI Abdomen	74181, 74182, 74183, S8037, +0698T
74185	MRA Abdomen	74185
74261	Diagnostic CT Colonoscopy (Virtual Colonoscopy, CT Colonography)	74261, 74262
75557	MRI Heart	75557, 75559, 75561, 75563, +75565, +0698T
75571	Coronary Artery Ca Score, Heart Scan, Ultrafast CT Heart, Electron Beam CT	75571, S8092
75572	CT Heart	75572
75573	CT Heart congenital studies, non-coronary arteries	75573
75574	CTA coronary arteries (CCTA)	75574
75635	CT Angiography, Abdominal Arteries	75635
76380	Follow-Up, Limited or Localized CT	76380, 70486, 70487, 70488
76390	MR Spectroscopy	76390, +0698T
76497	Unlisted Computed Tomography Procedure	76497
76498	Unlisted Magnetic Resonance Procedure	76498, +0698T

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77046	**MRI Breast**	**77046, 77047, 77048, 77049, +0698T**
77078	**CT Bone Density Study**	**77078**
77084	**MRI Bone Marrow**	**77084**
78429	**Heart PET Scan with CT for Attenuation**	**78459, 78491, 78492, +78434, 78429, 78430, 78431, 78432, 78433**
78451	**Myocardial Perfusion Imaging – Nuclear Cardiology Study**	**78451, 78452, 78453, 78454, 78466, 78468, 78469, 78481, 78483, 78499**
78459	**Heart PET Scan**	**78459, 78491, 78492, +78434**
78472	**MUGA Scan**	**78472, 78473, 78494, +78496**
78608	**PET Scan, Brain**	**78608, 78609**
78803	**Radiopharmaceutical Tumor Localization (SPECT), Single Area**	**78803**
78813	**PET Scan**	**78811, 78812, 78813, 78814, 78815, 78816**
78816	**PET Scan with concurrently acquired CT for attenuation correction and anatomic, localization.**	**78811, 78812, 78813, 78814, 78815, 78816**
93350	**Stress Echocardiography**	**93350, 93351, +93320, +93321, +93325, +93352, +93356**
93452	**Heart Catheterization****	**93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, +93462, +93463, +93464, +93565, +93566, +93567, +93568**
G0235	**PET imaging, any site, not otherwise specified**	**G0235**
S8037	**MR Cholangiopancreatography**	**S8037, 74181, 74182, 74183**
S8042	**MRI low field**	**S8042**

+ Payment for add-on codes may depend upon the appropriateness of the application of such codes related to the approved primary code.

** Right heart ONLY caths are not managed by Magellan Hawai‘i.

KAISER PERMANENTE® : KP HI Platinum 0/5 Plus CAM | **Coverage for: Individual/Family | Plan Type: HMO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see https://kp.org/plandocuments or call 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 Individual / $6,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care services this plan; doesn't cover, indicated in chart starting on page ; 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 / visit	Not covered	No charge for children through age 18.
	Specialist visit	$20 / visit	Not covered	None
	Preventive care/ screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$10 / day	Not covered	None
	Imaging (CT/PET scans, MRI's)	$100 / department per day (specialty, outpatient)	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	Retail: $5 per prescription; Mail Order: $10 per prescription	Not covered	Up to a 30-day supply retail or 90-day supply mail order. No charge female contraceptives, (subject to formulary guidelines).
	Preferred brand drugs	Retail: $45 per prescription; Mail Order: $90 per prescription	Not covered	Up to a 30-day supply retail or 90-day supply mail order. No charge female contraceptives, (subject to formulary guidelines).
	Non-preferred brand drugs	Retail: $45 per prescription; Mail Order: 50% coinsurance	Not covered	Up to a 30-day supply retail or 90-day supply mail order. No charge female contraceptives (subject to formulary guidelines).
	Specialty drugs	Retail: $200 per prescription; Mail Order: Not covered	Not covered	Up to a 30-day supply retail. No charge female contraceptives (subject to formulary guidelines).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.

Preventive services

Staying on top of your preventive care can help you:

- Track important numbers like your blood pressure and cholesterol level
- Get immunizations to help you avoid illness
- Catch health problems before they become serious

Under most Kaiser Permanente health plans, you can get preventive care services at no additional cost.[1] While all our service areas cover basic preventive care, you'll find additional benefits in certain states and Washington, D.C. Read on to find out which services are available to you under a plan that begins on or after **January 1, 2024.**

For information in other languages:

- Chinese preventive services flyer (PDF)
- Vietnamese preventive services flyer (PDF)

How to know if this information covers your plan

The information below **doesn't** apply to Medicare plans. Instead, it applies to nongrandfathered individual and group plans (except retiree-only plans), and grandfathered group plans and retiree-only group plans, that cover preventive services at no additional costs.[1]

If you're enrolled in grandfathered coverage or retiree-only coverage, see your *Evidence of Coverage* or other coverage documents to find out which preventive services are covered and the cost share that applies.[2] You can also talk to your employer's benefits administrator.

This is a summary of the preventive benefit. Refer to your *Evidence of Coverage* or other coverage documents for details about your coverage.

On this page:

What's new for 2024

The following are benefit changes for 2024, as required by the Affordable Care Act (ACA). Most of our plans will now cover the following services for plan years or policy years beginning on or after January 1, 2024:

- Anxiety screening in adults
- Vaccines and immunizing agents to protect against serious illness from respiratory syncytial virus for adults, infants, and older babies at high risk

Preventive services for adults

- **Abdominal aortic aneurysm screening** for men 65 to 75 who have ever smoked (one-time screening)
- **Alcohol misuse screening and counseling**
- **Annual lung cancer screening with low-dose computed tomography and counseling** for adults 50 to 80 who are at high risk based on their current or past smoking history
- **Anxiety screening for adults** (will be covered for plan years or policy years beginning on or after January 1, 2024)
- **Behavioral counseling interventions** to promote a healthy diet and physical activity for adults with cardiovascular risk factors
- **Behavioral counseling for sexually active adults** who are at increased risk for sexually transmitted infections
- **Behavioral counseling interventions for tobacco use and cessation**
- **Blood pressure screening**
- **Colon cancer screening** for adults 45 to 75, including:
    - Preconsultation
    - Bowel preparation
    - Pathology exam on a polyp biopsy

- **Depression screening**
- **FDA-approved medications for tobacco cessation,** including over-the-counter medications, when prescribed by a Plan provider
- **FDA-approved preexposure prophylaxis (PrEP) with effective antiretroviral therapy** for people at high risk for HIV, when prescribed by a Plan provider. Includes the following baseline and monitoring services for the use of PrEP:
    - HIV testing
    - Hepatitis B and C testing
    - Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR)
    - Pregnancy testing
    - Sexually transmitted infection (STI) screening and counseling
    - Adherence counseling
- **Hemoglobin A1c testing** for diabetes[3]
- **Hepatitis B screening** for adults at higher risk
- **Hepatitis C screening** for adults 18 to 79
- **Immunizations** (doses, recommended ages, and recommended populations vary):
    - COVID-19
    - Hepatitis A
    - Hepatitis B
    - Herpes zoster
    - Human papillomavirus
    - Influenza
    - Measles, mumps, rubella
    - Meningococcal (meningitis)
    - Pneumococcal
    - Respiratory syncytial virus (will be covered for plan years or policy years beginning on or after January 1, 2024)
    - Tetanus, diphtheria, pertussis
    - Varicella
- **International normalized ratio (INR) testing** for liver disease and/or bleeding disorders[3]
- **Latent tuberculosis infection screening**
- **Low-density lipoprotein (LDL) testing** for heart disease[3]
- **Low-dose aspirin use** for the prevention of cardiovascular disease or colorectal cancer when prescribed by a Plan provider[4]
- **Obesity and weight management,** including intensive behavioral counseling for overweight adults with a BMI of 30 or higher

- **Physical therapy** to prevent falls in community-dwelling adults 65 and older who are at increased risk of falling
- **Prediabetes and diabetes screening** (type 2) for adults 35 to 70 who are overweight or obese
- **Prostate cancer screening**[5]
- **Retinopathy screening** for diabetes[3]
- **Routine physical exam**
- **Sexually transmitted infection screenings** for adults at higher risk
    - Chlamydia
    - Gonorrhea
    - HIV
    - Syphilis
- **Statin use for the primary prevention of cardiovascular disease** in adults 40 to 75 with no history of cardiovascular disease (CVD), one or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater, when prescribed by a Plan provider
- **Unhealthy drug use screening**
- **Universal lipids screening** in adults 40 to 75 to identify dyslipidemia and a calculation of a 10-year CVD risk

Additional preventive services for women and pregnant people[6]

- **Anemia screening** for pregnant people[7]
- **Anxiety screening** for adolescent and adult women
- **Bacteriuria screening** in asymptomatic pregnant people
- **Behavioral counseling interventions aimed at promoting healthy weight** gain and preventing excess gestational weight gain in pregnancy
- **Behavioral counseling interventions for tobacco use and cessation** for pregnant people
- **BRCA genetic counseling** to assess risk of carrying breast or ovarian cancer genes
- **BRCA genetic testing** for high-risk women and when services are ordered by a Plan physician
- **Breast cancer screening** for average-risk women
- **Breastfeeding equipment and supplies:**
    - Retail-grade double-electric breastfeeding pump, including any equipment that's required for pump functionality
    - Breast milk storage supplies and other equipment/supplies as clinically indicated to support dyads with breastfeeding difficulties
- **Cervical cancer screening for** adolescents and women 21 to 65

