

# **EUTF PPO (HMA)**

**For Active EUTF State, City and County Employees**

## **Summary of Benefits**

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## Section 1: Important Information

### WHAT YOU SHOULD KNOW ABOUT THIS SUMMARY OF BENEFITS

#### About Your PPO Program

The Trust Fund has contracted with HMA to administer a health benefits plan (the Plan) as described in this Summary of Benefits. The type of health care coverage provided by the Plan is a ***Preferred Provider Organization***. If you enroll in our Preferred Provider Organization plan, this means you have medical benefits for your health care needs including office visits, inpatient facility services, outpatient facility services, and other provider services. This coverage offers you flexibility in the way you obtain medical benefits. Your opportunity to take an active role in your health care decisions makes this coverage special. In general, to get the best benefits possible, you should seek services from ***HMA Participating Providers***. For more information on coverage under this plan, see *Section 4: Description of Benefits*.

#### Terminology

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

The term **Provider** means an approved physician or other practitioner who provides you with health care services. Your provider may also be the place where you receive services, such as a hospital or skilled nursing facility. Additionally, your provider may be a supplier of health care products, such as a home or durable medical equipment supplier.

#### Definitions

Throughout this Summary, terms appear in Bold Italics the first time they are defined. Terms are also defined in the Glossary.

#### Questions

If you have any questions, please call us. Additional information about plan benefits will be provided free of charge. For your convenience, we list our telephone numbers on page 1 of this Summary.

## SUMMARY OF PROVIDER CATEGORIES

This chart shows how the provider categories impact your benefits.

	HMA Participating Provider	Nonparticipating Provider (in or out of state)
Does your provider contract with HMA?	Yes	No, does not contract with HMA.
Does your provider always file claims for you?	Yes	No, you may have to file your own claims.
Does your provider accept eligible charge as payment in full? If so, you are not responsible for any difference between actual charge and eligible charge.	Yes	No, you are responsible for any difference between the actual charge and the eligible charge. See <i>From What Provider Category Did You Receive Care?</i> in the section labeled <i>Questions We Ask When You Receive Care</i> later in this Section.
Do you pay the provider applicable deductibles and copayments? If so, we send benefit payment directly to the provider.	Yes	No, you pay provider in full. We send benefit payments to you.
Is your copayment percentage lower?	Yes	No, your copayment percentage is higher.
Does your provider obtain prior authorization approvals for you?	Yes	No, you are responsible for obtaining approval.

## QUESTIONS WE ASK WHEN YOU RECEIVE CARE

### Is the Care Covered?

To receive benefits, the care you receive must be a covered treatment, service, or supply. See *Section 4: Description of Benefits* for a listing of covered treatment, services and supplies.

### Does the Care Meet Payment Determination Criteria?

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

- Appropriate and necessary for the symptoms, diagnosis, and direct care or treatment of your illness or injury.
- Consistent with professionally recognized standards of health care in the United States, and given at the right time and in the right setting.
- Not primarily for your convenience or the convenience of your provider.

- The most appropriate supply or level of service that can safely be provided.

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

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

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

### **Is the Care Consistent with HMA's Medical Policies?**

To be covered, the care you receive must be consistent with HMA's medical policies. These are policies drafted by HMA Medical Directors, many of whom are practicing physicians, in conjunction with community physicians and nationally recognized authorities. Each policy provides detailed coverage criteria for a specific service, drug, or supply. If you have questions about the policies or would like to obtain a copy of a policy related to your care, please call us at one of the telephone numbers on the page 1 of this Summary.

### **From What Provider Category Did You Receive Care?**

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

When you see a nonparticipating provider you will owe any copayment applicable to the service plus the difference between HMA's eligible charge and the provider's actual charge. In addition, nonparticipating providers have not agreed to comply with HMA's payment policies and can bill you for services or additional charges which HMA does not cover. These amounts will be included in the nonparticipating provider's actual charge. Participating providers have agreed to comply with HMA's payment policies.

For more information on provider categories see the *Summary of Provider Categories* earlier in this Section.

***Please note:*** Your participating provider may refer services to a nonparticipating provider and you may incur a greater out-of-pocket expense. For example, your participating provider may send a blood sample to a nonparticipating laboratory for analysis. Or, your participating provider may send you to a nonparticipating specialist for additional care.

### **Is the Service or Supply Subject to a Benefit Maximum?**

***Benefit Maximum*** means the maximum benefit amount allowed for a covered service or supply. A coverage maximum may limit the dollar amount, the duration, or the number of visits. For information about benefit maximums, read *Section 2: Payment Information* and *Section 4: Description of Benefits*.

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

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

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

### **Is the Service or Supply Subject to Prior Authorization?**

Certain services require our prior approval. HMA participating providers obtain approval for you, other providers may not. If you receive services from a nonparticipating provider and approval for designated services is not obtained, benefits may be denied. In some cases, benefits are denied entirely. For services subject to approval, read *Section 5: Prior Authorization*.

