HMSA Plan

www.hmsa.com/federalplan
Customer service 800-776-4672

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

2018

A Health Maintenance Organization with a point of service product.

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This plan is accredited. See page 13.

Serving: All of Hawaii

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 15 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2018: Page 16
- Summary of benefits: Page 101

Enrollment codes for this Plan:

871 Self Only
873 Self Plus One
872 Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-010

Important Notice from the HMSA Plan About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the HMSA Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, TTY: 800-325-0778.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY: 877-486-2048.

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Introduction

This brochure describes the benefits of Hawai‘i Medical Service Association (HMSA), an independent licensee of the Blue Cross and Blue Shield Association under our contract (CS 1058) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 800-776-4672 for neighbor islands, and 808-948-6499 for Oahu or through our website: www.hmsa.com/federalplan. The address for HMSA's administrative offices is:

Hawai‘i Medical Service Association
818 Keeaumoku Street
Honolulu, Hawaii 96814

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2018 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2018 and changes are summarized on page 16. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) 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/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means HMSA.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 808-948-5166 and explain the situation.
  - If we do not resolve the issue

CALL-- THE HEALTH CARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

The HMSA Plan complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557 the HMSA Plan does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

For more information, please visit our web site at www.hmsa.com/non-discriminiation-notice/.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. **Keep and bring a list of all the medicines you take.**

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. **Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. **Talk to your doctor about which hospital or clinic is best for your health needs.**

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"

- "About how long will it take?"
- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.bemedwise.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events".

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use HMSA's preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) 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/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2018 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2017 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.Healthcare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. HMSA holds the following accreditation: National Committee for Quality Assurance. To learn more about this plan's accreditation, please visit the following website www.ncqa.org. We encourage you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurance described in this brochure. When you receive services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

We have Point of Service (POS) benefits

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may have higher out-of-pocket costs than our in-network benefits.

How we pay providers

We have over 3,500 Plan doctors, dentists, and other health care providers in Hawaii who agree to keep their charges for covered services below our eligible charge guidelines. When you go to a Plan provider, you will only be responsible for your cost-sharing (copayments, coinsurance, and non-covered services and supplies).

You may go to a non-Plan provider, however, the Plan pays a reduced benefit for certain services from non-Plan providers. You may have to file a claim with us. We will then pay our benefits to you and you must pay the provider. In addition, because non-Plan providers are not under contract to limit their charges, you are responsible for any charges in excess of eligible charges.

When you need covered services outside the state of Hawaii, you are encouraged to contact the Blue Cross and/or Blue Shield Plan in the area where you need services for information regarding specific Plan providers in their area. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Hawaii, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside of Hawaii, you will obtain care 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"). In some instances, you may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

BlueCard® Participating Providers

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, HMSA will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside of Hawaii and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of:

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over – and underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price HMSA uses for your claims because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Nonparticipating Providers Outside of Hawaii

When covered healthcare services are provided outside of Hawaii by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you will be liable for the difference between the amount the non-participating bills and the payment we will make for the covered services as set forth in this paragraph.

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by non-participating healthcare providers. In these situations, you will be liable for the difference between the amount that the non- participating healthcare provider bills and the payment we will make for covered services as set forth in this paragraph.

Dental Providers Outside of Hawaii

You can receive Plan dental benefits when you see a dental provider for covered services outside of Hawaii. To find a participating dentist, please visit our website at www.hmsa.com/federalplan.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, our providers, and our facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- We are currently in compliance with state licensing requirements
- We are in our 79th year of continuous service to the people of Hawaii
- We were founded in 1938 as a non-profit mutual benefit society

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website at www.hmsa.com/federalplan. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 808-948-6499, or write to P.O. Box 860, Honolulu, HI 96808. You may also visit our website at www.hmsa.com/federalplan.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website at www.hmsa.com/federalplan to obtain a Notice of our Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies or to administer this Plan.

Service Area

To enroll in this Plan, you must live in our service area. This is where our providers practice. Our service area is the islands of Hawaii, Kauai, Maui, Oahu, Molokai and Lanai.

If you or a covered family member move outside of our service area, you may remain in the Plan or you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you may remain in the Plan or you can consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2018

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this Plan

- Your share of the non-Postal premium will stay the same for Self Only, stay the same for Self Plus One, or stay the same for Self and Family. See page 102.
- We are providing a link to more information on Section 1557 of the Affordable Care Act (ACA), the HMSA Plan does not discriminate. See "Discrimination is Against the Law" on page 5.
- We are clarifying the exceptions that allow HMSA to use member information when reasonably necessary to administer the benefits of this Plan. See Section 1, "How this plan works" on page 15.
- We are updating our list of services requiring our prior approval. See Section 3, "How you get care" on pages 19.
- We are expanding the telehealth benefit to include services rendered by physicians through electronic means other than HMSA's Online Care application and network. See Section 5(a), "Medical services and supplies provided by physicians and other health care professionals" on page 26-27.
- We are covering pulmonary rehabilitation. For more information, see Section 5(a), "Medical services and supplies provided by physicians and other health care professionals" on page 35.
- We are clarifying the cochlear implant batteries benefit. See Section 5(a), "Medical services and supplies provided by physicians and other health care professionals" on page 37.
- We are covering chiropractic manipulations for the treatment of neuromusculoskeletal disorders related to the spinal column. For more information, see Section 5(a), "Medical services and supplies provided by physicians and other health care professionals" on page 39.
- We are recognizing licensed dietitians to provide treatment for eating disorders as part of a multidisciplinary network of Behavioral Health professionals. See Section 5(e). "Mental health and substance misuse disorder benefits" on page 57.
- We are modifying the criteria to meet the non-formulary exception process. See Section 5(f), "Prescription Drug Benefits" on page 61.
- We are covering Over-the-counter contraceptive drugs for men. For more information, see Section 5(f), "Prescription Drug Benefits" on page 64.
- We are updating the mail order reference of USPSTF Recommended Drugs to Preventive Care Medications. See Section 5 (f). "Prescription drug benefits" on page 65.
- We are removing the age limitation of the Occlusal Splint benefit. See Section 5(g). "Dental benefits" on page 68.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 808-948-6499 or write to us at P.O. Box 860, Honolulu, HI 96808. You may also request replacement cards through our website at www.hmsa.com/federalplan.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

To determine if a provider is recognized, we look at many factors including licensure, professional history, and type of practice. All Plan providers and some non-Plan providers are recognized. To find out if your physician is a participating provider, refer to your HMSA Directory of Participating Providers. If you need a copy, call us and we will send one to you or visit www.hmsa.com/federalplan.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

In order to receive Plan provider benefits for covered out-of-state services under this Plan, the services must be provided by a BlueCard® PPO provider.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website www.hmsa.com/federalplan.

You can receive Plan dental benefits when you see a dental provider for covered services outside of Hawaii. To find a participating dentist, please visit our website at www.hmsa.com/federalplan.

- **Non-Plan providers**

Non-Plan providers are physicians and other health care professionals who are not under contract with this Plan.

For out-of-state services under this Plan, non-Plan provider benefits are applied for covered services rendered by non-BlueCard® PPO providers, even if they participate in other Blue Cross and/or Blue Shield programs.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website at www.hmsa.com/federalplan.

What you must do to get covered care

You are encouraged to coordinate your care with a primary care physician who will provide or arrange most of your health care.

- **Primary care**

Your primary care physician can be a family practitioner, internist, obstetrician/gynecologist or pediatrician. Your primary care physician will provide most of your health care, or can refer you to see a specialist.

- **Specialty care**

You have direct access to Plan specialists when needed. However, you may wish to coordinate your specialty care with your primary care physician, who can help you arrange for the specialty care service you will need.

Here are some other things you should know about specialty care:

- Your primary care physician or specialist may create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, you are encouraged to coordinate your specialty care with your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist.
- If you are seeing a specialist and your specialist leaves the Plan, talk to your primary care physician, who will arrange for you to see another specialist. If you decide to continue seeing your specialist, you will pay a copayment/coinsurance plus the difference between the eligible charge and the specialist's billed charge.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or
  - reduce our service area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since we do not have a primary care physician requirement and we allow you to use non-Plan providers, you or your physician will need to obtain our prior approval before you receive certain services. The pre-service claim approval process for services is detailed in this Section. A pre-service claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification or prior approval and (2) will result in a denial or reduction of benefits if you do not obtain precertification or prior approval.

- **Inpatient hospital admission**

We do not require precertification prior to your hospital admission, however, we do require prior approval for other services.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we check if the service is covered and medically necessary for your condition. A few common examples of things you must obtain prior authorization 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, bariatric surgery, 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, habilitative services and devices, 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 for the treatment of obstructive sleep apnea.

This list of services requiring prior approval may change periodically. To ensure your treatment or procedure is covered, call us at 808-948-6499 or visit our website at www.hmsa.com/federalplan.

How to request precertification for an admission or get prior authorization for Other services

If you are under the care of:

- An HMSA participating physician or contracting physician, he or she will:
  - Obtain prior approval for you; and
  - Accept any penalties for failure to obtain prior approval.
- You are responsible for obtaining prior approval when receiving services from a BlueCard® PPO, BlueCard® Plan provider or a non-Plan provider. Please contact our Medical Management Department at 808-948-6464 on Oahu, or 800-344-6122 toll free from the Neighbor Islands. You may also contact our Medical Management Department by fax at 808-944-5611.