- **Comprehensive lactation support and counseling** before and after childbirth
- **Contraceptive devices, methods, and drugs** (FDA-approved and prescribed by your doctor), contraceptive device removal, and female sterilizations
- **Contraceptive counseling, education, and follow-up care**
- **Counseling intervention for pregnant or postpartum people** at increased risk of perinatal depression
- **Folic acid** for people who are capable of pregnancy, when prescribed by a Plan provider
- **FDA-approved medications for tobacco cessation** for pregnant people, including over-the-counter medications, when prescribed by a Plan provider[8]
- **Hepatitis B screening** for pregnant people at their first prenatal visit
- **HIV screening** for pregnant people
- **Low-dose aspirin after 12 weeks of gestation** for people who are at high risk for preeclampsia, when prescribed by a Plan provider
- **Medication for breast cancer prevention** for women 35 and older at increased risk, when prescribed by a Plan provider
- **Obesity prevention counseling** for women in midlife
- **Osteoporosis screening** for women 65 and older and those at higher risk
- **Perinatal depression screening** for pregnant and postpartum people
- **Postpartum visits**
- **Preeclampsia screening** for pregnant people with blood pressure measurements during pregnancy
- **Rh(D) blood typing and antibody testing** for pregnant people
- **Routine physical exam**
- **Routine prenatal care visits**[9]
- **Screening and counseling for interpersonal and domestic violence**
- **Screening for diabetes** in pregnancy
- **Screening for diabetes** after pregnancy
- **Screening for urinary incontinence** in women
- **Syphilis screening** for pregnant women

Preventive services for children

- **Age-appropriate routine physical exams**
- **Anxiety screening** in children and adolescents 8 to 18
- **Autism spectrum disorder screening** at 18 months and 24 months
- **Behavioral counseling for sexually active adolescents** who are at increased risk for sexually transmitted infections
- **Behavioral/social/emotional screening** throughout development
- **Blood pressure screening** for adolescents

- **Congenital hypothyroidism screening** for newborns
- **Depression screening** for adolescents 12 to 21
- **Developmental screening and surveillance** throughout infancy, childhood, and adolescence
- **Dyslipidemia screening** for children at higher risk of lipid disorders
- **FDA-approved medications for tobacco cessation,** including over-the-counter medications, when prescribed by a Plan provider
- **FDA-approved preexposure prophylaxis (PrEP) with effective antiretroviral therapy** for adolescents at high risk for HIV, when prescribed by a Plan provider). Includes the following baseline and monitoring services for the use of PrEP:
    - HIV testing
    - Hepatitis B and C testing
    - Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR)
    - Pregnancy testing
    - Sexually transmitted infection (STI) screening and counseling
    - Adherence counseling
- **Gonorrhea prevention medication** for the eyes for newborns
- **Height, weight, and body mass index (BMI) measurements** throughout development
- **Hepatitis B screening** for adolescents at higher risk
- **HIV screening** for adolescents at higher risk
- **Immunizations** from birth to 18. Doses, recommended ages, and recommended populations vary:
    - COVID-19
    - Diphtheria, tetanus, pertussis
    - *Haemophilus influenzae* type B
    - Hepatitis A
    - Hepatitis B
    - Human papillomavirus
    - Inactivated poliovirus
    - Influenza
    - Measles, mumps, rubella
    - Meningococcal (meningitis)
    - Pneumococcal
    - Respiratory syncytial virus (will be covered for plan years or policy years beginning on or after January 1, 2024)
    - Rotavirus
    - Varicella

- **Iron supplements for asymptomatic children** 6 to 12 months at increased risk for iron deficiency anemia, when prescribed by a Plan provider[10]
- **Lead screening** for children at risk of exposure
- **Medical history** throughout development
- **Newborn blood screenings,** including bilirubin testing and sickle cell screening
- **Obesity screening and counseling**
- **Oral health risk assessments** by primary care doctor for children younger than 5:
    - Fluoride supplementation starting at 6 months for children whose water supply is deficient in fluoride
    - Fluoride varnish for the primary teeth of all infants and children starting at the age of primary tooth eruption
- **Phenylketonuria screening** for newborns
- **Routine hearing screening**
- **Skin cancer counseling** for young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet radiation for people 6 months to 24 with fair skin types to reduce their risk of skin cancer
- **Sudden cardiac arrest and sudden cardiac death risk assessment**
- **Suicide risk assessment** as an element of universal depression screening for people 12 to 21
- **Tobacco, alcohol, or drug use assessment** for people 11 to 21
- **Tuberculin testing** for children at higher risk of tuberculosis
- **Vision screening**

Additional market-specific preventive services[11]

For health plans issued in one of the following states, additional market-specific preventive services are also listed.

California

- All contraceptive methods approved by the Food and Drug Administration (FDA) and obtained from a Plan Pharmacy, including items available over-the-counter or prescribed by a Plan provider, for all members regardless of gender.
- Vasectomy services and procedures (will be covered for plan years or policy years beginning on or after January 1, 2024)
- Clinical services related to contraception including, but not limited to, consultations, examinations, procedures, ultrasounds, and referrals.
- Retinal photography screenings for adults and children
- Travel immunizations
- Vision refraction exams for adults and children[12]

Colorado

- Breast cancer screening for all at-risk people regardless of age
- Contraception dispensed or furnished for 12 months as permitted by the member's prescription.
- Mental health wellness exam[13]
- Colon cancer screening for all at-risk people regardless of age
- Post-mammogram breast imaging services prior to biopsy/cancer diagnosis

Georgia

- Medically necessary labs and X-rays associated with a well-child visit
- Ovarian cancer surveillance test for women over 35 or at risk

Maryland

- Labs and X-rays associated with well-child visits

Oregon

- Screening and medically necessary services and prescription medications for the treatment of physical, mental, sexual, and reproductive health care needs that arise from a sexual assault
- Voluntary male sterilizations

Virginia

- Labs and X-rays associated with well-child visit

Washington — Southwest region

- Screening and medically necessary services and prescription medications for the treatment of physical, mental, sexual, and reproductive health care needs that arise from a sexual assault
- Voluntary male sterilizations

Washington, D.C.

- Adjuvant breast screening (follow-up breast MRI or ultrasound for women with dense breast tissue, after an inconclusive mammogram, or deemed high risk by their provider)
- Labs and X-rays associated with well-child visits

Disclaimers

[1] The preventive services described above also apply to all grandfathered and retiree-only large group plans that cover these services at no additional cost and all grandfathered small group plans in the state of California.

[2] Grandfathered plans are plans that have been in existence since, on, or before March 23, 2010, and that meet certain requirements. Grandfathered plans are exempt from some of the changes required under the Affordable Care Act, including those related to preventive services, and may have a cost share associated with these services. If a member is enrolled in a grandfathered plan, this will be stated in their *Evidence of Coverage* or other coverage documents. Also, grandfathered plans may not cover all services listed in this document, such as over-the-counter drugs. Members enrolled in grandfathered plans can also contact our Member Services at 1-800-464-4000 (TTY 711), 24 hours a day, 7 days a week (closed holidays), for information about their plan's coverage of specific preventive care services.

[3] On July 17, 2019, the Internal Revenue Service (IRS) and U.S. Treasury Department issued Notice 2019-45, which expands the list of preventive care benefits permitted to be provided without satisfying the deductible of a high deductible health plan (HDHP) under section 223(c)(2) of the Internal Revenue Code. Kaiser Permanente made the decision to add all these lab tests and screenings for specific chronic conditions allowed by IRS Notice 2019-45 to Kaiser Permanente's National Preventive Care package, effective all at once, on January 1, 2021. Self-Funded Plans may not have agreed to this expansion, please see your Summary Plan Description or other plan documents.

[4] In April 2022, the U.S. Preventive Services Task Force determined that the decision to initiate low-dose aspirin use for the primary prevention of cardiovascular disease in adults aged 40 to 59 years who have a 10% or greater 10-year CVD risk should be an individual one. The U.S. Preventive Services Task Force also concluded there is inadequate evidence to support low-dose aspirin use reduces colorectal cancer incidence or mortality. Despite this determination, Kaiser Permanente will continue to cover this service as preventive. Self-Funded Plans may not have agreed to this expansion, please see your Summary Plan Description or other plan documents.

[5] The U.S. Preventive Services Task Force recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small. Despite this determination, prostate cancer screening is a part of Kaiser Permanente's Preventive Care package, effective January 1, 2023. Self-Funded Plans may not have agreed to this expansion, please see your Summary Plan Description or other plan documents.

[6] Breast pumps and certain over-the-counter drugs may not be covered in plans that do not include an ACA preventive package (see your *Evidence of Coverage* or other coverage documents).

[7] In September 2015, the U.S. Preventive Services Task Force determined that current evidence is insufficient to assess the balance of benefits and harms of screening of iron deficiency in pregnant women to prevent adverse maternal health and birth outcomes. Despite this determination, Kaiser Permanente will continue to cover this service as preventive. Self-Funded Plans may not have agreed to this expansion, please see your Summary Plan Description or other plan documents.