### **Did You Receive Care from a Provider Recognized and Approved by Us?**

To determine if a provider is recognized and approved, we look at many factors including licensure, professional history, and type of practice. All participating providers and some nonparticipating providers are recognized and approved. To find out if your physician is a participating provider, refer to your *HMN Provider Directory by Island*. If you need a copy, call us at the telephone number shown on page 1 of this Summary and we will send one to you or visit [www.moabettah.com](http://www.moabettah.com).

### **Did a Provider Order the Care?**

All covered treatment, services, and supplies must be ordered by a recognized and approved provider.

### **Our Rights to Interpret this Document**

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

- to determine whether you meet the Trust Fund's written eligibility requirements;
- to determine the amount and type of benefits payable to you or your dependents in accord with the terms of this Summary of Benefits; and
- to interpret the provisions of this Summary of Benefits as is necessary to determine benefits, including determinations of medical necessity.

Our determinations and interpretations, and our decisions on these matters are subject to review by the Trust Fund. If you disagree with our interpretation or determination, you may appeal to

the Trust Fund after you have exhausted our appeal procedures. See *Section 8: Dispute Resolution*.

No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this Summary of Benefits, grant or void any coverage, or increase or reduce any benefits under this Plan.

## Section 2: Payment Information

### ELIGIBLE CHARGE

#### Definition

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

Participating providers agree to accept the eligible charge as payment in full for covered services. Nonparticipating providers generally do not. Therefore, if you receive services from a nonparticipating provider you are responsible for any difference between the actual charge and the eligible charge.

**Please note:** Eligible charge does not include excise or other tax. You are responsible for all taxes associated with the medical care you receive.

#### Example

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

- The physician's bill or actual charge = \$80.
- HMA's eligible charge = \$60.
- Your copayment = \$6 (10% of \$60).
- The difference between the actual charge and the eligible charge = \$20.
- You owe \$6. Please note: If you went to a nonparticipating provider you would owe the applicable copayment amount plus the \$20 difference between the actual charge and the eligible charge.

### ANNUAL DEDUCTIBLE

#### Definition

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

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

- Copayments for services that are not subject to the annual deductible.
- Payments for services subject to a maximum once you reach the maximum. See Benefit Maximum later in this Section.
- The difference between the actual charge and the eligible charge that you pay when you receive services from a nonparticipating provider.
- Penalties for not obtaining prior authorization approval. For services subject to approval, see *Section 5: Prior Authorization*.

- Payments for noncovered services.
- Any amounts you owe in addition to your copayment for covered services.

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

### **Amount of Annual Deductible**

\$100 per person or  
\$300 (maximum) per family

### **Example**

Here is an example of how the annual deductible works. Let's say you have single coverage, your annual deductible is \$100, and you go to a nonparticipating provider:

- In March, you break your leg and you rent crutches to get around while your leg is in a cast. The eligible charge is \$75. You are responsible for the entire amount because you have not met the annual deductible.
- In June, you receive physical therapy for your leg. The eligible charge is \$100. You owe \$25 to meet the remaining deductible balance, plus a \$22.50 copayment (30% of the remaining \$75 balance) and the difference between the actual charge and the eligible charge.

Here is an example of how your maximum per family deductible works when you go to a nonparticipating provider:

- In February, your son is tested for allergies at the doctor's office. The eligible charge is \$75. You are responsible for the entire amount because you have not met the annual deductible.
- In March, you become ill and require ground ambulance transportation to the hospital. The eligible charge is \$300. You are responsible for \$100 (because you have not met the per person annual deductible) plus a \$60 copayment (30% of the remaining \$200) and the difference between the actual charge and the eligible charge.
- In April, your spouse falls down the stairs and is prescribed outpatient physical therapy. The eligible charge for the covered sessions is \$200. You are responsible for \$100 (because your spouse has not met the per person annual deductible) plus a \$30 copayment (30% of the remaining \$100) and the difference between the actual charge and the eligible charge.
- In May, your daughter requires inhalation therapy. The eligible charge is \$125. You are responsible for \$25 (because you have previously paid \$275 in per person deductibles) plus \$30 (30% of the remaining \$100) and the difference between the actual charge and the eligible charge. For the remainder of the year, you will pay no per person deductibles.

## **COPAYMENT**

### **Definition**

*Copayment* applies to most covered services and is either a fixed percentage of the eligible charge or a fixed dollar amount.

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

### **Amount of Copayment**

See *Section 3: Summary of Benefits and Your Payment Obligations*.

### **Example**

Here's an example of how the copayment works.

- Let's say you have a sore throat and go to a participating physician's office to have it checked. Your copayment for the office visit is 10%. The eligible charge for the office visit is \$60. Your copayment would be \$6.