You will need to provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility;
- number of days requested for hospital stay; and
- clinical information.

If you do not receive prior approval and receive any of the services described in Section 3 *You need prior Plan approval for certain services - Other services*, benefits may be denied.

- **Non-urgent care claims**

We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-344-6122 for neighbor island, and 808-948-6464 for Oahu. You may also call OPM's Health Insurance (HI) 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-344-6122 for neighbor island, and 808-948-6464 for Oahu. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Failure to obtain prior approval may result in a denial of benefits if the services or devices do not meet HMSA's payment determination criteria.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding prior approval of a transplant or other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

   You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

   If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your cost for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance/copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you use your Plan pharmacy, you pay a copayment of $7 for generic drugs.

Deductible

We do not have a deductible.

Eligible Charges

For most medical services, we calculate our payment and your copayment/coinsurance based on eligible charges. The eligible charge is the lower of either the provider's actual charge or the amount we established as the *maximum allowable fee*.

For participating facilities, we calculate our payment based on the *maximum allowable fee*. Your coinsurance is based on the lower of the facility's actual charge or the *maximum allowable fee*. Your coinsurance and our payment will equal the *maximum allowable fee*.

Non-Plan providers are not under contract to limit their charges to our eligible charges. You are responsible for any charges in excess of eligible charges.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Example: When you receive an x-ray, you pay a coinsurance of 20% for Plan providers.

Your catastrophic protection out-of-pocket maximum

After your copayments and coinsurance total $3,000 for Self Only or $6,000 for Self Plus One, or $9,000 for Self and Family enrollment in any calendar year, you are no longer responsible for any coinsurance/copayment amounts for covered services. If you are enrolled in Self Plus One or Self and Family, each family member must individually meet the $3,000 Self Only out-of-pocket maximum but not to exceed the $9,000 Self and Family out-of-pocket maximum for a family of 3 or more.

Coinsurance/copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay coinsurance/copayments for these services even after you have met the out-of-pocket maximum:

- Adult Dental Care (19 years of age and older)
- Adult Vision Care (19 years of age and older)

The following amounts do not count toward meeting your catastrophic protection out-of-pocket maximum and you must continue to be responsible for the amounts below even after you have met the out-of-pocket maximum.

- Payment for services subject to a maximum once you reach the maximum.
- The difference between the actual charge and the eligible charge that you pay when you receive service from a non-Plan provider.
- Payments for non-covered services.
- Any amounts you owe in addition to your coinsurance/copayment for covered services.

Be sure to keep accurate records of your coinsurance/copayments. We will also keep records of your coinsurance/copayments and track your catastrophic protection out-of-pocket maximum.

Carryover	If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits - OVERVIEW

See page 16 for how our benefits changed this year and page 101 for a benefits summary. Note: This benefits section is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also, read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 808-948-6499 or on our website at www.hmsa.com/federalplan.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Prior Approval is required for certain services, supplies, and drugs. Please refer to the information shown in Section 3 to be sure which services, supplies, and drugs require prior approval.

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • During a hospital stay • In a skilled nursing facility • Medical consultations - inpatient and outpatient • At home • In an urgent care center • For an advance care planning visit Note: one visit per calendar year	Plan Provider $15 copayment per visit Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Telehealth services	
• Telehealth physician visits	Plan Provider $15 copayment Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
• Screening Services - Grade A and B Recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following: - Preventive Counseling Services	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Note: • Telehealth services are covered in accord with HMSA's medical policy for telehealth services.	

Telehealth services - continued on next page

Benefit Description	You pay
Telehealth services (cont.)	
• Online Care Note: 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. Care is available for 10 minute sessions which may be extended up to 5 additional minutes. Each session is limited to a total of 15 minutes.	Plan Provider Nothing Non-Plan Provider Not a benefit
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • Pre-surgical labs	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
• X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG • Pre-surgical diagnostic testing	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • *Outpatient thoracic electric bioimpedence in an outpatient setting which includes a physician's office.*	*All charges*
Preventive care, adult	
Well woman care based on current recommendations such as: • Cervical cancer screening (Pap smear) once every three years • Human Papillomavirus (HPV) testing • Chlamydia/Gonorrhea screening • Osteoporosis screening • Breast cancer screening • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
Routine screenings include: • Routine Prostate Specific Antigen (PSA) test - one annually for men age 50 and older	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Routine screenings include: • Routine mammogram– covered for women age 40 and older, one every calendar year. Note: A woman of any age may receive the screening more often if she has a history of breast cancer or if her mother or sister has a history of breast cancer	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
• Colorectal Cancer Screenings are covered in accord with HMSA's Preventive Services Guidelines for: - Fecal occult blood test - Sigmoidoscopy screening - Colonoscopy screening	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
• Complete Blood Count - one per calendar year • Urinalysis - one per calendar year • Chlamydial infection screening • TB Test - one per calendar year	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
• Routine Chest X-Ray - one per calendar year • Double contrast barium enema (DCBE) – once every five years, age 50 and above	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Screening Services – Grade A and B Recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following: • Preventive Counseling Services • Screening Laboratory Services: - Genetic Risk Assessment and BRCA Mutation Testing for Breast and Ovarian Cancer Susceptibility - 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	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
- 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 - Screening for Lung Cancer	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
• Routine Physical Exam – one per calendar year The following services are also covered when performed in conjunction with a covered routine physical exam: - Vision test - Hearing test Note: For vision and hearing tests not performed in conjunction with a routine physical exam, see Section 5(a) *Hearing services (testing, treatment, and supplies) and Vision services (testing, treatment, and supplies).*	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. • Standard Immunizations • Immunizations for high risk conditions such as Hepatitis B • Travel Immunizations	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Note: A complete list of preventive care services recommended under the U.S Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: www.healthcare.gov/preventive-care-women/ For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to: brightfutures.aap.org/Pages/default.aspx	

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
Not covered: • *Physical exams, immunizations and any associated screening procedures in connection with third party requests or requirements such as those for: employment (or work-related exposure), participation in employee programs, sports (athletic exams), camp, insurance, disability licensing, or on court order or for parole or probation* • *Physical exams obtained for, or related to, the purpose of travel* Note: Physical examinations that are needed by a third party and are coincidentally performed as part of a routine annual physical examination are covered.	*All charges*
Preventive care, children	
• Childhood immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics.	Plan Provider Nothing Non-Plan Provider Any difference between our eligible charge and the actual charge
Well-child visits and examinations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. • Examinations up to age 22 according to the following schedule: - Birth through age two: 12 visits - Age three through 21: one visit each calendar year Note: For vision and hearing tests not performed in conjunction with a routine physical exam, see *Section 5(a) Hearing services (testing, treatment, and supplies) and Vision services (testing, treatment, and supplies).*	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Laboratory tests: • Three urinalysis through age five • As recommended by Bright Futures/American Academy of Pediatrics through age 21 Note: Additional tests for children ages six and older, see Section 5(a), *Preventive care, adult.*	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS at www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to: brightfutures.aap.org/Pages/default.aspx	

Benefit Description	You pay
Maternity care	
Complete maternity (obstetrical) care, includes physician or certified nurse-midwife services for routine: • Prenatal care • Screening for gestational diabetes for pregnant women after 24 weeks • Delivery • Postnatal care Note: Here are some things to keep in mind: • We pay hospitalization, surgeon services, anesthesiology, lab, and ultrasound the same as for illness and injury. See Section 5(c) for hospital benefits, Section 5(b) for surgery and anesthesia benefits, and Section 5(a) for lab, x-ray, and other diagnostic tests benefits. • See page 26, Professional services of physicians, and page 50, hospital benefits, for how we pay benefits for other circumstances, such as complications of pregnancy and extended stays for you or your baby. • You do not need to obtain prior approval for your vaginal delivery and precertification for extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. Your physician will extend your inpatient stay if medically necessary. • Newborn child - We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. - See Section 5(c) for hospital benefits, Section 5(b) for surgery and anesthesia benefits, and Section 5(a) for lab, x-ray, and other diagnostic test benefits. - We cover care to treat a child's congenital defects and birth abnormalities for the first 31 days of birth. - We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. - Surgical benefits, not maternity benefits, apply to circumcision.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Breastfeeding support, supplies and counseling for each birth • Breast pumps - Purchase of one device including attachments are covered when purchased from a provider that provides medical equipment and supplies. • Rental of a hospital-grade breast pump is covered if an infant is unable to nurse directly on the breast due to a medical condition, such as prematurity, congenital anomaly and/or an infant is hospitalized.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: Routine sonograms to determine fetal age, size, or sex.	*All charges*