[8] In September 2015, the U.S. Preventive Services Task Force determined that current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women. Despite this determination, Kaiser Permanente will continue to cover this service as preventive. Self-Funded Plans may not have agreed to this expansion, please see your Summary Plan Description or other plan documents.

[9] Prenatal services are covered as routine base medical services that are included in global billing for maternity

services, which may be subject to cost sharing, as permitted by applicable law.

[10] In September 2015, the U.S. Preventive Services Task Force determined that current evidence is insufficient to assess the balance of benefits and harms of screening for iron deficiency anemia in children ages 6 to 24 months. The U.S. Preventive Services Task Force also determined that given the current widespread use of iron-fortified foods in the United States (including infant formulas and cereals), the impact of making a recommendation on physician-prescribed supplementation is likely limited. Despite this determination, Kaiser Permanente will continue to cover iron supplements as preventive. Self-Funded Plans may not have agreed to this expansion, please see your Summary Plan Description or other plan documents.

[11] Most self-funded groups are not subject to state mandates. For more information on preventive services, call Member Services or see your *Summary Plan Description* or other plan documents.

[12] Vision refraction services may or may not be subject to an HSA-qualified HDHP deductible. If the service is subject to the deductible on an HSA-qualified HDHP plan, it may be subject to a copay or coinsurance after the deductible has been met.

[13] Effective January 1, 2023, health plans must cover an annual mental wellness checkup for all individuals regardless of age. The applicable cost share for this service may apply to grandfathered plans.

The required preventive services are based on recommendations by the U.S. Preventive Services Task Force, Health Resources & Services Administration, and the Centers for Disease Control and Prevention. The services listed in this document may be subject to certain guidelines, such as age and frequency. They may be subject to a copay or coinsurance if they are not provided in accord with these guidelines.

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Comprehensive Plus Plan

Description of Coverage (DOC)

January 2024

220 South King Street, Suite 1200
Honolulu, HI 96813

Phone (808) 941-4622
Toll-Free (888) 941-4622

www.hmaa.com

* = See page 10 ** = See page 10	More info on page:	Annual Deductible Applies?	% = Coinsurance (Percentage based on eligible charge) $ = Copayment (Fixed dollar amount)	
			Participating	Non-Participating
Rehabilitation Therapy *(continued)*				
Speech Therapy Services — Inpatient	28	No	20%	20%
**Speech Therapy Services — Outpatient	28	Yes	20%	20%
Special Benefits – Disease Management and Preventive Services				
Disease Management	28	No	None	Not covered
Gonorrhea (screening)	28	No	None	None
Preventive Services — Laboratory	28	No	None	None
Preventive Services — Physical Exam	28	No	None	None
Screening Services and Preventive Counseling	28	No	None	None
Special Benefits for Children				
Newborn Care	29	No	10%	10%
Newborn Circumcision	29	Yes	20%	20%
Well Child Care Immunizations	29	No	None	None
Well Child Care Laboratory Tests	29	No	None	None
Well Child Care Physician Office Visits	29	No	None	None
Special Benefits for Men				
Erectile Dysfunction	30	Your Deductible and copayment/coinsurance amounts vary depending on the type of service or supply. See copayment/coinsurance amounts listed in this chart for the service or supply you receive.		
Prostate Specific Antigen (PSA) Test (screening)	30	No	None	None
Vasectomy	30	No	20%	20%
Special Benefits for Women				
*Breast Pump	30	No	None	Not Covered
Chlamydia Screening	30	No	None	None
Contraceptive Implants (generic)	30	No	None	None
Contraceptive Injectables (generic)	30	No	None	None
Contraceptive IUD (generic)	30	No	None	None
Intra-UterineInsemination	30	No	20%	20%
In Vitro Fertilization	30	Yes	20%	20%
Mammography (screening)	31	No	None	None
Maternity Care	31	No	10%	10%
Pap Smears (screening)	31	No	None	None
Pregnancy Termination	31	No	20%	20%
Tubal Ligation	31	No	None	None
Well Woman Exam	31	No	None	None

Speech Therapy Services

Covered, for the treatment of 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 HMAA's medical policies for speech therapy services. Information on our policies can be found at www.hmaa.com.
- The therapy is not for developmental delay/developmental learning disabilities.
- The therapy does not duplicate service provided by 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.

Special Benefits – Disease Management and Preventive Services

Disease Management

Covered, for programs available through HMAA for members with diseases such as asthma, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and behavioral health conditions (mental health and substance abuse). The programs offer services to help you and your physician manage your care and make informed health decisions.

Gonorrhea (screening)

Covered.

Preventive Services – Laboratory

Covered.

Preventive Services – Physical Exam

Covered.

Screening Services and Preventive Counseling

Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following:

- Preventive Counseling Services
- Preventive Services
- Screening Laboratory Services:
  - Screening for Lipid Disorders in Adults
  - Screening for Asymptomatic Bacteriuria in Adults
  - Screening for Gonorrhea
  - Screening for Hepatitis B Virus Infection
  - Screening for HIV
  - Screening for Syphilis Infection
  - Screening for Type 2 Diabetes Mellitus in Adults
  - Screening for Iron Deficiency Anemia
  - Screening for Rh (D) Incompatibility
  - Screening for Congenital Hypothyroidism
  - Screening for Phenylketonuria (PKU)
  - Screening for Sickle Cell Disease in Newborns
- Screening Radiology Services:
  - Screening for Abdominal Aortic Aneurysm
  - Screening for Osteoporosis in Postmenopausal Women

Please Note: The list of U.S. Preventive Services Task Force (USPSTF) recommended screening may change. If you need more information about the USPSTF recommended screenings, including a current list of recommendations, please visit our website at http://www.hmaa.com/USPSTF-Recommendations-List or call us at our telephone numbers on the front cover of this DOC.

Please Note: Benefits for other U.S. Preventive Services Task Force (USPSTF) Grade A and B recommended screenings may be found in other sections of this chapter under *Surgical Services, Testing, Laboratory, and Radiology,* and *Special Benefits for Women.*

Covered for recommended preventive services for woman developed by the Institute of Medicine (IOM) and supported by the Health Resources and Services Administration (HRSA), such as the following:

- Breastfeeding Support and Counseling – but only when received from a trained physician or midwife during pregnancy and/or in the postpartum period.
- Contraceptive Counseling.
- Gestational Diabetes Screening.
- Human Papillomavirus (HPV) DNA Testing.
- Interpersonal and Domestic Violence Screening and Counseling.

Please Note: Benefits for other IOM recommended preventive services for women may be found in this section under other sections of this chapter under *Special Benefits for Women* and *Prescription Drugs and Supplies.*

Special Benefits for Children

Newborn Care

All newborns are covered for the baby's non-surgical physician services and nursery care after birth for the first 48 or 96 hours dependent upon the Newborn's Act requirements. Newborns are covered after the first 48 or 96 hours if added to your coverage within 31 days of birth. See *Chapter 10: General Provisions* under *Eligibility for Coverage.*

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.*

Newborn Circumcision

Covered.

Well Child Care

Covered, from birth through age twenty-one including office visits for history, physical exams, sensory screenings, developmental/behavioral assessments, anticipatory guidance, lab tests, and immunizations. ***Well Child Care*** means routine and preventive care for children through age twenty-one. If your child needs medical care as the result of an illness or injury, physician visit benefits apply (and not well child care benefits). See *Physician Services* earlier in this chapter.

Well Child Care Immunizations

Covered, in accord with Hawaii law and the guidelines set by the Advisory Committee on Immunization Practices (ACIP).

Well Child Care Laboratory Tests

Covered, in conjunction with office visits, from birth through age twenty-one. Laboratory tests are covered during the well child care period as identified on the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care, in addition to one urinalysis through age five.

Well Child Care Physician Office Visits

Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) including routine sensory screening, and developmental/behavioral assessments according to the American Academy of Pediatrics 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 through twenty-one years: one visit per year

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Option Plus One

Description of Coverage (DOC)

January 2024

220 South King Street, Suite 1200
Honolulu, HI 96813

Phone (808) 941-4622
Toll-Free (888) 941-4622

www.hmaa.com

* = See page 10 ** = See page 10 # = See page 10	More info on page:	Annual Deductible Applies?		% = Coinsurance (Percentage based on eligible charge) $ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating	Participating	Non-Participating
Special Benefits – Disease Management and Preventive Services					
Disease Management	27	No	Not covered	None	Not covered
Gonorrhea (screening)	27	No	Yes	None	20%
Preventive Services — Laboratory	27	No	Yes	None	20%
Preventive Services — Physical Exam	27	No	Yes	None	$10 + 20%
Screening Services and Preventive Counseling	27	No	Yes	None	20%
Special Benefits for Children					
Newborn Circumcision — Inpatient	28	Yes	Yes	10%	20%
Newborn Circumcision — Outpatient	28	No	No	10%	20%
Newborn Care	28	No	Yes	10%	20%
Well Child Care Immunizations	29	No	No	None	None
Well Child Care Laboratory Tests	28	No	No	None	20%
Well Child Care Physician Office Visits	28	No	No	None	$10 + 20%
Special Benefits for Men					
Erectile Dysfunction	28	Your Deductible and copayment/coinsurance amounts vary depending on the type of service or supply. See copayment/coinsurance amounts listed in this chart for the service or supply you receive.			
Prostate Specific Antigen (PSA) Test (screening)	29	No	No	10%	20%
Vasectomy	29	No	Yes	10%	20%
Special Benefits for Women					
*Breast Pump	29	No	Not Covered	None	Not Covered
Chlamydia Screening	29	No	Yes	None	20%
Contraceptive Implants (generic)	29	No	No	None	30%
Contraceptive Injectables (generic)	29	No	No	None	30%
Contraceptive IUD (generic)	29	No	No	None	30%
Intra-uterine Insemination	29	No	Yes	10%	30%
In Vitro Fertilization	29	No	No	10%	20%
Mammography (screening)	30	No	No	None	20%
Maternity Care	30	No	Yes	10%	20%
Pap Smears (screening)	30	No	No	None	20%
Pregnancy Termination	30	No	No	10%	20%
Tubal Ligation	30	No	No	None	20%
Well Woman Exam	30	No	No	None	20%

Speech Therapy Services

Covered, for the treatment of 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 HMAA's medical policies for speech therapy services. Information on our policies can be found at www.hmaa.com.
- The therapy is not for developmental delay/developmental learning disabilities.
- The therapy does not duplicate service provided by 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.