Let's say you have a sore throat and go to a nonparticipating physician's office to have it checked. Your copayment for the office visit is 30%. The eligible charge for the office visit is \$60. Your copayment would be \$18. In addition, you would owe any difference between the provider's actual charge and our eligible charge.

## **ANNUAL COPAYMENT MAXIMUM**

### **Definition**

The *Copayment Maximum* is the maximum deductible and copayment amounts you pay in a calendar year. Once you meet the copayment maximum you are no longer responsible for deductible or copayment amounts, except as described below in "When You Pay More".

### **Amount of Copayment Maximum**

\$2,000 per person

\$6,000 (maximum) per family

### **When You Pay More**

The following amounts do not apply toward meeting the copayment maximum. In addition, you continue to be responsible for these amounts even after you have met the copayment maximum.

- Copayments for Contraceptives and Medical Foods.
- Payments for services subject to a maximum once you reach the maximum. See *Benefit Maximum* later in this Section.
- The difference between the actual charge and the eligible charge that you pay when you receive services from a nonparticipating provider.
- Penalties for not obtaining prior authorization approval. For services subject to approval, see *Section 5: Prior Authorization*.
- Payments for noncovered services.
- Any amounts you owe in addition to your copayment for covered services.

## **MAXIMUM ALLOWABLE FEE**

### **Definition**

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

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

- For most services, supplies, or procedures, we consider:
  - increases in the cost of medical and non-medical services in Hawaii over the previous year; the relative difficulty of the service 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 nonparticipating hospitals, our maximum allowable fee for all-inclusive daily rates established by the hospital will never exceed more than if the hospital had charged separately for services.

### **Lifetime Maximum**

There is no overall lifetime maximum under this plan.

## **BENEFIT MAXIMUM**

### **Definition**

A Benefit Maximum is a limitation that applies to a specified covered service or supply. A service or supply may be limited by dollar amount, duration, or number of visits. The maximum may apply per:

- Service. For example, outpatient mental health visits are limited to no more than 50 minutes per day.

- Calendar year. For example, you are eligible to receive benefits for up to 120 skilled nursing facility days each calendar year.

**Where to Look for Benefit Maximum Limitations**

See *Section 4: Description of Benefits*.

## Section 3: Summary of Benefits and Your Payment Obligations

### ABOUT THE BENEFIT AND PAYMENT CHART

The benefit and payment chart:

- is a summary listing of covered services and supplies.
- tells you if a covered service or supply is subject to limitations or prior authorization.
- tells you if the annual deductible applies and what the copayment percentage or fixed dollar amount is for covered services and supplies.

***Please note:*** Special limitations may apply to a service or supply listed in this benefit and payment chart.

An “A” next to a service or supply means that our approval is required. If you receive care from a nonparticipating provider be sure and review *Section 5: Prior Authorization*.

An asterisk “\*” next to a service or supply means either:

- More than one copayment may apply.
- Application of the deductible varies.
- A service dollar maximum may apply.
- You may owe amounts in addition to your copayment.

Please read the detailed benefit information on the page referenced.

## BENEFIT AND PAYMENT CHART

A = approval required * = see page 12	More info on page:	DOES THE ANNUAL DEDUCTIBLE APPLY?		COPAYMENT (based on eligible charges)	
		Participating	Nonparticipating	Participating	Nonparticipating
<b>Hospital and Facility Services</b>					
Ambulatory Surgical Center (ASC)	20	No	Yes	10%	30%
Emergency Room	20	No	No	10%	10%
Hospital Ancillary Services	21	No	Yes	10%	30%
* Hospital Room and Board	21	No	Yes	10%*	30%*
Intensive Care Unit/Coronary Care Unit	22	No	Yes	10%	30%
Intermediate Care Unit	22	No	Yes	10%	30%
Isolation Care Unit	22	No	Yes	10%	30%
Skilled Nursing Facility	22	No	Yes	10%	30%
<b>Physician Services</b>					
Anesthesia	22	No	Yes	10%	30%
Consultation Services	23	No	Yes	10%	30%
Immunizations (standard)	23	No	No	None	None
Immunizations (Hepatitis B)	23	No	No	None	None
Physician Visits	23	No	Yes	10%	30%
Physician Visits - Emergency Room	23	No	No	10%	10%
<b>Surgical Services</b>					
Assistant Surgeon Services	24	No	Yes	10%	30%
Cutting Surgery	24	No	Yes	10%	30%
Non-cutting Surgery	25	No	Yes	10%	30%
* Reconstructive Surgery	25	No	Yes	10%*	30%*
Surgical Supplies	25	No	Yes	10%	30%