Benefit Description	You pay
Family planning	
Contraceptive counseling on an annual basis	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
A range of voluntary family planning services, limited to: • Voluntary sterilization. See Section 5(b) *Surgical procedures*. • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms/Cervical Caps Note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. We cover oral contraceptives under the prescription drug benefits. See Section 5(f) for benefit level.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling, except as identified on the U.S. Preventive Services Task Force list of Grade A and B recommendations* • *Contraceptives such as condoms, foam, or creams which do not require a prescription*	*All charges*
Infertility services	
Diagnosis of infertility Treatment of infertility limited to: • Artificial insemination (AI): - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • In Vitro Fertilization (IVF) Note: Coverage is limited to a one time only benefit for one outpatient in vitro procedure in accord with our criteria and in compliance with Hawaii law. • Injectable fertility drugs Note: We cover oral fertility drugs under the prescription drug benefit. See Section 5(f) *Prescription drug benefits*.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	
Not covered: • *In Vitro Fertilization (IVF) for civil union partners* • *Assisted reproductive technology (ART) procedures, such as:* - *Embryo transfer, gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures except In Vitro Fertilization* • *Services of a surrogate* • *Cost of donor sperm* • *Cost of donor egg* • *Any donor-related services, including but not limited to collection, storage, and processing of donor eggs and sperm* • *Cryopreservation of oocytes, semen and embryos*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections • Treatment materials	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Allergy serum	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: Provocative food testing and sublingual allergy desensitization.	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants starting on page 44. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy and Intravenous nutrient solutions for primary diet • Outpatient injections • Specialty Injectable Drugs	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	
• Specialty Self-Injectables Note: For Specialty inhaled drugs and specialty oral drugs, see Section 5(f) *Prescription drug benefits.* Note: Home IV Therapy and some injections require prior approval. See Section 3 *You need prior Plan approval for certain services - Other services.* • Medical foods and low-protein modified food products for the treatment of inborn errors of metabolism in accord with Hawaii Law and Plan guidelines. • Growth hormone therapy (GHT) Note: We only cover GHT when we prior approve the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Section 3 *You need prior Plan approval for certain services - Other services.* Note: Drugs must be FDA approved. See Section 3 *You need prior Plan approval for certain services - Other services.* • Applied Behavior Analysis (ABA) Therapy Note: Applied Behavior Analysis Therapy requires prior approval, see Section 3. *You need prior Plan approval for certain services - Other services.*	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Physical and occupational therapies	
Physical and occupational therapies are covered: • When the therapy is provided by a qualified provider of physical and occupational therapy services. A qualified provider is one who is licensed appropriately, performs within the scope of his or her license and is recognized by HMSA. • In accord with HMSA's medical policies for habilitative services and devices and for rehabilitative services and devices. Note: • Prior approval is required for physical and occupational therapy subject to HMSA's criteria. Plan providers obtain approval for you, non-Plan providers do not. See Section 3 *You need prior Plan approval for certain services - Other services.* • Rehabilitation is the process of evaluation, treatment and education for the purpose of improving or restoring skills and functions lost or impaired due to illness or injury. • Rehabilitative services and devices are health care services that assist an individual in improving or restoring skills and functions of daily living that have been lost or impaired due to illness or injury.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	
• Habilitation is the process of evaluation, treatment and education for the purpose of developing, improving and maintaining skills and function which the individual has not previously possessed. • Habilitative services and devices are health care services that assist an individual in partially or fully acquiring skills and functions of daily living.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs, except as offered through an HMSA program. See Section 5(a) Pulmonary rehabilitation.* • *Cardiac Rehabilitation, except as offered through an HMSA program. See Section 5(h) Wellness and Other Special features.*	*All charges*
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. Note: These services require prior approval. See Section 3. *You need prior Plan approval for certain services - Other services.*	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Speech therapy	
Speech therapy services include: • Speech/language therapy • Swallow/feeding therapy • Aural rehabilitation therapy • Augmentative/alternative communication therapy We only cover therapy: • When rendered by and requires the judgment and skills of a speech language pathologist certified as competent (CCC-SLP) by the American Speech-Language Hearing Association (ASHA). Prior approval is required for speech therapy subject to HMSA's criteria. Plan providers obtain approval for you, non-Plan providers do not. See Section 3, *You need prior Plan approval for certain services – Other services.*	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	
Note: • Hearing testing performed in conjuction with a physical exam for children up to age 22, see Section 5(a), *Preventive care, children;* • See Section 5(a), *Orthopedic and prosthetic devices* for Hearing aids and Diagnostic hearing tests	
Vision services (testing, treatment, and supplies)	
• Eyeglasses or contact lenses for certain medical conditions limited to one pair of eyeglasses, replacement lenses, or contact lenses (or equivalent supply of disposable contact lenses) per incident.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
• Annual vision exam and eye refraction Note: • For vision tests performed in conjunction with a routine physical exam, see Section 5(a) *Preventive care, adult and children.* For information on your out-of-pocket maximum, see Section 4, *Your cost for covered services.*	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Contact lens fitting*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of a ny instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Hearing Aids, limited to: - one per ear every 60 months • Hearing aid evaluation Note: For hearing tests performed in conjunction with a routine physical exam, see Section 5(a) *Preventive care, adult and children.* • Diagnostic hearing test • Prosthetic devices, such as artificial limbs and lenses following cataract removal • Orthopedic devices, such as braces • Orthodontic services for the treatment of orofacial anomalies. Note: Orthodontic services requires prior approval, see Section 3. *You need prior Plan approval for certain services - Other services.* • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants and batteries, and surgically implanted breast implant following mastectomy Note: See Section 5(b) for coverage of the surgery to insert the device.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • *Nonstandard or deluxe hearing aids and hearing aid features* • *All other hearing tests* • *Repair of hearing aids* • *Fitting and Adjustments of hearing aids* • *Hearing aid batteries, except cochlear implant batteries* • *Orthopedic and corrective shoes, podiatric shoes, arch supports, heel pads and heel cups* • *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.* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Microprocessor-controlled/computer-controlled and myoelectric components for lower and upper limb prosthetics*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
• *Services or supplies related to the treatment of baldness or hair loss regardless of condition. This includes hair transplants and topical medications.*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Mobility assistive equipment (wheelchairs, crutches, walkers, power mobility devices) • Blood glucose monitors • Insulin pumps	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
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 for the treatment of 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 for details. • Repair and replacement of durable medical equipment is covered subject to certain limitations and exclusions. Please call for details. See Section 3 *You need prior Plan approval for certain services - Other services.*	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible chargeand the actual charge
Not covered: • *Environmental Control Equipment and 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* • *Educational equipment* • *Comfort or convenience items*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
• *Duplicate durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances that are intended to be used as a back-up device, for multiple residences, or for traveling, e.g., 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.* • *Repairs or replacements of durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances covered under the manufacturer or supplier warranty or 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.*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a qualified home health agency for the treatment of 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 leave home, doing so requires a considerable and taxing effort. • Services provided for up to 150 visits per calendar year. Note: If you need home health care services for more than 30 days, a physician must certify that there is further need for the services and provide a continuing plan of treatment at the end of each 30-day period of care.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	
• Chiropractic manipulation Prior plan approval is required for chiropractic services subject to HMSA's criteria. Plan providers obtain approval for you, non-Plan providers do not. See Section 3 *You need prior Plan approval for certain services - Other services.*	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Benefit Description	You pay
Alternative treatments	
No Benefit	*All charges*
Not covered: • *Biofeedback and other forms of self-care or self-help training and any related diagnostic testing.* • *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 and disposable underpads.*	*All charges*
Educational classes and programs	
Coverage is provided for: • Disease Management Programs Programs are available for members with asthma, diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and behavioral health conditions (mental health and substance misuse disorder). The programs offer services to help you and your physician manage your care and make informed health choices. HMSA reserves the right to at any time add other programs. HMSA cannot guarantee the continued participation of a program. Call 808-948-6499 for more information. • Preventive Services Programs HMSA believes in the importance of helping members stay healthy, preventive care is the key to do this. Preventive care may include immunizations, screenings, lab tests, and health guidance. You and your covered family members can receive preventive care from your PCP at checkup visits and other times. Healthier lifestyles, immunizations, and early detection and treatment can prevent many serious diseases. That is why HMSA offers preventive care services to help keep you and your family healthy. HMSA reserves the right to at any time add other programs. HMSA cannot guarantee the continued participation of a program. Call 808-948-6499 for more information. • Tobacco Cessation Program Tobacco programs are available through the Well-Being Connection for members who need help to quit tobacco use, including coaching methods through online support, phone consultations, or both. For more information contact Well Being Connection at 1-855-329-5461. Note: Prescribed Over-the-Counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence, see Section 5(f) Prescription drug benefits.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	
Not covered except as offered through HMSA programs: • *Weight reduction programs* • *Tobacco Cessation programs* • *Nutrition Counseling, except as identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations*	*All charges*

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). Note: Organ/tissue transplant services billed by Blue Distinction Centers for Transplants and most Contracted Providers will include both the physician and facility charges.
- For cornea, kidney, and intestinal transplant related services billed by a Plan provider see section 5(a).
- **YOU MUST GET PRIOR APPROVAL FOR SOME SURGICAL PROCEDURES**. Please refer to the information on obtaining a prior approval shown in Section 3 to be sure which services require prior approval and identify which surgeries require prior approval.