Special Benefits – Disease Management and Preventive Services

Disease Management

Covered, for programs available through HMAA for members with diseases such as asthma, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and behavioral health conditions (mental health and substance abuse). The programs offer services to help you and your physician manage your care and make informed health decisions.

Gonorrhea (screening)

Covered.

Preventive Services – Laboratory

Covered.

Preventive Services – Physical Exam

Covered.

Screening Services and Preventive Counseling

Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following:

- Preventive Counseling Services
- Preventive Services
- Screening Laboratory Services:
  - Screening for Lipid Disorders in Adults
  - Screening for Asymptomatic Bacteriuria in Adults
  - Screening for Gonorrhea
  - Screening for Hepatitis B Virus Infection
  - Screening for HIV
  - Screening for Syphilis Infection
  - Screening for Type 2 Diabetes Mellitus in Adults
  - Screening for Iron Deficiency Anemia
  - Screening for Rh (D) Incompatibility
  - Screening for Congenital Hypothyroidism
  - Screening for Phenylketonuria (PKU)
  - Screening for Sickle Cell Disease in Newborns
- Screening Radiology Services:
  - Screening for Abdominal Aortic Aneurysm
  - Screening for Osteoporosis in Postmenopausal Women

Please Note: The list of U.S. Preventive Services Task Force (USPSTF) recommended screening may change. If you need more information about the USPSTF recommended screenings, including a current list of recommendations, please visit

our website at http://www.hmaa.com/USPSTF-Recommendations-List or call us at our telephone numbers on the front cover of this DOC.

Please Note: Benefits for other U.S. Preventive Services Task Force (USPSTF) Grade A and B recommended screenings may be found in other sections of this chapter under *Surgical Services, Testing, Laboratory, and Radiology,* and *Special Benefits for Women.*

Covered for recommended preventive services for woman developed by the Institute of Medicine (IOM) and supported by the Health Resources and Services Administration (HRSA), such as the following:

- Breastfeeding Support and Counseling – but only when received from a trained physician or midwife during pregnancy and/or in the postpartum period.
- Contraceptive Counseling.
- Gestational Diabetes Screening.
- Human Papillomavirus (HPV) DNA Testing.
- Interpersonal and Domestic Violence Screening and Counseling.

Please Note: Benefits for other IOM recommended preventive services for women may be found in this section under other sections of this chapter under *Special Benefits for Women* and *Prescription Drugs and Supplies.*

Special Benefits for Children

Newborn Care

All newborns are covered for the baby's non-surgical physician services and nursery care after birth for the first 48 or 96 hours dependent upon the Newborn's Act requirements. Newborns are covered after the first 48 or 96 hours if added to your coverage within 31 days of birth. See *Chapter 10: General Provisions* under *Eligibility for Coverage.*

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.*

Newborn Circumcision

Covered.

Well Child Care

Covered, from birth through age twenty-one including office visits for history, physical exams, sensory screenings, developmental/behavioral assessments, anticipatory guidance, lab tests, and immunizations. ***Well Child Care*** means routine and preventive care for children through age twenty-one. If your child needs medical care as the result of an illness or injury, physician visit benefits apply (and not well child care benefits). See *Physician Services* earlier in this chapter.

Well Child Care Immunizations

Covered, in accord with Hawaii law and the guidelines set by the Advisory Committee on Immunization Practices (ACIP).

Well Child Care Laboratory Tests

Covered, in conjunction with office visits, from birth through age twenty-one. Laboratory tests are covered during the well child care period as identified on the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care, in addition to one urinalysis through age five.

Well Child Care Physician Office Visits

Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) including routine sensory screening, and developmental/behavioral assessments according to the American Academy of Pediatrics 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 through twenty-one years: one visit per year

Special Benefits for Men

Erectile Dysfunction

Services, supplies, prosthetic devices, and injectables approved by us are covered to treat erectile dysfunction due to Organic diseases as defined by HMAA. See physician visits, supplies, prosthetic devices, and injectables for benefits.

Topic	Description	Grade	Release Date of Current Recommendation
Lung Cancer: Screening: adults aged 50- 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	March 2021*
Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.	B	June 2017*
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.	A	January 2019*
Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. See the Clinical Considerations section for information on risk assessment.	B	June 2018*
Osteoporosis to Prevent Fractures: Screening: women 65 years and older	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.	B	June 2018*
Perinatal Depression: Preventive Interventions: pregnant and postpartum persons	The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.	B	February 2019

* Previous recommendation was an “A” or “B.”

† The Department of Health and Human Services, under the standards set out in revised Section 2713(a)(5) of the Public Health Service Act and Section 223 of the 2021 Consolidated Appropriations Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2016 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening.

ALOHACARE

JANUARY 1, 2023 – DECEMBER 31, 2023

2023 EVIDENCE OF COVERAGE

AlohaCare Advantage Plus (HMO SNP)

H5969_EOC11502301_C

Services that are covered for you	**What you must pay** when you get these services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.

UHA HEALTH INSURANCE
Better Health. Better Life.

Medical Benefits Guide
Preferred Provider Plan

UHA One Plan℠

January 2024

SECTION 4: SUMMARY OF BENEFITS AND PAYMENT OBLIGATIONS

This Section provides a summary of the Benefits available under this Agreement and identifies your payment obligations for the Covered Services depending on whether you receive them from a Participating or Non-Participating Provider. **This summary of benefits below is subject to the description of benefits and related limitations of benefits in Section 5 and the exclusions in Section 6.**

Prior Authorization is required for some services. From time to time, it is necessary to change our Prior Authorization requirements so that benefits remain current with the way therapies are delivered. Changes may occur any time during your plan year. Please call UHA's Health Care Services Department at 532-4006 (or 1-800-458-4600, extension 300, from the Neighbor islands) to see if a service has been added to or deleted from the list, which is also available on our website at uhahealh.com under "Member Forms."

As stated previously in Section 1 of this document, the Service Area for this Plan is the State of Hawaii and the following require Prior Authorization (Section 7: Health Care Services Program):

- If you are a Hawaii resident and require medical services that are not available in Hawaii, your physician should contact us for an authorization for a referral to a mainland provider
- Hawaii residents seeking services, procedures or medical care on the mainland when clinically similar services, procedures or medical care are performed and available in Hawaii
- Mainland residents seeking elective ASC or hospital based procedures, or any advanced imaging

If it is reasonable for you to receive elective services, procedures or medical care in Hawaii, but you elect to have the services, procedures or medical care performed on the mainland, then services, procedures or medical care obtained from providers participating with the mainland contractor may be paid at the Non-Participating Provider benefit level, and you will be responsible for the provider's charges in excess of UHA's payment. Please refer to UHA's "Out-of-State Referrals for Medical Services" policy on UHA's website for more information, and please be aware that generally UHA requires two weeks' advance notice for Prior Authorizations.

Please remember that in addition to the payment amounts shown in this section, you are responsible for:

1. payment of all applicable taxes and non-covered services charged by the provider
2. if you see a Non-Participating Provider, any difference between the Eligible Charge and the Actual Charge made by the provider, in addition to the Co-payment or Coinsurance amount listed

A. PREVENTIVE CARE SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Well Child Care Physician Office Visits	None	None
All ACIP (Advisory Committee on Immunization Practices) recommended Childhood Immunizations	None	None
Well Child Care Laboratory Tests (Newborn through 5 years old)	None	None
Preventive Medicine Office Visit	None	None
Well Woman Exam	None	None
Screening Laboratory Services	None	None

All ACIP recommended Adult Immunizations	None	None
Mammography for Breast Cancer Screening	None	None
Cervical Cancer Screening (Pap Smear)	None	None
Chlamydia Screening	None	None
Osteoporosis Screening (Peripheral DEXA Scan or Ultrasound of the heel)	None	None
Colorectal Cancer Screening	None	None
Diabetes Prevention Program	None	20% of Eligible Charge
Gonorrhea Screening	None	None

B. DISEASE MANAGEMENT PROGRAMS	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Smoking Cessation Program	None	None
Nutritional Counseling Programs	None	None
Asthma Education Program	None	None
Diabetes Self-Management Training and Education Program	None	None

C. PHYSICIAN SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Anesthesia	20% of Eligible Charge	20% of Eligible Charge
Physician Visits: • Office • Hospital (inpatient or outpatient) • Emergency Room	• $12 Co-payment • $12 Co-payment • $12 Co-payment	• $12 Co-payment • $12 Co-payment • $12 Co-payment
Second Opinions **Prior Authorization required for opinions rendered by out-of-state providers.**	$12 Co-payment	$12 Co-payment
Consultations	$12 Co-payment	$12 Co-payment

D. SURGICAL SERVICES (Certain Surgical Services may require Prior Authorization)	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Assistant Surgeon	20% of Eligible Charge	20% of Eligible Charge

SECTION 5: DESCRIPTION OF BENEFITS

This Section describes the Benefits available to you under this Agreement, including any limitations.