A = approval required * = see page 12	More info on page:	DOES THE ANNUAL DEDUCTIBLE APPLY?		COPAYMENT (based on eligible charges)	
		Participating	Nonparticipating	Participating	Nonparticipating
<b>Testing, Laboratory and Radiology</b>					
Allergy Testing	25	No	Yes	10%	30%
Allergy Treatment Materials	25	No	Yes	10%	30%
Diagnostic Testing - Inpatient	25	No	Yes	10%	30%
Diagnostic Testing - Outpatient	25	No	Yes	10%	30%
Diagnostic Testing within 48 Hours of Injury - Inpatient	25	No	Yes	10%	30%
Diagnostic Testing within 48 Hours of Injury - Outpatient	25	No	Yes	10%	30%
Laboratory and Pathology - Inpatient	26	No	Yes	10%	30%
Laboratory and Pathology - Outpatient	26	No	Yes	10%	30%
Laboratory and Pathology within 48 Hours of Injury - Inpatient	26	No	Yes	10%	30%
Laboratory and Pathology within 48 Hours of Injury - Outpatient	26	No	Yes	10%	30%
Radiology - Inpatient	26	No	Yes	10%	30%
Radiology - Outpatient	26	No	Yes	10%	30%
Radiology within 48 Hours of Injury - Inpatient	26	No	Yes	10%	30%
Radiology within 48 Hours of Injury - Outpatient	26	No	Yes	10%	30%
Tuberculin Test	26	No	Yes	10%	30%

<b>Chemotherapy &amp; Radiation Therapy</b>					
Chemotherapy	26	No	Yes	10%	30%
Radiation Therapy - Inpatient (for malignancy)	26	No	Yes	10%	30%
Radiation Therapy - Outpatient (for malignancy)	26	No	Yes	10%	30%
Radiation Therapy - Inpatient (for non-malignancy)	26	No	Yes	10%	30%
Radiation Therapy - Outpatient (for non-malignancy)	26	No	Yes	10%	30%

A = approval required * = see page 12	More info on page:	DOES THE ANNUAL DEDUCTIBLE APPLY?		COPAYMENT (based on eligible charges)	
		Participating	Nonparticipating	Participating	Nonparticipating
<b>Other Medical Services and Supplies</b>					
Ambulance (air)	27	No	Yes	10%	30%
Ambulance (ground)	27	No	Yes	10%	30%
Blood and Blood Products	27	No	Yes	10%	30%
Dentist, Services of	27	No	Yes	10%	30%
Dialysis and Supplies	27	No	Yes	10%	30%
* Evaluations for Hearing Aids	27	No	Yes	*	*
<b>A</b> Growth Hormone Therapy	28	No	Yes	10%	30%
Home IV Therapy	28	No	Yes	10%	30%
Inhalation Therapy	28	No	Yes	10%	30%
Injections	28	No	Yes	10%	30%
Medical Equipment, Appliances, and Supplies	28	No	Yes	10%	30%
Medical Foods	29	No	No	10%	20%
Prosthetics & Orthotics	29	No	Yes	10%	30%
Private Duty Nursing	50	Not Covered	Not Covered	Not Covered	Not Covered

<b>Rehabilitation Therapy</b>					
Cardiac Rehabilitation	51	Not Covered	Not Covered	Not Covered	Not Covered
Physical and Occupational Therapy - Inpatient	29	No	Yes	10%	30%
Physical and Occupational Therapy - Outpatient	29	No	Yes	10%	30%
Speech Therapy - Inpatient	30	No	Yes	10%	30%
Speech Therapy - Outpatient	30	No	Yes	10%	30%

A = approval required * = see page 12	More info on page:	DOES THE ANNUAL DEDUCTIBLE APPLY?		COPAYMENT (based on eligible charges)	
		Participating	Nonparticipating	Participating	Nonparticipating
<b>Special Benefits - Disease Management &amp; Preventive Services</b>					
Disease Management and Preventive Services Programs	30	No	Not Covered	None	Not Covered
* Physical Examinations (routine annual checkup for ages 6-12)	31	No	No	None	*Balance after 100% of EC Paid by HMA
* Physical Examinations (routine annual checkup for ages 13 - 39)	31	No	No	None	*Balance after 100% of EC Paid by HMA
* Physical Examinations (routine annual checkup for ages 40 and above)	31	No	No	None	*Balance HMA 100% of EC Paid by HMA

<b>Special Benefits for Children</b>					
Newborn Circumcision	31	No	Yes	10%	30%
Well Child Care Immunizations	31	No	No	None	None
Well Child Care Laboratory Tests	32	No	No	10%	30%
Well Child Care Physician Office Visits	32	No	No	None	30%

<b>Special Benefits for Men</b>					
* Erectile Dysfunction	32	No	Yes	10%*	30%*
Prostate Specific Antigen Test (PSA)	32	No	Yes	10%	30%
Vasectomy	32	No	Yes	10%	30%