Benefit Description	You pay
Surgical procedures	
Surgery includes preoperative and postoperative care. Note: Non-Plan providers may bill separately for preoperative care, the surgical procedure, and postoperative care. In such cases, the total charge is often more than the eligible charge. You are responsible for any amount that exceeds the eligible charge.	
Surgical procedures, such as: • Operative procedures • Treatment of fractures, including casting • Acne treatment destruction of localized lesions by chemotherapy (excluding silver nitrate) • Cryotherapy • Diagnostic injections including catheter injections into joints, muscles, and tendons • Electrosurgery • Correction of amblyopia and strabismus • Diagnostic and Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices. See Section 5(a) *Orthopedic and prosthetic devices* for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns • Newborn circumcision	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• Surgical treatment of morbid obesity (bariatric surgery) is covered with the following criteria: - Patient is morbidly obese, which is defined as at least 100 pounds over or twice the ideal weight according to current underwriting standards OR patient has a body mass index (BMI) greater than 40 OR patient has a BMI between 35 and 40 with a high-risk comorbidity, such as: severe sleep apnea, Pickwickian syndrome, heart problems, or severe diabetes - OR patient has a BMI between 30 and 34.9 with type II diabetes - There is documentation of failure to lose weight - Only those surgical procedures that have proven long term efficacy and safety in peer reviewed scientific literature will be approved - Prior approval is required for this surgery. See Section 3 *You need prior Plan approval for certain services - Other services.*	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot. See Section 5(a) Foot care.*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements. See Section 5(a) *Orthopedic and prosthetic devices* Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
• Gender reassignment surgery - Prior approval is required for this surgery. See Section 3 *You need prior Plan approval for certain services - Other services.* - For benefits for covered services related to the surgery, see Section 5(a) for Professional services of physicians, Section 5(b) for anesthesia benefits, Section 5(c) for hospital benefits, and Section 5(f) for prescription drug benefits.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Reversal of gender reassignment surgery*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental surgeries generally done by dentists and not physicians* • *Services, drugs or supplies for nondental treatment of temporomandibular joint (TMJ) syndrome*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior approval procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with liver	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior approval procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Blood or marrow stem cell transplants. The plan extends coverage for the diagnosis as indicated below. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells can grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Adrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior approval procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocol. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic Inflammatory Demyelination Polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin's lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
Organ donor services: Note: • We cover related medical and hospital expenses of the donor when we cover the recipient. • We cover donor screening for up to three potential donors and the actual donor for allogeneic bone marrow/stem cell transplants. • 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 Please refer to the prior approval information shown in Section 3.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Transplant evaluation (office consultation) Note: For those procedures such as laboratory and diagnostic tests, and psychological evaluations used in evaluating a potential transplant candidate, see Section 5(a) *Lab, X-ray and other diagnostic tests and* Section 5(e) *Mental health and substance misuse disorder benefits*.	Plan Provider $15 per visit Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • Donor screening tests and donor search expenses, except those performed for the actual donor and for allogeneic bone marrow/stem cell transplant donors as shown above • Implants of artificial organs, except for total artificial hearts when used as a bridge to a permanent heart transplant • Transplants not listed as covered • Mechanical or non-human organs • Your transportation for organ or tissue transplant services • Transportation of organs or tissues • Organ Donor Services when you are donating an organ to someone else	All charges
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note: Professional services include general anesthesia; regional anesthesia; and monitored anesthesia when you meet the Plan's high risk criteria.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • Semiprivate accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Note: Hospital transfers – If you are transferred directly from one hospital to another, a separate per-admission copayment will not be charged for the admission to the second hospital. Hospital Discharge and Readmission – If you are discharged and then readmitted to a hospital (not transferred) whether or not on the same day, a separate per-admission copayment will be charged for your readmission.	Plan Provider $200 per admission (based on semiprivate room rate) Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge (based on semiprivate room rate)
Special care units, such as: • Intensive care • Cardiac care units	Plan Provider $200 per admission Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma cost, blood processing, blood bank services • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as adult day care, intermediate care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Additional charges for autologous blood*	*All charges*
Outpatient hospital or ambulatory surgical center	
Outpatient medical services provided by a hospital or ambulatory surgical center, not related to an outpatient surgery: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • X-rays • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma cost, blood processing, blood bank services • Pre-surgical testing (non-laboratory) is covered but only when you meet our criteria • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics • Anesthesia service (See Section 5(b) *Anesthesia*) Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures except those services that are described in the Dental Benefits section.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Outpatient medical services provided by a hospital limited to: • Diagnostic laboratory tests and pathology services • Pre-surgical laboratory tests are covered but only when you meet our criteria • Immunizations	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Services associated with an outpatient surgery provided by an ambulatory surgical center (ASC) only, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center (cont.)	
• Blood and blood plasma cost, blood processing, blood bank services • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics • Anesthesia service (See Section 5(b) *Anesthesia*) • Orthopedic and prosthetic devices (See Section 5(a) *Orthopedic and prosthetic devices*) Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures except those services that are described in the Dental Benefits section.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Extended care benefits/Skilled nursing care facility benefits	
Skilled Nursing Facility (SNF): A facility that provides continuous skilled nursing services as ordered and certified by your physician. Room and Board is covered, but only for semiprivate rooms when: • You are admitted by your physician • Care is ordered and certified by your physician • We approve the confinement • You accept the first available Skilled Nursing Facility bed • Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care • If days exceed 30, the attending physician must submit a report showing the need for additional days at the end of each 30-day period • The confinement is not longer than 100 days in any one calendar year Services and supplies are covered, including routine surgical supplies, drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy benefits.	Plan Provider Nothing (based on semiprivate room) Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge (based on semiprivate room)
Not covered: Custodial care, rest cures, domiciliary or convalescent care	*All charges*

Benefit Description	You pay
Hospice care	
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. • Inpatient residential room and board • Referral visits	Plan Provider Nothing Non-Plan Provider Not a benefit
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*
Ambulance	
Ground professional ambulance service is covered when: • Medically appropriate • Services to treat your illness or injury are not available in the hospital or nursing facility where you are an inpatient	Plan Provider Nothing Non-Plan Provider Any difference between our eligible charge and the actual charge

Section 5(d). Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

If you are in an emergency situation, please call your primary care doctor. Your primary care doctor will provide the necessary care, refer you to other Plan providers, or make arrangements with other providers. If you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Emergencies within and outside our service area:

Emergency care is covered within or outside our Service Area. Please refer to the "You Pay" column below for the applicable emergency care copayment and coinsurance for Plan and non-Plan providers.

Benefit Description	You pay
Emergency within our service area	
Professional emergency services of physicians • In an emergency room	Plan Provider 20% of eligible charges Non-Plan Provider 20% of eligible charges and any difference between our eligible charge and the actual charge
• Emergency diagnostic tests • Emergency x-rays	Plan Provider 20% of eligible charges Non-Plan Provider 20% of eligible charges and any difference between our eligible charge and the actual charge

Emergency within our service area - continued on next page

Benefit Description	You pay
Emergency within our service area (cont.)	
• Emergency laboratory tests • Emergency surgery	Plan Provider Nothing Non-Plan Provider Any difference between our eligible charge and the actual charge
• Emergency room facility Note: Other plan benefits may also apply in addition to the emergency room benefit. However, if you are admitted as an inpatient following a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits.	Plan Provider 20% of eligible charges Non-Plan Provider 20% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
Professional emergency services of physicians • In an emergency room	Plan Provider 20% of eligible charges Non-Plan Provider 20% of eligible charges and any difference between our eligible charge and the actual charge
• Emergency diagnostic tests • Emergency x-rays	Plan Provider 20% of eligible charges Non-Plan Provider 20% of eligible charges and any difference between our eligible charge and the actual charge
• Emergency laboratory tests • Emergency surgery	Plan Provider Nothing Non-Plan Provider Any difference between our eligible charge and the actual charge
• Emergency room facility Note: Other plan benefits may also apply in addition to the emergency room benefit. However, if you are admitted as an inpatient following a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits.	Plan Provider 20% of eligible charges Non-Plan Provider 20% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: Elective care or non-emergency care	*All charges*

Benefit Description	You pay
Ambulance	
Ground professional ambulance service when the following apply: • Transportation begins at the place where an injury or illness occurred or first required emergency care • Transportation ends at the nearest facility equipped to furnish emergency treatment • Transportation is for the purpose of emergency treatment See Section 5(c) for non-emergency service.	Plan Provider Nothing Non-Plan Provider Any difference between our eligible charge and the actual charge
Air ambulance is limited to intra-island or inter-island transportation within the state of Hawaii. • Transportation begins at the place where an injury or illness occurred or first required emergency care. • Transportation ends at the nearest facility equipped to furnish emergency treatment • Transportation is for the purpose of emergency treatment Note: Non-Plan provider air ambulance services will be covered the same as Plan provider air ambulance services when our Plan provider is not available to respond to the emergency. To get this benefit, you must first contact the Plan provider. Once we are able to secure the confirmation in writing that they were unable to provide services, you will only be responsible for the copayment amount you would have paid had you received the service from a Plan provider.	Plan Provider 20% of eligible charges Non-Plan Provider 20% of eligible charges and any difference between our eligible charge and the actual charge