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 uhahealth.com.

A. PREVENTIVE CARE SERVICES

UHA covers all U.S. Preventive Services Task Force (USPSTF) A and B recommended screening services at 100% as required under the provisions of the Affordable Care Act (ACA).

Well Child Care Physician Office Visits

Covered, including routine sensory screening, and developmental/behavioral assessments according to the American Academy of Pediatrics 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
- ages three years through twenty-one years: one visit per year

If your child requires medical care for an illness or injury, benefits for physician visits, not Well Child Care, apply.

Well Child Immunizations

Covered, in accord with Hawaii law and the guidelines set by the national CDC Advisory Committee on Immunization Practices (ACIP)

Well Child Care Laboratory Tests

Covered, UHA clinical preventive services guidelines are derived from the clinical recommendations of the USPSTF and Bright Futures. USPSTF guidelines are evidence-based and rely on current scientific studies, and are the basis for the guidelines in the ACA. Bright Futures guidelines represent a consensus by the American Academy of Pediatrics (AAP).

Preventive Medicine Office Visit

Covered, one per calendar year for a preventive health examination for members who are 22 and older. This benefit is in addition to the Well Woman Exam Benefit described below.

Well Woman Exam

Covered, for one annual health assessment per calendar year. The assessment should include screening, evaluation and counseling, and immunizations based on age and risk factors.

Please refer to the Cervical Cancer Screening (Pap Smear) language below for specific benefit information.

Screening Laboratory Services

Covered, UHA clinical preventive services guidelines are derived from the clinical recommendations of the USPSTF. USPSTF guidelines are evidence-based and rely on current scientific studies, and are the basis for the guidelines in the ACA.

Adult Immunizations

Covered, for standard Immunizations and for high risk conditions such as Hepatitis B and other vaccines in accord with the guidelines set by the Advisory Committee on Immunization Practices

Mammography for Breast Cancer Screening	Covered, one per calendar year for women ages 40 and older. Annual screening for women under 40 is allowed with a physician's order for women with a personal history of breast cancer, a history of chest irradiation, a family history of breast cancer in a first degree relative or a known genetic predisposition to breast cancer. Each member's frequency of testing should be determined after consultation with her physician to assure that current recommendations and personal risk factors are considered. Please note: mammograms that are not done for breast cancer screening fall under your diagnostic mammography benefits, which are included in the heading "Diagnostic Testing, Laboratory and Radiology Services."
Cervical Cancer Screening (Pap Smear)	Covered, one every three years for women ages 21 to 65.
Chlamydia Screening	Covered, one per calendar year
Osteoporosis Screening	Covered, coverage for initial screening and repeat testing interval is based on age and risk factors per USPSTF and National Osteoporosis Foundation guidelines.
Colorectal Cancer Screening	Covered, based on age and risk factors in compliance with current USPSTF guidelines.
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. Coverage is limited to one program per lifetime. If you receive benefits for this program under a UHA Plan, you will not be eligible for benefits for the program under any other UHA Plan.
Gonorrhea Screening	Covered, one per calendar year

B. DISEASE MANAGEMENT PROGRAMS

Smoking Cessation Program	Covered
Nutritional Counseling Programs	Covered, but only when counseling is provided: • by a Registered Dietician (RD), Certified Nutrition Specialist (CNS), or Certified Diabetes Educator (CDE); and • for the treatment of eating disorders, convulsions/seizures, cardiovascular disease, hypertension, renal disease (chronic kidney disease and end stage renal disease), Crohn's disease, gastrointestinal disorders, gout, obesity in adults (BMI ≥ 30 kg/m2), loss of weight, pediatric overweight and obesity (BMI > 95%), pancreatitis, pre- and post-bariatric surgery, pre-natal diet regulation, obstructive sleep apnea, squamous cell - oropharynx, or diabetes

January 1 – December 31, 2024

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Wellcare 'Ohana Dual Align (HMO D-SNP)

This document gives you the details about your Medicare and Hawaii Med-QUEST Division Program (Medicaid) health care and prescription drug coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 1-888-846-4262. (TTY users should call 711). Hours are: Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. This call is free.

This plan, Wellcare 'Ohana Dual Align (HMO D-SNP), is offered by Wellcare Health Insurance Of Arizona, Inc. (Wellcare by 'Ohana Health Plan) (When this *Evidence of Coverage* says "we," "us," or "our," it means Wellcare Health Insurance Of Arizona, Inc. (Wellcare by 'Ohana Health Plan) When it says "plan" or "our plan," it means Wellcare 'Ohana Dual Align (HMO D-SNP).)

We must provide information in a way that works for you (in audio, in braille, in large print, or other alternate formats, etc.). Please call Member Services if you need plan information in another format.

Benefits, and/or copayments/coinsurance may change on January 1, 2025.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

Services that are covered for you	**What you must pay** when you get these services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. Please read the FEHB Plan brochure RI 72-007 that contains the complete terms of this plan. All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure. Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure at www.compassrosebenefits.com/brochure , and view the Glossary at https://www.healthcare.gov/sbc-glossary You can call 888-438-9135 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 PPO Self Only $1,000 PPO Self Plus One $1,000 PPO Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. PPO preventive care, PPO professional services of physicians in a physician's office, emergency services/accidents, prescriptions.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$9,000 PPO Self Only; $18,000 PPO Self Plus One or Self and Family for you or any covered family member combined; Pharmacy Network providers are included in PPO limit	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, healthcare this plan	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

	doesn't cover, expenses for dental care, noncompliance penalties	
Will you pay less if you use a network provider?	Yes. See https://www.compassrosebenefits.com/uhc or call 888-438-9135 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$10/visit for provider with premium designation; $25/visit for provider without premium designation; Deductible does not apply	Not Covered	None
	Specialist visit	$30/visit for provider with premium designation; $70/visit for provider without premium designation; Deductible does not apply	Not Covered	None
	Preventive care/screening/ immunization	No Charge; Deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at compassrosebenefits.com/formulary	Generic drugs	$5/prescription for retail; $10/prescription for mail order; Deductible does not apply	Not Covered	Price for retail pharmacy is for up to a 30-day supply (you can receive a 90-day supply of maintenance medications at Walgreens and CVS retail stores for the same cost as mail order); Price for mail order is for a 90-day supply
	Preferred brand drugs	40% of the plan cost up to a max of $400, for retail; 40% of the plan cost up to a max of $800, for mail order; Deductible does not apply	Not Covered	
	Non-preferred brand drugs	100% coinsurance	Not Covered	
	Specialty drugs	Generic-50% of the plan cost up to a max of $500; Formulary-50% of the plan cost up to max of $1,000; Non-Formulary-100% coinsurance Deductible does not apply	Not Covered	Price is for up to a 30-day supply; Must be obtained through Optum Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	None
	Physician/surgeon fees	30% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	$500/visit; Deductible does not apply	$500/visit; Deductible does not apply	Copayment is waived if admitted to the hospital
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	$50/visit; Deductible does not apply	Not Covered	Copayment is waived if admitted to the hospital
	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	Prior authorization required (maximum

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you have a hospital stay	Physician/surgeon fees	30% coinsurance	Not Covered	$500 penalty)
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	Not Covered	25-visit maximum per calendar year for residential treatment services and other outpatient services, including: partial hospitalization, half-way house, full day hospitalization or facility based intensive outpatient treatment. Prior authorization required for residential treatment services and partial hospitalization (maximum $500 penalty)
	Inpatient services	30% coinsurance	Not Covered	Prior authorization required (maximum $500 penalty)
If you are pregnant	Office visits	30% coinsurance	Not Covered	None
	Childbirth/delivery professional services	30% coinsurance	Not Covered	None
	Childbirth/delivery facility services	30% coinsurance	Not Covered	Prior authorization required if hospital stay goes beyond 48 hours for a vaginal delivery and 96 hours for a cesarean delivery or if newborn stays after mother's discharge (maximum $500 penalty). Non-routine maternity services may have applicable copayment/coinsurance applied.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	25-visit maximum per calendar year; Prior authorization required after 12th visit (maximum $500 penalty)
	Rehabilitation services	30% coinsurance	Not Covered	25 total combined outpatient physical, occupational and speech therapy visits per calendar year; Prior authorization required after first 12 visits (maximum $500 penalty)
	Habilitation services	30% coinsurance	Not Covered	
	Skilled nursing care	Not Covered	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
	Durable medical equipment	30% coinsurance	Not Covered	Prior authorization is required for items costing $500 or more to rent or $1,500 or more to purchase (maximum $500 penalty)
	Hospice services	30% coinsurance	Not Covered	Prior authorization required (maximum $500 penalty)
If your child needs dental or eye care	Children's eye exam	No charge; Deductible does not apply	Not Covered	None
	Children's glasses	Charges in excess of $100 annual maximum	Charges in excess of $100 annual maximum	None
	Children's dental check-up	Charges in excess of $39, twice per year	Charges in excess of $39, twice per year	The Plan covers $39 twice a year for routine oral examinations, including x-rays, cleaning, diagnosis and preparation of a treatment plan. These expenses are not included in the out-of-pocket limit.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Custodial Care
- Hearing aids
- Long term care
- Private duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. **This isn't a complete list.** Please see your FEHB Plan brochure.)