A = approval required * = see page 12	More info on page:	DOES THE ANNUAL DEDUCTIBLE APPLY?		COPAYMENT (based on eligible charges)	
		Participating	Nonparticipating	Participating	Nonparticipating
<b>Special Benefits for Women</b>					
Chlamydia Screening	32	No	Yes	10%	30%
* Complications of Pregnancy	32	No	Yes	10%*	30%*
Contraceptive Implants	33	No	No	50%	50%
Contraceptive Injectables	33	No	No	50%	50%
Contraceptive IUD	33	No	No	50%	50%
Mammography (screening)	33	No	No	10%	30%
* Newborn Care	34	No	Yes	10%*	30%*
Nurse Midwives	34	No	Yes	10%	30%
Pap Smears (routine)	34	No	Yes	10%	30%
Pregnancy Termination	34	No	Yes	10%	30%
* Total Maternity Care	34	No	Yes	10%*	30%*
Tubal Ligation	34	No	Yes	10%	30%
Well Woman Exam	34	No	Yes	10%	30%

<b>Special Benefits for Participant and Covered Spouse</b>					
* In Vitro Fertilization	34	No	Yes	10%*	30%*

<b>Special Benefits for Homebound, Terminal, or Long-term Care</b>					
Home Health Care	35	No	Yes	None	30%
Hospice Services	35	No	Not Covered	None	Not Covered

A = approval required * = see page 12	More Info on Page	DOES THE ANNUAL DEDUCTIBLE APPLY?		COPAYMENT (based on eligible charges)	
		Participating	Nonparticipating	Participating	Nonparticipating
<b>Behavioral Health - Mental Health and Substance Abuse</b>					
Mental Health Facility Services	36	No	Yes	10%	30%
Mental Health Physician Services - Inpatient	36	No	Yes	10%	30%
Psychological Testing - Inpatient	36	No	Yes	10%	30%
Psychological Testing - Outpatient	36	No	Yes	10%	30%
Substance Abuse Facility Services	36	No	Yes	10%	30%
Substance Abuse Physician Services - Inpatient	36	No	Yes	10%	30%

<b>Organ and Tissue Transplants</b>					
* Corneal Transplants	41	No	Yes	10%*	30%*
* Kidney Transplants	41	No	Yes	10%*	30%*
Organ Donor Services	41	No	Yes	10%	30%
A Small Bowel and * Multivisceral Transplants	42	No	Yes	10%*	30%*
A Transplant Evaluation	39	No	Not Covered	None	Not Covered

HMA has contracted with certain providers for the following transplant services. You must receive services from a provider that is under contract for the specific type of transplant you will receive for these benefits to apply.

A = approval required * = see page 12	More info on page:	DOES THE ANNUAL DEDUCTIBLE APPLY?		COPAYMENT (based on eligible charges)	
		Participating	Nonparticipating	Participating	Nonparticipating
<b>Other Organ and Tissue Transplants</b>					
<b>A</b> Bone Marrow Transplants	39	No	Not Covered	None	Not Covered
<b>A</b> Heart Transplants	41	No	Not Covered	None	Not Covered
<b>A</b> Heart and Lung Transplants	41	No	Not Covered	None	Not Covered
<b>A</b> Liver Transplants	41	No	Not Covered	None	Not Covered
<b>A</b> Lung Transplants	41	No	Not Covered	None	Not Covered
<b>A</b> Simultaneous Kidney/Pancreas Transplant	42	No	Not Covered	None	Not Covered

## Section 4: Description of Benefits

### HOSPITAL AND FACILITY SERVICES

#### Review of Inpatient Hospital Care

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

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

#### Ambulatory Surgical Center (ASC)

Covered, including operating rooms, surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics, blood transfusion services, routine laboratory and x-ray associated with surgery. Ambulatory Surgical Center is an outpatient facility that provides surgical services without an overnight stay. This facility may be in a hospital or it may be a separate independent facility.

#### Emergency Room

Covered, but only if a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

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

Examples of an emergency include chest pain or other heart attack signs, poisoning, loss of consciousness, convulsions or seizures, broken back or neck, heavy bleeding, sudden weakness on one side, severe pain, breathing problems, drug overdose, severe allergic reaction, severe burns, and broken bones. Examples of non-emergencies are colds, flu, earaches, sore throats, and using the emergency room for your convenience or during normal physician office hours for medical conditions that are treatable in a physician's office.

If you require emergency services, call 911 or go to the nearest emergency room for treatment. Prior authorization is not required.

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

## **Hospital Ancillary Services**

Covered, including surgical supplies, hospital anesthesia services and supplies, diagnostic and therapy services, drugs, dressings, oxygen, antibiotics, and hospital blood transfusion services.

## **Hospital Room and Board**

Covered, including:

- **Semi-Private Rooms.** If you are hospitalized at a participating facility, your copayment is based on the facility's medical/surgical semi-private room rate. If you are hospitalized at a nonparticipating facility, your copayment is based on HMA's maximum allowable fee for semi-private rooms. In addition, you owe the difference between the nonparticipating hospital's room charge and HMA's maximum allowable fee for semi-private rooms.
- **Private Rooms.**

### **At Participating Hospitals:**

If you are hospitalized in a participating facility with private rooms only, your copayment is based on HMA's maximum allowable fee for semi-private rooms.