Section 5(e). Mental health and substance misuse disorder benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Please refer to the prior approval information shown in Section 3 for services requiring prior approval.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Mental health and substance misuse disorder benefits	
All diagnostic and treatment services recommended by a provider and contained in a treatment plan. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as licensed physicians, psychiatrists, psychologists, or clinical social workers, marriage and family therapists, advanced practice registered nurses (APRN), dietitians, or mental health counselors • Medication management	Plan Provider $15 copayment per visit Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
• Diagnostic tests • Psychological Testing • Laboratory tests	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
• Inpatient services provided by a hospital or other facility • Inpatient services in approved alternative care settings such as residential treatment, full-day hospitalization	Plan Provider $200 per admission Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge

Mental health and substance misuse disorder benefits - continued on next page

Benefit Description	You pay
Mental health and substance misuse disorder benefits (cont.)	
• Partial hospitalization • Outpatient Facility	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Not covered: • *Marriage and Family Counseling or other training services* • *Services we have not approved* • *Hypnotherapy* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs that are FDA approved, as described in the chart beginning on page 62.
- Members must make sure their provider obtains prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications/drugs.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription?** A recognized provider practicing within the scope of his or her license.
- **Where you can obtain them?** You may fill the prescription at a Plan or non-Plan pharmacy, by mail, or by a Plan or non-Plan provider. We pay a higher level of benefits when you use a Plan provider than if you use a non-Plan provider.
- **We use a Formulary.** We have a managed formulary, called the HMSA Essential Prescription Formulary which is a list of drugs by therapeutic category, and is meant to assist physicians in their selection of drugs for your treatment. Our formulary consists of:
  - **Tier 1** Preferred Generic Drugs. A drug, which is prescribed or dispensed under its commonly used generic name, no longer protected by patent laws, and is identified by us as "Preferred Generic".
  - **Tier 2**
    - Non-Preferred Generic Drugs**.** A drug, which is prescribed or dispensed under its commonly used generic name, no longer protected by patent laws, and is identified by us as "Non-Preferred Generic".
    - Preferred Drugs**.** A Brand Name Drug, contraceptive, supply, or insulin that is identified as preferred or is listed in Tier 2 on the HMSA Essential Prescription Formulary.
  - **Tier 3** Other Brand Drugs. A Brand Name Drug, contraceptive, supply, or insulin that is not identified as Preferred or is listed in Tier 3 on the HMSA Essential Prescription Formulary.
  - **Tier 4** Preferred Specialty Drugs. A specialty drug or supply that is identified as a preferred Specialty or is listed in Tier 4 on the HMSA Essential Prescription Formulary.
  - **Tier 5** Non-Preferred Specialty Drugs. A specialty drug or supply that is identified as a non-preferred specialty or is listed in Tier 5 on the HMSA Essential Prescription Formulary.

If your provider believes a name brand product is necessary or there is no generic available, your provider may prescribe a name brand drug from the formulary list. The list of name brand drugs includes a preferred list of drugs that have been selected to meet patients' clinical and financial needs. Discuss your options with your provider when you need a new prescription.

- **Why use generic drugs?** Generic drugs on the formulary are therapeutically equivalent to the brand name drugs and are less expensive. You may reduce your out-of-pocket costs by choosing to use a generic drug
- **What is a specialty drug?** Specialty drugs may be considered a brand or generic product, and are typically high in cost (more than $600 per month), and have one or more of the following characteristics:
  - Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required
  - Coordination of care is required prior to drug therapy initiation and/or during therapy
  - Unique patient compliance and safety monitoring requirements

- Unique requirements for handling, shipping and storage
- Restricted access or limited distribution.

- **Drugs Benefit Management Program.** We have arranged with Plan Pharmacies to assist in managing the usage of certain types of drugs, including drugs listed in the HMSA Essential Prescription Formulary
- ***Prior Plan Approval.*** We have identified certain kinds of drugs listed in the HMSA Essential Prescription Formulary that require prior approval. See Section 3 - You need prior Plan approval for certain services. The criteria for prior approval are that:
  - The drug is being used as part of a treatment plan
  - There are no equally effective drug substitutes; an
  - The drug meets the "medical necessity" criteria and other criteria as established by HMSA.
- ***Step Therapy.*** Another type of prior approval. Before we cover selected drugs, you may be required to try one or more specific drugs to treat a particular condition.
- ***Quantity Limitation.*** Certain drugs may be covered up to a certain quantity. This quantity is not to exceed the FDA maximum recommended dose. Doses that exceed the quantity limits are subject to prior approval.

  A list of these drugs in the HMSA Essential Prescription Formulary has been distributed to all Plan Pharmacies.
  - Plan Pharmacies will dispense a maximum of a 30-day supply or fraction thereof for first time prescriptions of maintenance drugs. For subsequent refills, the Plan pharmacist may dispense a maximum 90-day supply or fraction thereof after confirming that:
    - You have tolerated the drug without adverse side effects that may cause you to discontinue using the drug, an
    - Your doctor has determined that the drug is effective
- **These are the dispensing limitations.**
  - Prescription drugs prescribed by a doctor and obtained at a pharmacy will be dispensed with a maximum limit of a 30-day supply or fraction thereof. For example, if your physician prescribes a 30-day supply of a drug that is packaged in less than a 30-day quantity, such as a 28-day quantity, the pharmacy will fill the prescription by dispensing one package of the drug. You will owe one copayment for a 30-day supply dispensed.
  - Drugs Dispensed in Manufacturer's Original Unbreakable package: Copayments for prescription drugs that are dispensed in a manufacturer's original package are determined by the number of calendar days that are covered by the prescription. You will owe one copayment for each prescription for up to 59 days, two copayments for 60-89 days, and three copayments for 90-119 days. Examples of drugs that come in unbreakable packages are insulin, eye drops and inhalers.
  - Refills are available if indicated on the original prescription (maximum allowable by law), provided that the refill prescription is purchased only after two-thirds of the original prescription has already been used.
  - A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug that is on the HMSA Essential Prescription Formulary when a federally-approved generic drug is available, and your provider has not specified "Dispense as Written" for the name brand drug, you have to pay the generic copayment plus the difference in cost between the name brand drug and the generic.
- **Mail Order and Maintenance Choice®** Prescription Drug Program
  - You may pick up a 3-month supply of prescribed maintenance medications/drugs at:
    - Long's/CVS Pharmacies or;
    - Through our mail order pharmacy
  - Mail order and Maintenance Choice® prescriptions are limited to prescribed maintenance medications.
  - Mail order prescription drugs are available only from contracted providers. For a list of contracted providers call us at 808-948-6499.
  - Prescription drugs will be dispensed with a maximum limit of a 90-day supply or fraction thereof. For example, if your provider prescribes a 90-day supply of a drug that is packaged in less than a 30-day quantity, such as a 28-day quantity, the Plan pharmacy will fill the prescription by dispensing three packages of the drug. This amounts to an 84-day quantity since each package contains a 28-day quantity. You will owe the mail order copayment for a 90-day supply.

- **Tier 3 Copayment Exceptions**

You may qualify to purchase Tier 3 drugs at the lower Tier 2 copayment if you have a chronic condition that lasts at least three months, have tried and failed treatment with at least two comparable Tier 1 or Tier 2 drugs (or one comparable drug if only one alternative is available), or all other comparable lower tier drugs are contraindicated based on your diagnosis, other medical conditions or other drug therapy. When prescription drugs become available as therapeutically equivalent over-the-counter drugs, they must have also been tried and failed before a Tier 3 Drug Copayment Exception is approved.

You have failed treatment if you meet 1, 2, or 3 below:

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

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

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

This benefit requires prior approval. You or your physician must provide legible medical records which substantiate the requirements of this section in accord with the Plan's polices and to the Plan's satisfaction.

When prescription drugs become available as therapeutically equivalent over-the-counter drugs, they are considered as comparable therapy for tier lowering.

This exception is not applicable to Tier 4 drugs, Tier 5 drugs, controlled substances, off label uses, Tier 3 drugs if there is an FDA approved A rated generic equivalent, compound drugs, or if we have a drug specific policy which has criteria different from the criteria in this section. You can call us to find out if HMSA has a drug policy specific to the drug prescribed for you.

- **Non-Formulary Exceptions**

If your drug is not listed in one of the five tiers and is not excluded, you may qualify for a non-formulary exception if you have a condition in which treatment with all or three, whichever is less, formulary alternatives within the same or similar category or class of drug have been tried and failed or formulary alternatives are contraindicated based on your diagnosis, other medical conditions, or other drug therapy. When prescription drugs become available as therapeutically equivalent over-the-counter drugs, they must have also been tried and failed before a non-formulary exception is approved. You have failed treatment if you meet 1, 2, or 3 of the Tier 3 Copayment Exception criteria, see *Tier 3 Copayment Exceptions* section above. If you qualify for a non-formulary exception you owe the Tier 3 Copayment or Tier 5 copayment for Specialty drugs.