- Acupuncture for anesthesia and pain relief up to a maximum of 12 visits per calendar year
- Bariatric surgery when an Optum Bariatric Resource Services program provider is used
- Chiropractic care up to a maximum of 12 visits per calendar year
- Dental care (Adult) limited to $39 twice a year for routine oral examinations
- Infertility treatment up to $1,000 per calendar year. Three cycles of drugs and medical services related to artificial insemination and three cycles for in-vitro fertilization related drugs
- Non-emergency care when traveling outside the U.S. See www.compassrosebenefits.com/brochure
- Routine eye care (Adult) limited to $100 a year
- Weight loss programs limited to 4 nutritional counseling sessions per year

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 888-438-9135 or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or

temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: 888-438-9135.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 888-438-9135.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-438-9135.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 888-438-9135.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-438-9135.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The **plan's** overall deductible	$500
Specialist *copayment*	$30
Hospital (facility) *copayment*	$400
Other *coinsurance*	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$3,700
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$4,240

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The **plan's** overall deductible	$500
Specialist *copayment*	$30
Hospital (facility) *copayment*	$400
Other *coinsurance*	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$130
Coinsurance	$1,630
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,130

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The **plan's** overall deductible	$500
Specialist *copayment*	$30
Hospital (facility) *copayment*	$400
Other *coinsurance*	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$420
Coinsurance	$630
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,550

The plan would be responsible for the other costs of these EXAMPLE covered services.

March 29, 2024

FROM: Lee Ellen Buenconsejo-Lum, MD, FAAFP
Interim Dean, John A. Burns School of Medicine, University of Hawai‘i
Affiliate member, UH Cancer Center
On behalf of the Early Lung Cancer Screening working group

Aloha!

The State of Hawaii enacted Act 162(2022) which requested the Department of Health to convene an Early Lung Cancer Screening Task Force. House Concurrent Resolution 207(2023) extended the deadlines for the Task Force to submit a detailed report, due July 31, 2024.

I know you are incredibly busy, but I am hoping that you or someone from your team could complete this short survey about low-dose computed tomography (LDCT) screening for lung cancer by April 15, 2024.

A smaller working group composed of UHCC, JABSOM, and Kaiser research representatives has been working to gather information and report back to the larger Task Force that will be meeting again sometime in September. At that and subsequent meetings, the Task Force will review currently available information and make recommendations to include in the interim report to the legislature, which is due in early December 2023. The final report is due July 31, 2024.

Per statute, the Working Group should include the following in its report, to the extent possible:

1. An analysis of the costs associated with early lung cancer screening;
2. A list of qualified facilities in the State that perform lung cancer screenings;
3. Protocols for health care providers and health care systems to identify populations at high risk for lung cancer;
4. An explanation of how healthcare providers are made aware of available insurance coverage for early lung cancer screenings;
5. Copies of guidelines used by health insurance providers to determine coverage for early lung cancer screening;
6. A discussion of cultural and social barriers associated with lung cancer screenings;
7. Policy recommendations for increasing early lung cancer screenings; and
8. A work plan that identifies the steps needed in the next five years to increase lung cancer screenings in the State.

The US Preventive Services Task Force 2021 (current) recommendations for lung cancer screening with low-dose computed tomography (LDCT) are:

- *Annual screening for lung cancer with LDCT in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.*
- *Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.*

Based on our review of all payors in Hawaii, the screening is covered. However, there may remain differences in understanding that this is now a covered service, or differences in processes to get these tests ordered, etc. In 2022, Hawai‘i had the lowest rates of cancer

screening in the United States, with a disproportionately high burden of late-stage disease and mortality in Native Hawaiians and Filipinos.

We would greatly appreciate it if your organization could answer the following questions by April 15, 2024, which will help us answer items 2, 3, 4, 7 above. Please forward this request (and cc LBUENCON@HAWAII.EDU) to individual(s) in your organization who could best answer the questions. Please send this completed survey to the following email address LBUENCON@HAWAII.EDU

Name of facility / facilities: _____

Q1. Do you offer low-dose CT (LDCT) for lung cancer screening at your facility? *(check, bold or highlight your answers)*

- □ Yes
- □ No. Please indicate why:
  - □ LDCT is not available in my facility
  - □ LDCT is available, but other components (Lung-RADS or other software package, etc.) are not available or reliably available
  - □ Insufficient staffing to support LDCT screening
  - □ Other reason (please state):

If your facility does NOT provide low-dose CT screening for lung cancer, you may end here. Please send the form back to LBUENCON@HAWAII.EDU.

Q2/Table. If you offer low-dose CT (LDCT) for lung cancer screening **(CPT G0297),** could you please share the following information in the table below. ***If you are not able to complete this table, please complete Q3 below.***

CY = calendar year. If you are answering for multiple hospitals in your system, you may aggregate the numbers below. Please make sure that you have entered the names of all facilities at the beginning of the survey.

Data requested	**CY 2019**	**CY 2020**	**CY2021**	**CY2022**	**CY2023**
# of LDCT (CPT code G0297) performed (total)					
# of LDCT in unduplicated patients					
If available, denominator data (i.e., # of people eligible*)					

*Age 50-80, 20-pack year history, current smoker or quit within the last 15 years

Q3. If you are not able to provide any types of numbers in the table above, please briefly describe the barriers you have to pulling the data or running reports to complete the above.

From your hospital, health system, and/or network perspective, **what measures have you implemented to achieve the following desired states:**

Q4. Increase provider awareness of the eligibility criteria for lung cancer LDCT screening *(check, bold, or highlight all that apply)*

- □ Email
- □ Newsletters
- □ Grand Rounds
- □ Webinars
- □ Published protocols for providers
- □ Other (please specify):

Q5. Facilitate or promote processes to make it easier for providers to order the LDCT in eligible patients *(check, bold, or highlight all that apply)*

- □ Utilize an EHR-based tool to help identify eligible patients based on age (50-80), smoking status (current or former that quit within 15 years), AND pack-year information (at least 20 pack-years)
- □ EHR-based prompt based on age (50-80) and smoking status (current or former that quit within 15 years)
- □ EHR-based prompt based on age only (50-80)
- □ Utilize “Best Practice Advisories” or similar
- □ Utilize a “health maintenance due”- type tool/flag
- □ Quality program staff (or other staff (e.g., medical assistants, nurses, nurse navigators) to identify eligible patients at the system level
- □ Quality program staff (or other staff (e.g., medical assistants or nurses) to identify eligible patients at the clinic level
- □ Quality program staff (or other staff (e.g., medical assistants, patient services reps or radiology technicians) to identify eligible patients at the imaging department level
- □ Accountable Care Organization-based effort
- □ Other: *please describe*
- □ None

Q6. Ensure timely follow-up of abnormal LDCT screening results *(check, bold, or highlight all that apply):*

- □ Standing orders or protocols where radiology staff schedule the follow-up appointment and notify the ordering physician
- □ Protocols where the radiologist communicates directly with the ordering physician or their office staff (but ordering is up to the discretion of the ordering physician)
- □ Automatic forwarding or CC of the finalized radiology reports to the ordering physician
- □ Tracking or Quality Assurance mechanism based within the diagnostic imaging department to follow up on LDCT findings
- □ Tracking or Quality Assurance mechanism based within an organized "lung (or thoracic) cancer program" to follow up on LDCT findings
- □ Tracking or Quality Assurance mechanism based within our accountable care organization to follow up on LDCT findings
- □ Adoption of the American College of Radiology Incidental Findings Quick Guide to assist nurse navigators in care coordination
- □ Participation in the American College of Radiology Lung Cancer Screening Registry
- □ Other: *please describe*
- □ None

Q7. From your hospital, health system, and/or network perspective, please describe **actual or perceived barriers to patients receiving timely follow-up** of abnormal LDCT screening results *(check, bold, or highlight all that apply)*

- □ Suboptimal communication with ordering physician
- □ Communication protocols in place but the ordering physician doesn't order
- □ Suboptimal patient understanding of the importance for follow-up (this may be "evidenced by" patient cancellation after the appointment is made)
- □ Patient out-of-pocket costs (actual or patient's fear of)
- □ Transportation challenges
- □ Insufficient staffing in the diagnostic imaging department
- □ Insufficient staffing and/or time in the ordering physician's office
- □ Other: please describe

Q8. Please briefly describe what attempts have been made to better determine the "denominator" or eligible population (age 50-80, 20-pack year history, current smoker or quit within the last 15 years).

Q9. Please briefly describe what attempts have been made to ensure the tobacco use fields (to determine pack-year history) are completed in the EHR of adult patients.