If you are hospitalized in a participating facility with semi-private and private rooms, your copayment is based on the facility's medical/surgical semi-private room rate. In addition, you owe the difference between the facility's charges for private and semi-private rooms. Exception: If you are hospitalized for conditions identified by HMA as conditions which require a private room, your copayment is based on the facility's medical/surgical private room rate.

### **At Nonparticipating Hospitals:**

If you are hospitalized in a nonparticipating facility, your copayment is based on HMA's maximum allowable fee for semi-private rooms. In addition, you owe the difference between the facility's private room charge and HMA's maximum allowable fee for semi-private rooms.

Exception: If you are hospitalized for conditions identified by HMA as conditions which require a private room, your copayment is based on HMA's maximum allowable fee for private rooms. In addition, you owe the difference between the facility's private room charge and HMA's maximum allowable fee for private rooms.

- Intensive care or coronary units.
- Intermediate care units.
- Isolation units.
- Operating rooms.

Benefits for remote monitoring services, such as the "LifeBed", will be available when a hospital provides for inpatient care with the appropriate technology.

### **Intensive Care Unit/Coronary Care Unit**

Covered.

### **Intermediate Care Unit**

Covered.

### **Isolation Care Unit**

Covered.

### **Skilled Nursing Facility**

Room and Board is covered, but only for semi-private rooms. Eligibility for benefits requires that all of the following statements are true:

- You are admitted by your physician.
- Care is ordered and certified by your physician.
- We approve the confinement.
- 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 120 days in any one calendar year.
- The confinement is not for custodial care.

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

## **PHYSICIAN SERVICES**

### **Anesthesia**

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

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

## **Consultation Services**

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

- The attending physician must require the consultation.
- If the consultation is for inpatient services, you must be confined as a registered bed patient.
- If the consultation is for inpatient services, the consultant's report must be acceptable to us and be included as a part of the record kept by the hospital or skilled nursing facility.
- The consultation must be for reasons other than compliance with requirements imposed by the hospital or skilled nursing facility.

## **Immunizations (standard)**

Covered, but only standard immunizations and immunizations for high risk conditions and other vaccines in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP).

If you would like information about high risk criteria, call our customer service number and we will help you. Our phone number is listed on the back cover of this Summary. Travel immunizations are covered under Injections.

## **Immunizations (Hepatitis B)**

Covered.

## **Physician Visits**

Covered, for an illness or injury, when you are inpatient or outpatient. A physician visit may be received in the physician's office, your home, or a facility setting. You are also covered for family planning counseling services. For physician visit limitations associated with mental health and substance abuse services, see later in this Section under Mental Health and Substance Abuse.

***Please note:*** You are covered for physician visits related to routine physical examinations, as described under Special Benefits for Children, Special Benefits for Women, and Special Benefits for Men (pages 31 through 34).

## **Physician Visits - Emergency Room**

Covered, but only if a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child);

- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Examples of an emergency include chest pain or other heart attack signs, poisoning, loss of consciousness, convulsions or seizures, broken back or neck, heavy bleeding, sudden weakness on one side, severe pain, breathing problems, drug overdose, severe allergic reaction, severe burns, and broken bones. Examples of non-emergencies are cold, flu, earache, sore throat, and using the emergency room for your convenience or during normal physician office hours for medical conditions that are treatable in a physician's office.

## **SURGICAL SERVICES**

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

### **Approval for Certain Surgical Procedures**

Certain surgical procedures must receive prior authorization from HMA. See *Section 5: Prior Authorization*.

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

If you are under the care of a:

- participating physician, the physician will obtain approval for you.
- nonparticipating physician, the physician will not necessarily obtain approval for you. Obtaining approval is your responsibility. See *Section 5: Prior Authorization*.

### **Assistant Surgeon Services**

Covered, but only when:

The complexity of the surgery requires an assistant; and

- The facility does not have a resident or training program; or
- The facility has a resident or training program, but a resident or intern on staff is not available to assist the surgeon.

### **Cutting Surgery**

Covered, including preoperative and postoperative care.

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

### **Non-cutting Surgery**

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

### **Reconstructive Surgery**

Covered, but only for corrective surgery required to restore, reconstruct or correct:

- any bodily function that was lost, impaired, or damaged as a result of an illness, injury,
- developmental abnormalities when present from birth and which severely impair or impede normal, essential bodily functions, or
- the breast on which a mastectomy for cancer or the prevention of cancer was performed, and surgery for the reconstruction of the other breast to produce a symmetrical appearance (including prostheses). Treatment for complications of mastectomy and reconstruction, including lymphedema, is also covered.