Specialty drugs and oral chemotherapy drugs will be limited to a maximum 30-day supply or fraction thereof. Copayments may be pro-rated when a reduced day supply is dispensed for first time prescriptions. Specialty drugs and oral chemotherapy drugs will not be available through mail order.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following drugs and supplies prescribed by a recognized provider practicing within the scope of his or her license and obtained from a Plan or non-Plan Pharmacy, or through our mail order program: • Drugs that, by Federal law of the United States, require a physician's prescription for their purchase, except those listed as *Not covered*. • Injectable drugs limited to those designated as covered in the HMSA formulary on our website at www.hmsa.com or call us at 808-948-6499 for the most current list of covered injectable drugs. Note: Specialty injectable drugs and intravenous fluids and drugs for home use may be covered under your medical coverage. See Section 5(a) *Treatment therapies*. • Drugs for sexual dysfunction Benefits are limited to the following: - Quantity limits may apply - Up to four doses every 30 days for erectile dysfunction drugs - Up to three months dispensed at a time (Multiple copayments will apply) - Covered for gender approved by FDA - Physician must certify in advance that the patient has impotence due to organic causes from vascular or neurological disease • Oral fertility drugs • Vitamins and minerals limited to: - The treatment of an illness that in the absence of such vitamins and minerals could result in a serious threat to the member's life - Sodium fluoride if dispensed as a single drug to treat tooth decay • Compound Drugs made with non-specialty, non-bulk chemicals are subject to a Tier 3 copayment. Compound Drugs made with specialty, non-bulk chemicals are subject to a Tier 5 copayment. Tier exceptions are not applicable for compound drugs. • Specialty Drugs - Benefits are not available through HMSA's Prescription Drug Mail Order Program - You must purchase these drugs from a Plan Specialty Pharmacy - Limited to up to a 30-day supply dispensed at a time - Copayments may be prorated when a reduced supply of specialty medications is dispensed for the first time. - Includes specialty inhaled drugs and specialty oral drugs Please refer to the prior approval information shown in Section 3.	**Tier 1 (Preferred Generic):** Plan Pharmacy $7 copayment Non-Plan Pharmacy $7 copayment plus 20% of remaining eligible charges and any difference between our eligible charge and the actual charge **Tier 2 (Non-Preferred Generic and Preferred Brand):** Plan Pharmacy $35 copayment Non-Plan Pharmacy $35 copayment plus 20% of remaining eligible charges and any difference between our eligible charge and the actual charge **Tier 3 (Other Brand):** Plan Pharmacy $70 copayment Non-Plan Pharmacy $70 copayment plus 20% of remaining eligible charges and any difference between our eligible charge and the actual charge **Tier 4 (Preferred Specialty):** Plan Specialty Pharmacy $80 copayment Non-Plan Pharmacy Not a benefit **Tier 5 (Non-Preferred Specialty):** Plan Specialty Pharmacy $200 copayment Non-Plan Pharmacy Not a benefit

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• Tobacco Cessation Drugs - Includes prescribed over-the-counter Tobacco Cessation Drugs - You must receive a written prescription from a recognized provider practicing within the scope of his or her license for Tobacco Cessation Drugs	Plan Pharmacy Nothing Non-Plan Pharmacy Any difference between our eligible charge and the actual charge
• Spacers for inhaled drugs and peak flow meters are limited to those designated as covered in the HMSA formulary on our website at www.hmsa.com or call us at 808-948-6499 for the most current list of covered spacers for inhaled drugs and peak flow meters.	Plan Pharmacy Nothing Non-Plan Pharmacy Any difference between our eligible charge and the actual charge
• Insulin Note: When obtained by prescription.	**Preferred Brand Insulin:** Plan Pharmacy $7 copayment Non-Plan Pharmacy $7 copayment plus 20% of eligible charges and any difference between our eligible charge and the actual charge **Other Brand Insulin:** Plan Pharmacy $35 copayment Non-Plan Pharmacy $35 copayment plus 20% of eligible charges and any difference between our eligible charge and the actual charge
Diabetic supplies include: • Insulin syringes • Needles • Lancets • Lancet devices • Glucose test tablets and test tapes • Acetone test tablets	**Preferred Brand Diabetic Supplies:** Plan Pharmacy Nothing Non-Plan Pharmacy Any difference between our eligible charge and the actual charge **Other Brand Diabetic Supplies:** Plan Pharmacy $35 copayment Non-Plan Pharmacy $35 copayment and any difference between our eligible charge and the actual charge

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• Women's contraceptive drugs and devices - Oral Contraceptives - Contraceptive Rings and Patches • Over-the-counter contraceptive drugs and devices Note: Over-the-counter contraceptive drugs and devices for men and women approved by the FDA require a written prescription by a recognized provider practicing within the scope of his or her license.	**Tier 1 (Preferred Generic):** Plan Pharmacy Nothing Non-Plan Pharmacy $7 copayment plus 20% of remaining eligible charges and any difference between our eligible charge and the actual charge **Tier 2 (Non-Preferred Generic and Preferred Brand):** Plan Pharmacy Nothing Non-Plan Pharmacy $35 copayment plus 20% of remaining eligible charges and any difference between our eligible charge and the actual charge **Tier 3 (Other Brand):** Plan Pharmacy Nothing Non-Plan Pharmacy $70 copayment plus 20% of remaining eligible charges and any difference between our eligible charge and the actual charge
• Internally implanted time-release contraceptive drugs • Contraceptive drugs injected periodically and intrauterine devices	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
• Diaphragms and Cervical Caps	Plan Pharmacy Nothing Non-Plan Pharmacy $10 copayment and any difference between our eligible charge and the actual charge

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
Mail Order Drug Program:	
Preferred Generic Drugs	Nothing
Non-Preferred Generic Drugs	Nothing
Preferred Brand Name Drugs	$75 Copayment
Other Brand Name Drugs	$185 Copayment
Preferred Brand Name Insulin	$11 Copayment
Other Brand Insulin	$75 Copayment
Preferred Brand Name Diabetic Supplies	Nothing
Other Brand Name Diabetic Supplies	$75 Copayment
Tobacco Cessation Drugs	Nothing
Spacers for inhaled drugs and peak flow meters	Nothing
Preventive Care Medications	Nothing
Oral Contraceptives	Nothing
Contraceptive Rings and Patches	Nothing
Diaphragms and Cervical Caps	Nothing
Over-the-counter contraceptive drugs and devices	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Vitamins, nutrients, and food supplements not listed as a covered benefit, even if a physician prescribes or administers them* • *Over-the-Counter drugs are limited to those designated as covered in the HMSA Essential Prescription Formulary on our website at www.hmsa.com or call us at 808-948-6499 for the most current list of covered nonprescription medicines.* • *Medical supplies such as dressings and antiseptics* • *Compound drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration* • *Compound drugs that are available as a similar commercially available prescription drug product* • *Bulk chemicals* • *Compounds made with bulk chemicals* • *Replacement for lost, stolen or destroyed prescriptions* • *Non-FDA approved drugs* *Note: Prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit. (See page 63)*	*All charges*

Benefit Description	You pay
Preventive care medications	
Medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a Pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-1year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 Note: • These drugs are limited to those listed as covered in the HMSA formulary on our website at www.hmsa.com or call us at 808-948-6499 for the most current list. • You must receive a written prescription from a recognized provider practicing within the scope of his or her license.	Plan Pharmacy Nothing Non-Plan Pharmacy Any difference between our eligible charge and the actual charge

Section 5(g). Dental benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with Medicare and other coverage*.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works and for information on your out-of-pocket maximum. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Accidental injury is defined as bodily injury sustained solely through violent, external and accidental means.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
Dental benefits	**High Option**
Preventive dental care • Annual exam/visit • Annual cleaning (prophylaxis)	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our eligible charge and the actual charge
• X-rays [One set of bitewings (1-4 films) per calendar year and one full mouth series every 5 years] • Periapical X-rays	Plan Provider 30% of eligible charges Non-Plan Provider 50% of eligible charges and any difference between our eligible charge and the actual charge
Standard dental service for permanent teeth only • Fillings (composite resin for anterior teeth and single, stand-alone facial surfaces of bicuspids only; amalgam; and silicate) • Extractions • Root canal treatment • Treatment for diseases of the gum • Space maintainers • Anesthesia	Plan Provider 30% of eligible charges Non-Plan Provider 50% of eligible charges and any difference between our eligible charge and the actual charge

Dental benefits - continued on next page

Benefit Description	You Pay
Dental benefits (cont.)	**High Option**
Dental Surgery • Incision and drainage of abscess • Alveolectomy • Excision of cysts	Plan Provider 30% of eligible charges Non-Plan Provider 50% of eligible charges and any difference between our eligible charge and the actual charge
Occlusal Splint When precertified and determined by the Plan, occlusal splint therapy is covered for the treatment of temporomandibular disorder involving the muscles of mastication (chewing). Coverage of occlusal splint therapy is subject to the following limitations. • A removable acrylic appliance is used in conjunction with the therapy • The disorder is present at least one month prior to the start of the therapy and the therapy does not exceed ten weeks • The therapy does not result in any irreversible alteration in the occlusion • It is not intended to be for the treatment of bruxism • It is not for the prevention of injuries of the teeth or occlusion • The benefit is limited to one treatment episode per lifetime	Plan Provider or Non-Plan Provider 50% of eligible charges and any difference between our eligible charge and the actual charge Note: Maximum Plan payment not to exceed $125
Not covered: • *All other dental services, including topical application of fluoride* • *Dental appliances, such as false teeth, crowns, bridges, and repair of dental appliances* • *Dental prostheses, dental splints (except as covered under occlusal splint therapy), dental sealants, orthodontia, or other dental appliances regardless of the symptoms or illness being treated* • *Osseointegration (dental implants) and all related services*	*All charges*