Q10. What resources or policies would be needed to help improve the percentage of lung cancer screening (via LDCT) in eligible patients residing in Hawai‘i?

Thank you for your time!

Appendix 2: Healthcare Facility (HCF) Survey Results

Number of surveys sent or forwarded to a provider of LDCT on the island: 11
Number of responses: 9
Number of HCF providing lung cancer screening via LDCT = 8 *(denominator for responses below, unless otherwise indicated)*

Q1: See report, Table 1, for the list and comments. For the 1 respondent not providing LCDT, this was due to both lack of the software package and insufficient staffing.

Number of locations served by respondents: 18
Islands or regions without LDCT: Lanai, Molokai, Niihau, Oahu Koolauloa, Koolaupoko

Q2: 75% of respondents were unable to provide a denominator (i.e., number of patients eligible for screening based on age, smoking status, and pack-year history).
The two (25%) that provided denominator information utilized their business intelligence staff and available smoking status and pack-year history (despite some inaccurancies). One of the two facility (much smaller facility, population, and catchment area) completes a smoking assessment on all patients in our EHR, then runs reports (business intelligence). This facility also started offering LDCT in late 2023.

Q3: For the 75% of respondents unable to provide any numeric information or denominator information, the most commonly cited reason was lack of staffing or resources, and inaccurate or incomplete smoking history in the EHR

Q4: What measures have you implemented to achieve increased provider awareness of the eligibility criteria for lung cancer LDCT screening
N = 8

Email	50%
Newsletters	50%
Grand Rounds	38%
Webinars	13%
Published protocols for providers	63%
Notification to providers throughout the network or system	25%
Other: (one each) Reference documents embedded in the EHR Numerous community, union, large employer partnerships for education and outreach Provider working groups (primary care, radiology) IT working groups (interdisciplinary)	

Appendix 2: Healthcare Facility (HCF) Survey Results

Q5: What measures have you implemented to facilitate or promote processes to make it easier for providers to order the LDCT in eligible patients
N=8 except as noted below for the ACO-based effort

Utilize an EHR-based tool to help identify eligible patients based on age (50-80), smoking status (current or former that quit within 15 years), AND pack-year information (at least 20 pack-years)	13%
EHR-based prompt based on age (50-80) and smoking status (current or former that quit within 15 years)	13%
EHR-based prompt based on age only (50-80)	13%
Utilize “Best Practice Advisories” or similar	38%
Utilize a “health maintenance due”- type tool/flag	25%
Quality program staff (or other staff (e.g., medical assistants, nurses, nurse navigators) to identify eligible patients at the system level	25%
Quality program staff (or other staff (e.g., medical assistants or nurses) to identify eligible patients at the clinic level	25%
Quality program staff (or other staff (e.g., medical assistants, patient services reps or radiology technicians) to identify eligible patients at the imaging department level	25%
Accountable Care Organization-based effort ***(Note, N=2 for this item)***	50%
Other: no responses	

Q6: What measures have you implemented to ensure timely follow-up of abnormal LDCT screening results?
N=8

Standing orders or protocols where radiology staff schedule the follow-up appointment and notify the ordering physician	0%
Protocols where the radiologist communicates directly with the ordering physician or their office staff (but ordering is up to the discretion of the ordering physician)	0%
Automatic forwarding or CC of the finalized radiology reports to the ordering physician	50%
Tracking or Quality Assurance mechanism based within the diagnostic imaging department to follow up on LDCT findings	38%

Appendix 2: Healthcare Facility (HCF) Survey Results

Tracking or Quality Assurance mechanism based within an organized "lung (or thoracic) cancer program" to follow up on LDCT findings	25%
Tracking or Quality Assurance mechanism based within our accountable care organization to follow up on LDCT findings ***Note N=2 for this item***	50%
Adoption of the American College of Radiology Incidental Findings Quick Guide to assist nurse navigators in care coordination	13%
Participation in the American College of Radiology Lung Cancer Screening Registry *Note, this also means that only these three facilities can be "found" or referred to via the American Lung Association navigation website*	38%
Other: none reported	

Q7. From your hospital, health system, and/or network perspective, please describe **actual or perceived barriers to patients receiving timely follow-up** of abnormal LDCT screening results
N=8

Suboptimal communication with ordering physician	25%
Communication protocols in place but the ordering physician doesn't order	63%
Suboptimal patient understanding of the importance for follow-up (this may be "evidenced by" patient cancellation after the appointment is made)	38%
Patient out-of-pocket costs (actual or patient's fear of)	25%
Transportation challenges	38%
Insufficient staffing in the diagnostic imaging department	13%
Insufficient staffing and/or time in the ordering physician's office	25%
Other: Lack of Integration with facilities that perform follow-up on the finding (i.e., obtaining biopsy results). HIPAA concerns with providing findings outside the Imaging Center.	

Q8. Please briefly describe what attempts have been made to better determine the "denominator" or eligible population (age 50-80, 20-pack year history, current smoker or quit within the last 15 years).

- Utilize business intelligence
- Complete a smoking assessment on all patients in their EHR, then run reports (business intelligence)
- Little or no effort yet due to staffing, or other priorities (i.e., education of ordering providers (primary care providers))

- Participating in a national research study of developing an algorithm that is integrated into the EHR
- At the imaging visit, staff obtains detailed smoking history; radiologist then recommends if the patient is eligble for LDCT based on the patient's insurance coverage

Q9. Please briefly describe what attempts have been made to ensure the tobacco use fields (to determine pack-year history) are completed in the EHR of adult patients.

- Working group meetings with providers (PCP teams, IT) to discuss opportunities or strategies
- Staff training on importance of obtaining complete smoking history
- Radiology staff document tobacco use in a free text field (technical comments), if it is pertinent to the procedure.
    - However, patients are less likely to fill out a redundant form to discuss information that was shared elsewhere with the PCP
- Tobacco is a quality measure required to be entered into the EHR
- Focus on PCP education

Q10. What resources or policies would be needed to help improve the percentage of lung cancer screening (via LDCT) in eligible patients residing in Hawai‘i?

Ranked in order of frequency (i.e., most commonly cited at the top of the list)

- Public outreach and education via large media, small media, social media
- Education for ordering providers via website, social media, print, talks, conferences, grand rounds
- Standardized policies and procedures throughout the state (i.e., standard order sets, protocols, communication protocols)
- Differing insurance coverage eligibility requirement (i.e.,. Medicare age 50-77 used by some, USPSTF age 50-80 used by some) make it very confusing for patients and providers (ordering providers and radiology providers). It would be ideal to have uniform criteria.
- Develop lung cancer screening working group
- One-stop lung nodule clinics where the PCP refers patients for a lung nodule and all subsequent care is coordinated/provided by the lung nodule clinic (including biopsy, treatment if applicable, ordering of follow-up scans, communication back to the PCP)
- Place information about lung cancer screening in patient waiting rooms
- Develop follow-up processes to ensure LDCT was done (if indicated, if ordered)

Early Lung Cancer Screening Task Force Survey

Start of Block: Introduction

Q0 Aloha!

The State of Hawaii enacted Act 162(2022) which requested the Department of Health convene an Early Lung Cancer Screening Task Force (Task Force). A smaller working group composed of UHCC, JABSOM, and Kaiser research representatives has been working to gather information and report back to the larger Task Force.

Among the responsibilities of the Task Force, the working group has been asked to, 1) identify qualified facilities in the State that perform lung cancer screenings, 2) determine protocols used by healthcare providers and healthcare systems to identify populations at high risk for lung cancer, and 3) determine how health care providers are made aware of available insurance coverage for early lung cancer screening.

To help us address this challenge we would greatly appreciate it if your organization could answer the following survey questions. Please forward this request to your organization's clinical care provider(s) who could best answer the survey questions. It should take less than 10 minutes to complete this survey.

Please submit only one response to this survey. If you have questions or need more information, please use the email link at the end of this survey.

Q1 In what type of practice do you provide clinical care? (select all that apply)

- [ ] Solo practice (1)
- [ ] Independent group practice (2)
- [ ] Employed practice (3)
- [ ] Independent contractor (4)
- [ ] Locum tenens (5)
- [ ] Direct primary care (6)
- [ ] Federally qualified healthcare center (7)
- [ ] Other (please specify) (8) _
- [ ] I do not provide clinical care (9)

Q2 What is your age?

_____

Q3 What is your ethnicity?

_____

Q4 What is your specialty?

_____

Q5 On what island is your practice located? (select all that apply)

- [ ] Hawaii (1)
- [ ] Oahu (2)
- [ ] Maui (3)
- [ ] Lanai (4)
- [ ] Molokai (5)
- [ ] Kauai (6)

Q6 In a typical week, roughly what percentage of your patients are...?

- O Current smokers (1) _____
- O Former smokers who quit LESS than 15 years ago (2) _____
- O Former smokers who quit MORE than 15 years ago (3) _____

Q7 Do you provide and/or refer current smokers to cessation therapy or services?