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

### **Surgical Supplies**

Covered.

## **TESTING, LABORATORY, and RADIOLOGY**

### **Allergy Testing**

Covered, but no more than one series of tests per calendar year.

### **Allergy Treatment Materials**

Covered.

### **Diagnostic Testing**

Covered when related to an injury or illness. Examples of diagnostic testing include:

- Electroencephalograms (EEG).
- Electrocardiograms (EKG or ECG).
- Holter Monitoring.
- Stress Tests.

## **Genetic Testing and Screening**

Covered, but only if you meet HMA's criteria.

*Please note:* certain services require prior authorization. See *Section 5: Prior Authorization*.

## **Laboratory and Pathology**

Covered, when related to an illness or injury. For additional routine and preventive laboratory services, see later in this Section in the Special Benefits sections.

## **Radiology**

Covered. Examples of radiology include:

- Computerized Tomography Scan (CT Scan).
- Diagnostic mammography.
- Nuclear Medicine.
- Ultrasound.
- X-rays.

Some radiological procedures may require prior authorization. See *Section 5: Prior Authorization*.

## **Tuberculin Test**

Covered for one tuberculin test (TB) per calendar year.

## **CHEMOTHERAPY and RADIATION THERAPY**

### **High-dose Limitation**

Benefits for high-dose chemotherapy, high-dose radiation therapy, or related services and supplies are limited to those conditions described later in this Section under Bone Marrow Transplants in the section Organ and Tissue Transplants.

### **Chemotherapy**

Covered, including chemical agents and their administration for the treatment of a malignancy subject to the high-dose limitation described above.

### **Radiation Therapy (for malignancy)**

Covered, subject to the high-dose limitation described above.

## **Radiation Therapy (for non-malignancy)**

Covered.

## **OTHER MEDICAL SERVICES and SUPPLIES**

### **Ambulance**

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

We will cover your ambulance transportation if all of the following apply:

- Services to treat your illness or injury are not available in the hospital or nursing facility where you are an inpatient.
- Transportation 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.
- Transportation takes you to the nearest facility equipped to furnish emergency treatment.

*Please note:* Air ambulance is limited to intra-island or inter-island transportation within the state of Hawaii.

### **Blood and Blood Products**

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

You are not covered for:

- Peripheral stem cell transplants except as described in this Section under Bone Marrow Transplants.

### **Dental Services**

Covered, but only when the dentist is performing emergency or surgical services that could also be performed by a physician. The initial visit to diagnose temporomandibular joint (TMJ) disorder will be covered. All other services related to the treatment of TMJ are not covered.

### **Dialysis and Supplies**

Covered.

### **Evaluations for Hearing Aids**

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

## **Growth Hormone Therapy**

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

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

*Please note:* these services require prior authorization. See *Section 5: Prior Authorization*.

## **Home IV Therapy**

Covered, for services and supplies for outpatient injections, biological therapeutics, biopharmaceuticals, or intravenous nutrient solutions required for primary diet.

*Please note:* certain services require prior authorization. See *Section 5: Prior Authorization*.

## **Inhalation Therapy**

Covered.

## **Injections**

Covered, for outpatient services and supplies for the injection or intravenous administration of medication, biological therapeutics and biopharmaceuticals, or nutrient solutions required for primary diet, and travel immunizations in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP).

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

*Please note:* certain services require prior authorization. See *Section 5: Prior Authorization*.

## **Medical Equipment, Appliances, and Supplies**

Covered, but only when prescribed by your provider.

Examples of appliances and medical equipment include hearing aids (one device per ear every five years); cardiac pacemakers; crutches, walkers, oxygen and rental equipment for its administration, and rental of wheelchairs and hospital-type beds.

**Please note:** Benefit payment for the rental of appliances and medical equipment is limited to no more than the purchase price.

**Please note:** certain equipment require prior authorization. See *Section 5: Prior Authorization*.

## **Medical Foods**

Covered, for the treatment of inborn errors of metabolism in accord with Hawaii law and HMA guidelines.

**Please note:** Copayments for Medical Foods do not apply toward meeting the Annual Copayment Maximum.

## **Prosthetics and Orthotics**

Covered, but only when prescribed by your provider.

Examples of prosthetics and orthotics include artificial limbs, eyes, hips, and similar appliances.

Vision appliances, which includes eyeglasses and contact lenses, for certain medical conditions are subject to special limitations. Please call the number listed on the back cover for details.

**Please note:** Exclusions or limitations apply. See *Section 6: Services Not Covered under DENTAL, DRUG, and VISION and Miscellaneous Exclusions*.

## **Routine Care Associated With Clinical Trials**

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

**Please note:** These services require prior authorization. See *Section 5: Prior Authorization*.

## **REHABILITATION THERAPY**

### **Physical and Occupational Therapy**

Covered, but only when all of the following are true:

- The therapy is ordered by a physician under an individual treatment plan.
- The therapy is received from a licensed physical or occupational therapist.