Section 5(h). Wellness and Other Special features

Feature	Description
Feature	**High Option**
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Drug Benefits Management Program	We have arranged with Plan Pharmacies to assist in managing the usage of certain kinds of drugs, including drugs listed in the HMSA Essential Prescription Formulary. We have identified certain kinds of drugs listed in the HMSA Essential Prescription Formulary that require prior approval. The criteria for prior approval are that: • The drug is being used as part of a treatment plan; • There are no equally effective drug substitutes; and • The drug meets the "medical necessity" criteria and other criteria as established by us. Step Therapy is another type of prior approval. Before we cover selected medications, you may be required to try one or more specific drugs to treat a particular condition. Quantity Limitation. Certain medications may be covered up to a certain quantity. This quantity is not to exceed the FDA maximum recommended dose. Doses that exceed the quantity limits are subject to prior approval. A list of these drugs in the HMSA Essential Prescription Formulary has been distributed to all participating providers.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
	Plan Pharmacists will dispense a maximum of a 30-day supply or fraction thereof for first time prescriptions of maintenance drugs. For subsequent refills, the Plan pharmacist may dispense a maximum 90-day supply or fraction thereof after confirming that: • You have tolerated the drug without adverse side effects that may cause you to discontinue using the drug, and • Your doctor has determined that the drug is effective.
Routine Care Associated With Clinical Trials	Routine care associated with clinical trials is covered in accord with criteria established by us. These services require prior approval. Please refer to the prior approval information shown in Section 3.
Supportive Care Program	The program will offer members with advanced life limiting diseases, who have not elected hospice, access to comprehensive symptom management and care coordination services in addition to life prolonging therapies for a 90-day period. These services are aimed at providing relief of symptoms, spiritual, social and psychological support and access to interdisciplinary care to support the life prolonging therapy. • Participants must meet supportive care eligibility criteria and guidelines. • Participants must be referred by their physician or specialist. • Participants must obtain necessary specialty referrals if needed for symptom management. • Services will be limited to a 90-day period per 12 months.
Dr. Ornish's Program for Reversing Heart Disease™	• Participants must meet HMSA's eligibility criteria and guidelines. You are eligible for this program if you meet one or more of the criteria below: - 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. • 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

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
	- Support group - Experiential education session with group meal 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.

Section 5(i). Point of Service benefits

Point of Service (POS) Benefits

Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care. When you obtain covered non-emergency medical treatment from a non-Plan doctor, you are subject to a higher copayment/coinsurance.

Non-Plan providers are physicians and other health care professionals who are not under contract with this Plan.

For out-of-state services under this Plan, non-Plan provider benefits are applied for covered services rendered by non-Blue Cross and/or Blue Shield providers.

What is covered and not covered

- Medical services and supplies provided by physicians and other health care professionals (Section 5(a))
- Surgical and anesthesia services provided by physicians and other health care professionals (Section 5(b))
- Services provided by a hospital or other facility, and ambulance service (Section 5(c))
- Emergency services/accidents (Section 5(d))
- Mental health and substance misuse disorder benefits (Section 5(e))
- Prescription drug benefits (Section 5(f))
- Dental benefits (Section 5(g))

Please refer to the general exclusions listed in Section 6 for additional information.

You need prior Plan approval for certain services

You or your physician must obtain prior approval for the services listed in Section 3. A non-Plan provider may not necessarily obtain a prior approval on your behalf. You are responsible for ensuring that the services are prior approved. Services may not be covered if you do not obtain prior approval. If you need more information, call us at 808-948-6499.

You may receive services from a non-Plan provider. Non-Plan provider services have higher out-of-pocket costs. Please refer to the non-Plan provider benefits in Section 5.

Your cost for covered services from non-Plan providers

There is no calendar year deductible for non-Plan provider services.

We calculate our payment and your copayment/coinsurance based on eligible charges. The eligible charge is the lower of either the provider's actual charge or the amount we established as the maximum allowable fee.

Non-Plan providers are not under contract to limit their charges to our eligible charges. You are responsible for any charges in excess of eligible charges.

Coinsurance is the percentage of our eligible charge that you must pay for your care. After your coinsurance totals $3,000 per person or $9,000 per family of 3 or more enrollment in any calendar year, you are no longer responsible for coinsurance/copayment amounts for covered services. However, coinsurance/copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay coinsurance/copayments for these services even after you have met the out-of-pocket maximum:

- Adult Dental Care (19 years of age and older)
- Adult Vision Care (19 years of age and older)

The following amounts do not count toward meeting your catastrophic protection out-of-pocket maximum and you must continue to be responsible for the amounts below even after you have met the out-of-pocket maximum.

- Payment for services subject to a maximum once you reach the maximum.
- The difference between the actual charge and the eligible charge that you pay when you receive service from a non-Plan provider.
- Payments for non-covered services.
- Any amounts you owe in addition to your coinsurance/copayment for covered services.

Be sure to keep accurate records of your coinsurance/copayment. We will also keep records of your coinsurance/copayment and track your out-of-pocket maximum.

Hospital/extended care

Your coinsurance for services from a non-Plan facility is 30% of the eligible charges (based on semiprivate room rate) and in addition, you are responsible for any difference between our eligible charge and the actual charge. See Section 5(c). The facility's charge does not include any charges for physician's services. Benefits for physician's services will depend on whether the physician is a Plan provider or non-Plan provider and will be paid according to the benefits listed in Section 5 (a). We cannot guarantee that a participating hospital will have participating physicians on staff. Benefits will be paid according to each individual provider and the type of service rendered by the provider.

Emergency benefits

Emergency care is covered within or outside our service area, regardless of whether a Plan provider or non-Plan provider is used. See Section 5(d) for your copayments and coinsurance for services from a non-Plan provider.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 808-948-6499.

Limited Health Benefit Insurance

If you are a Hawaii resident under the age of 65, you can apply for the following insurance coverage for yourself and your eligible family members. Please call us at 808-538-8900 for more information.

- **Accident Elite** Accident Elite provides supplemental coverage for costs associated with accidental injury and death occurring on and off-the-job.
- **CriticalCare Elite** CriticalCare Elite provides supplemental coverage for costs associated with the first positive diagnosis of a covered critical illness.
- **Hospital Confinement Plan** Hospital Confinement Plan provides coverage in the form of a fixed daily benefit during periods of hospitalization.

HMSA Individual Plans

HMSA offers a variety of individual health plans to choose from. If you are losing this Plan's coverage, you may be eligible to apply for HMSA's Individual Plan Coverage as long as you apply within 31 days of losing your coverage. For more information on these health plans, please visit our website at www.hmsa.com or call 808-948-5555 on Oahu or 800-620-4672 on the Neighbor Islands.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services***.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Professional services or supplies when furnished to you by a provider who is within your immediate family (i.e., parent, child, or spouse).
- Services when someone else has the legal obligation to pay for your care, and when, in the absence of this brochure, you would not be charged.
- Services, drugs, or supplies you receive without charge while in active military service.
- Treatments, services or supplies that are prescribed, ordered or recommended primarily for your convenience or the convenience of your provider.
- Extra care costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers, facilities and pharmacies file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form; facilities must file on the UB-04 form; dental services must be on the American Dental Association (ADA) form; and pharmacies must file on the Universal Drug form. For claims questions and assistance, contact us at 808-948-6499.

When you must file a claim – such as for services you receive outside the Plan's service area – submit it on one of the forms indicated above or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

For Physician claims
HMSA-CMS 1500 claims
P.O. Box 44500
Honolulu, Hawaii 96804-4500
808-948-6499

For Facility claims
HMSA-UB04 claims
P.O. Box 32700
Honolulu, Hawaii 96803-2700
808-948-6499

Filing a claim for covered services (cont.)

Prescription drugs	**Submit your claims to:** **For Prescription drug claims** **CVS Health** **P.O. Box 52066** **Phoenix, AZ 85072-2066**
Other supplies or services	**Submit your claims to:** **For Dental claims** **HMSA-Dental claims** **P.O. Box 1187** **Elk Grove Village, IL 60009-1187** **808-948-6440 or toll free at 800-792-4672**
Deadline for filing your claim	All Plan and most non-Plan providers in the State of Hawaii file claims for you. If your non-Plan provider does not file the claim for you, you must submit an itemized bill and receipt for the services you received by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. File a separate claim for each covered family member and each provider. For more information, please call us at 808-948-6499.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.hmsa.com/federalplan/.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs, or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as transplants.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Member Advocacy & Appeals by writing to P.O. Box 1958, Honolulu, HI 96805 or calling 808-948-5090 or 800-462-2085.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Hawai‘i Medical Service Association, Attn: Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958 (for Dental, send your request to HMSA-Dental P.O. Box 69437, Harrisburg PA 17106-9437); and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address, if you would like to receive our decision via email. Please note that by giving us your email address, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

The disputed claims process *(continued)*

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurace, Federal Employee Insurance Operations, Health Insurance (HI) 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call our Medical Management Department at 808-948-6464 on Oahu or 800-344-6122 toll-free from the Neighbor Islands. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance (HI) 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage".