- O Yes, I refer patients to the Quitline (1)
- O Yes, I prescribe cessation medication (2)
- O Yes, I both refer my patients to the Quitline and prescribe cessation medications (3)
- O I do not refer my patients to the Quitline nor prescribe cessation medications (4)

Q8 How are you presently screening for lung cancer? (select all that apply)

- [ ] Low Dose Computed Tomography (1)
- [ ] Chest X-ray (2)
- [ ] Sputum sample (3)
- [ ] I do not screen my patients (4)

Q9 What methods do you rely on to keep updated with lung cancer screening recommendations? (select all that apply)

- [ ] Review US Preventive Services Task Force Recommendations (1)
- [ ] Review journal articles (2)
- [ ] Review American College of Radiology Guidelines (3)
- [ ] Review American Cancer Society Guidelines (4)

Q10 What are the major **barriers** to ordering and completing lung cancer screening for eligible individuals? (select all that apply)

- [ ] No or insufficient low-dose CT availability in the community where my patients live (1)
- [ ] Insufficient time or staff to determine who is eligible for screening and/or have the discussion with the patient (2)
- [ ] The electronic health record (EHR) system does not have a way to help easily or accurately identify eligible individuals (3)
- [ ] The EHR lacks reminders that this type of health maintenance screening is "due" or overdue (4)
- [ ] Lack of institutional support/policy across the board (5)
- [ ] Insufficient organizational emphasis (i.e., policy, procedures, staffing) on the importance of lung cancer screening (6)
- [ ] Insufficient communication between the health provider/system and the patients (7)
- [ ] Insufficient access to a health navigator to ensure patients attend their appointments (8)
- [ ] Insufficient provider education regarding guidelines, insurance coverage, how to order, etc. (9)
- [ ] Insufficient provider buy-in to the importance of lung cancer screening (10)
- [ ] Insufficient access to trained interpreters who can help explain (11)
- [ ] Language and cultural barriers (12)
- [ ] Patient financial/insurance barriers (13)
- [ ] Patient transportation barriers (14)
- [ ] Insufficient patient access to care (15)
- [ ] Insufficient patient buy-in to the importance of lung cancer screening (16)
- [ ] Vulnerability of the population (high rates of cancer and smoking) (17)

☐ Large homeless population (18)

Carry Forward Selected Choices from "What are the major barriers to ordering and completing lung cancer screening for eligible individuals? (select all that apply)"

Q11-A Please rank the **#1 barrier** to ordering and completing lung cancer screening in your practice. (select from dropdown menu)

▼ No or insufficient low-dose CT availability in the community where my patients live (1) ... Large homeless population (18)

Carry Forward Selected Choices from "What are the major barriers to ordering and completing lung cancer screening for eligible individuals? (select all that apply)"

Q11-B Please rank the **#2 barrier** to ordering and completing lung cancer screening in your practice. (select from dropdown menu)

▼ No or insufficient low-dose CT availability in the community where my patients live (1) ... Large homeless population (18)

Carry Forward Selected Choices from "What are the major barriers to ordering and completing lung cancer screening for eligible individuals? (select all that apply)"

Q11-C Please rank the **#3 barrier** to ordering and completing lung cancer screening in your practice. (select from dropdown menu)

▼ No or insufficient low-dose CT availability in the community where my patients live (1) ... Large homeless population (18)

Q12 What are the major **facilitators** that support ordering and completing lung cancer screening for eligible individuals? (select all that apply)

- [ ] Good allocation of resources for radiology and referral services (1)
- [ ] Using non-physician staff for screening (2)
- [ ] Minimal/brief workflow and process time for providers (EHR) (3)
- [ ] Provider involvement and education (4)
- [ ] Evidence-based guidelines (5)
- [ ] Buy-in from administration (cost-benefit) (6)
- [ ] Maximum involvement of auxiliary staff (7)
- [ ] Time for providers to query patients and discuss issues (8)
- [ ] Health maintenance reminders (9)
- [ ] Case management for positive screens and patient navigation (10)
- [ ] Direct communication with patients (phone or in-person) (11)
- [ ] Patient awareness, education, and/or buy-in (12)
- [ ] Patient transportation (13)

Carry Forward Selected Choices from "What are the major facilitators that support ordering and completing lung cancer screening for eligible individuals? (select all that apply)"

Q13-A Please rank the **#1 facilitator** that supports ordering and completing lung cancer screening in your practice. (select from dropdown menu)

▼ Good allocation of resources for radiology and referral services (1) ... Patient transportation (13)

Carry Forward Selected Choices from "What are the major facilitators that support ordering and completing lung cancer screening for eligible individuals? (select all that apply)"

Q13-B Please rank the **#2 facilitator** that supports ordering and completing lung cancer screening in your practice. (select from dropdown menu)

▼ Good allocation of resources for radiology and referral services (1) ... Patient transportation (13)

Carry Forward Selected Choices from "What are the major facilitators that support ordering and completing lung cancer screening for eligible individuals? (select all that apply)"

Q13-C Please rank the **#3 facilitator** that supports ordering and completing lung cancer screening in your practice. (select from dropdown menu)

▼ Good allocation of resources for radiology and referral services (1) ... Patient transportation (13)

End of Block: Block 2

Start of Block: Block 3

Q14 We are also conducting brief interviews with local clinical providers. The interviews should take about 1/2 hour, and we are offering an incentive for your time. Please add your name and phone number, if you are interested in participating in this interview. Otherwise, please click the "Next" arrow.

O Name (1) _____

O Phone number (2) _____

O Best time to call (3) _____

End of Block: Block 3

Provider Survey Data

In a typical week, roughly what percentage of your patients are...? - **Current smokers**	**Category (%)**	**Count**
	0-9	7
	10-19	7
	20-29	5
	30-39	1
	40-49	1
	50-59	2
	60+	0

In a typical week, roughly what percentage of your patients are...? - **Former smokers who quit LESS than 15 years ago**	**Category (%)**	**Count**
	0-9	11
	10-19	6
	20-29	2
	30-39	3
	40-49	1
	50-59	0
	60+	0

In a typical week, roughly what percentage of your patients are...? - **Former smokers who quit MORE than 15 years ago**	**Category (%)**	**Count**
	0-9	10
	10-19	5
	20-29	2
	30-39	2
	40-49	3
	50-59	0
	60+	1

Do you provide and/or refer current smokers to cessation therapy or services?	**Answer**	**Count**
	Yes, I refer patients to the Quitline	1
	Yes, I prescribe cessation medication	5
	Yes, I both refer my patients to the Quitline and prescribe cessation medications	17
	I do not refer my patients to the Quitline nor prescribe cessation medications	0

Provider Survey Data

How are you presently screening for lung cancer? (select all that apply)	Answer	Count
	Low Dose Computed Tomography	21
	Chest X-ray	5
	Sputum sample	0
	I do not screen my patients	3

What methods do you rely on to keep updated with lung cancer screening recommendations? (select all that apply)	Answer	Count
	Review US Preventive Services Task Force Recommendations	20
	Review journal articles	8
	Review American College of Radiology Guidelines	3
	Review American Cancer Society Guidelines	37

What are the major barriers to ordering and completing lung cancer screening for eligible individuals? (select all that apply)	Answer	Count	#1 Barrier	#2 Barrier	#3 Barrier
	No or insufficient low-dose CT availability in the community where my patients live	4	2	3	1
	Insufficient time or staff to determine who is eligible for screening and/or have a discussion with the patient	10	7	3	1
	The electronic health record (EHR) system does not have a way to help easily or accurately identify eligible individuals	11	2	2	2
	The EHR lacks reminders that this type of health maintenance screening is "due" or overdue	8	1	2	1
	Lack of institutional support/policy across the board	5	1	3	1
	Insufficient organizational emphasis (i.e., policy, procedures, staffing) on the importance of lung cancer screening	2	0	0	1
	Insufficient communication between the health provider/system and the patients	3	0	0	0
	Insufficient access to a health navigator to ensure patients attend their appointments	6	0	1	0
	Insufficient provider education regarding guidelines, insurance coverage, how to order, etc.	5	1	1	1
	Insufficient provider buy-in to the importance of lung cancer screening	1	0	0	0

Provider Survey Data

	Insufficient access to trained interpreters who can help explain	1	0	0	0
	Language and cultural barriers	5	0	0	1
	Patient financial/insurance barriers	10	1	2	1
	Patient transportation barriers	10	1	1	1
	Insufficient patient access to care	8	1	0	2
	Insufficient patient buy-in to the importance of lung cancer screening	10	4	1	4
	Vulnerability of the population (high rates of cancer and smoking)	4	0	2	0
	Large homeless population	6	1	0	0

What are the major facilitators that support ordering and completing lung cancer screening for eligible individuals? (select all that apply)	Answer	**Count**	**#1 Facilitator**	**#2 Facilitator**	**#3 Facilitator**
	Good allocation of resources for radiology and referral services	11	5	5	3
	Using non-physician staff for screening	8	2	1	0
	Minimal/brief workflow and process time for providers (EHR)	11	4	2	2
	Provider involvement and education	8	1	0	3
	Evidence-based guidelines	12	1	3	4
	Buy-in from administration (cost-benefit)	3	0	1	0
	Maximum involvement of auxiliary staff	2	0	0	0
	Time for providers to query patients and discuss issues	9	3	3	1
	Health maintenance reminders	6	3	1	0
	Case management for positive screens and patient navigation	8	1	1	3
	Direct communication with patients (phone or in-person)	7	1	2	0
	Patient awareness, education, and/or buy-in	7	1	1	3
	Patient transportation	2	0	0	1

Provider Survey Data