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.hmsa.com/federalplan.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will pay after the primary plan pays. Payment will not exceed the amount this plan would have paid if it had been your only coverage. Additionally, when this plan is secondary, benefits will be paid only for those services or supplies covered under this plan.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When others may be responsible for payment of your medical expenses (due to tort liability, insurance or otherwise), our Third Party Liability and Motor Vehicle Insurance Rules ("Rules") apply, and you should request a copy of these Rules from HMSA, as they provide further details that are incorporated here by this reference.

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

We will provide benefits in connection with the injury or illness in accord with the terms of this brochure only if you cooperate with us by doing the following:

- Give Us Timely Notice. You must give us written timely notice (within 30 days) of each of the following: (1) your knowledge of any potential claim against any third party or other source of recovery in connection with the injury or illness; (2) 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 (3) 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. Such notice must be sent to HMSA, Attn: 8 CA/Third Party Liability, P.O. Box 860, Honolulu, Hawaii 96808-0860
- 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 all information reasonably related to our investigation of our liability for coverage and our recovery rights. This includes Injury/Illness information, 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.

If you do not cooperate with us as required by these Rules, 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 payment of benefits or has prejudiced our rights to recover payments.

If you have complied with these Rules, 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 brochure. 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 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, even if the recovery proceeds obtained (by settlement, judgment, award, insurance proceeds, or other payment): (a) do not specifically include medical expenses; (b) are stated to be for general damages only; (c) are for less than the actual loss or alleged loss suffered by you due to the injury or illness; (d) are obtained on your behalf by any person or entity, including your estate, legal representative, parent, or attorney; or (e) are without any admission of liability, fault, or causation by the third party or payor.

Our lien shall not be reduced by your attorneys fees, costs or other expenses related to the recovery. 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. We shall also have rights of set-off; subrogation (substituting us to your rights of recovery); and other equitable and statutory rights, as further described in the Rules.

Nothing in these Rules shall limit our ability to coordinate benefits as described in this section, nor limit your responsibility for your copayments, deductibles, timeliness in submission of claims, and other obligations under this brochure.

Motor Vehicle Insurance Rules: 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 your HMSA coverage.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.BENEFEDS.com or by phone at 877-888-3337 (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-772-1213, (TTY: 800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 800-772-1213, (TTY: 800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be prior approved as required.

We will not waive any of our copayment/coinsurance for services or supplies that are not covered by Original Medicare (for example, hearing aids). Your regular Plan benefits will be applied to your claim and you are responsible for any applicable copayments or costs.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. We will coordinate benefits under this Plan 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 receive 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). To find out if you need to do something to file your claim, call us at 808-948-6499 or see our website at www.hmsa.com/federalplan.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$0	$0
Out of Pocket Maximum	$3,000 per person/$9,000 family	$3,000 per person/$9,000 family
Primary Care Physician	$15 Copayment	$0
Specialist	$15 Copayment	$0
Inpatient Hospital	$200 Copayment per admission	$200 Copayment per admission
Outpatient Hospital	20% of eligible charges	20% of eligible charges
Rx	Tier 1 (Preferred Generic): $7 Copayment Tier 2 (Non-Preferred Generic and Preferr Brand): $35 Copayment Tier 3 (Other Brand): $70 Copayment Tier 4 (Preferred Specialty (30 day supply)): $80 Copayment Tier 5 (Non-Preferred Specialty): $200 copayment	Tier 1 (Preferred Generic): $7 Copayment Tier 2 (Non-Preferred Generic and Preferred Brand): $35 Copayment Tier 3 (Other Brand): $70 Copayment Tier 4 (Preferred Specialty (30 day supply)): $80 Copayment Tier 5 (Non-Preferred Specialty): $200 copayment
Rx – Mail Order (90 day supply)	Preferred Generic / Non-Preferred Generic: $0 Copayment Preferred Brand: $75 Copayment Other Brand: $185 Copayment	Preferred Generic / Non-Preferred Generic: $0 Copayment Preferred Brand: $75 Copayment Other Brand: $185 Copayment

Facilities or Providers Not Eligible or Entitled to Medicare Payment - When services are rendered at a facility or by a provider that is not eligible or entitled to receive reimbursement from Medicare, and Medicare is allowed by law to be the primary payor, 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 receive such payments, regardless of whether or not Medicare benefits are paid.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage Plan called Akamai Advantage and also remain enrolled in our FEHB Plan. If you have Medicare Parts A and B, you can enroll in our Akamai Advantage Plans. For more information, please call us at 808-948-5555 on Oahu or 800-620-4672 toll-free on the Neighbor Islands. Our telephone representatives are available 8 a.m. to 8 p.m. TTY: users should call 948-6222 on Oahu or 877-298-4672 toll-free on the Neighbor Islands. You may also visit our website at www.hmsa.com/advantage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, and for services paid by a Medicare Advantage plan we will waive, for example, our Plan physician visit and emergency room copayments. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. • Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 22.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 22.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance/copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Helps you meet your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Custodial care lasting 90 days or more is sometimes known as long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. We do not have a deductible.
Experimental or investigational service	Services, supplies, devices, procedures, drugs, or treatment that is not yet accepted as common medical practice.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity also referred to as Payment Determination Criteria	All care you receive 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.

- 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 which are experimental or investigational and which are not known to be effective in improving health outcomes do not meet Payment Determination Criteria.

Definitions of terms and additional information 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, drug, or supply does not in itself mean that the service, drug, or supply is medically necessary, 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 which are excluded from coverage without obtaining a written acknowledgement of financial responsibility from you or your representative.

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

Plan Allowance also referred to as Eligible Charge

The eligible charge for most medical services, is the amount we use to determine our payment and your coinsurance for covered services. We determine our eligible charge as 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, or treatment. We use the following method 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 previous year;
  - the relative difficulty of the services compared to other services;
  - changes in technology; and
  - payment for the service under federal, state, and other private insurance programs.
- For some facility-billed services (not to include practitioner-billed facility services), we use a per case, per treatment, or per day fee (per diem) rather than an itemized amount (fee for service). For Non-Plan 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 participating facilities, we calculate our payment based on the maximum allowable fee. Your coinsurance is based on the lower of the facility's actual charge or the maximum allowable fee. Your coinsurance and our payment will equal the maximum allowable fee.

	Plan providers agree to accept the eligible charge for covered services. Non-Plan providers generally do not. Therefore, if you received services from a non-Plan provider you are responsible for any difference between the actual charge and the eligible charge.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Medical Management Department at 808-948-6464 on Oahu or 800-344-6122 toll-free from the Neighbor Islands. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and We refer to HMSA
You	You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about four Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,600 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).

- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit **www.FSAFEDS.com** or call an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS, 877-372-3337 (TTY, 866-353-8058), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia but it may be limited. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 877-888-3337, (TTY: 877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. Long term care can be received in your home, in a nursing home, in an assisted living facility or in adult day care. You must apply, answer health questions (called underwriting) and be approved for enrollment. Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Your qualified relatives can apply even if you do not. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 800-LTC-FEDS (800-582-3337), (TTY: 800-843-3557), or visit www.ltcfeds.com.

The Federal Employees' Group Life Insurance Program - *FEGLI*

Peace of Mind for You and Your Family

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the HMSA Plan - 2018

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page, we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- When you receive services from a non-Plan provider, you have higher out-of-pocket costs. You generally must pay any difference between our eligible charge and the billed amount.

Benefits	You pay	Page
Medical services provided by physicians:		
• Physician visits	$15 copayment	26
• Other diagnostic and treatment services provided in the office	Nothing for laboratory and pathology services; 20% of eligible charges for X-rays	27
Services provided by a hospital:		
• Inpatient	$200 copayment per admission	50
• Outpatient	20% of eligible charges	51
Emergency benefits:		
• In-area	20% of eligible charges for physician visit; 20% of eligible charges for emergency room facility copay; Nothing for laboratory tests; and 20% of eligible charges for other emergency services	54
• Out-of-area	20% of eligible charges for physician visit; 20% of eligible charges for emergency room facility copay; Nothing for laboratory tests; and 20% of eligible charges for other emergency services	55
Mental health and substance misuse disorder treatment:	$15 copayment for professional services and medication management; Nothing for diagnostic tests, psychological testing, and laboratory tests; $200 per inpatient admission; and Nothing for partial hospitalization and outpatient facility	57
Prescription drugs:	$7 copayment for Tier 1 (preferred generic drugs); $35 copayment for Tier 2 (non-preferred generic and preferred brand drugs); $70 copayment for Tier 3 (other brand drugs); $80 copayment for Tier 4 (specialty drugs); $200 copayment for Tier 5 (non-preferred specialty drugs)	62
Dental care:	Nothing for preventive dental care	67
Vision care:	20% of eligible charges for an annual vision exam	36
Point of Service benefits - Yes		72
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $3,000 per person or $9,000 per Family enrollment per year Some costs do not count toward this protection	22

2018 Rate Information

For 2018 FEHB plan premium information, please see:

https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribal employer's Human Resources department.