- The therapy is necessary to restore neurological or musculoskeletal function that was lost or impaired due to an illness or injury.
- The therapy and diagnosis are described as covered in HMA's medical policies on physical and occupational therapy.

Benefit maximums apply. Visits are covered up to the number of visits necessary to restore sufficient neurological or musculoskeletal function but not more than the maximum number of visits defined in HMA's medical policies on physical and occupational therapy. If you are receiving occupational and physical therapy for the same injury, the total number of visits covered is limited to the maximum number of visits for either occupational therapy or physical therapy but not both combined. Neurological or musculoskeletal function is sufficient when one of the following first occurs:

- Neurological or musculoskeletal function is the level of the average healthy person of the same age, or
- When further significant functional gain is unlikely.

Physical and occupational therapy visits beyond the benefit maximums described above are covered only when precertified and approved by us. See *Section 5: Prior Authorization*.

Group exercise programs are not covered.

Physical therapy evaluations are not covered when provided by an occupational therapist.

### **Speech Therapy**

Speech therapy is covered only when all of the following statements are true:

- The therapy is ordered by a physician under an individual treatment plan.
- The therapy is necessary to restore speech function that was lost or impaired by illness or injury.
- The therapy is received from a speech therapist who is certified as clinically competent by the American Speech-Language-Hearing Association (ASHA).
- The therapy is short term (long-term maintenance programs are not covered).
- The therapy is not for developmental learning disabilities, or developmental delay.

### **SPECIAL BENEFITS - Disease Management and Preventive Services**

#### **Disease Management Programs**

Description of any Disease Management programs available through HMA.

#### **Preventive Services Programs**

Covered, for HMA programs.

You may be automatically enrolled in some of these preventive services programs and may elect not to participate by contacting us. HMA reserves the right to at any time add other programs or to terminate programs currently in use. Call the HMA office at (808) 951-4621 or Neighbor Islands may call (866) 377-3977 for more information. As described below, each calendar year you are eligible for one Physical Examination (routine annual checkup).

### **Physical Examinations (routine annual checkup)**

Covered. Includes a routine physical exam and recommended screening tests for your age and gender.

Recommended examinations for ages 6 through 12.

- Preschool examination Form 414.

Additionally, for ages 13 and above:

- Complete history and physical examination.
- Audiogram (optional).
- Urinalysis.
- Blood count.
- Chest X-ray (not more than once every two years).

Also for ages 40 and above:

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

## **SPECIAL BENEFITS FOR CHILDREN**

### **Newborn Circumcision**

Covered.

### **Well-Child Care**

Covered, from birth through age five including office visits for history, physical examinations, developmental assessments, anticipatory guidance, laboratory tests, and immunizations. *Well Child Care* means routine and preventive care for children under age six. If your child requires medical care as the result of an illness or injury, physician visit benefits apply (and not well-child care benefits). See Physician Services earlier in this Section.

### **Well Child Care Immunizations**

Covered, in accord with Hawaii law.

## **Well Child Care Laboratory Tests**

Covered, in conjunction with office visits, from birth through age five. Laboratory tests are limited during the well-child care period to:

- Two tuberculin tests
- Two blood tests (hemoglobin or hematocrit)
- One urinalysis

## **Well Child Care Physician Office Visits**

Covered, also includes routine vision and hearing tests, according to the following schedule:

- Birth to one year: six visits (one additional visit is covered when a newborn child is discharged within 48 hours of birth)
- Age one year: two visits
- Age two years: one visit
- Age three years: one visit
- Age four years: one visit
- Age five years: one visit

## **SPECIAL BENEFITS for MEN**

### **Erectile Dysfunction**

Services, supplies, prosthetic devices, and injectables approved by us are covered to treat erectile dysfunction due to organic cause as defined by HMA.

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

Covered, but only one prostate specific antigen test per calendar year for men age 50 or older.

### **Vasectomy**

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

## **SPECIAL BENEFITS for WOMEN**

### **Chlamydia Screening**

Covered.

### **Complications of Pregnancy**

Covered.

## **Contraceptive Implants**

Covered.

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

Copayments for Contraceptives do not apply toward meeting the Annual Copayment Maximum.

## **Contraceptive Injectables**

Covered.

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

Copayments for Contraceptives do not apply toward meeting the Annual Copayment Maximum.

## **Contraceptive IUD**

Covered.

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

Copayments for Contraceptives do not apply toward meeting the Annual Copayment Maximum.

## **Mammography (screening)**

Covered according to the following schedule:

- Age 35 - 39 years of age, one baseline mammogram.
- Age 40 years of age or older, one mammogram per calendar year.

**Please note:** A woman of any age may receive the screening more often if she has a history of breast cancer or if her mother or sister has a history of breast cancer. For diagnostic mammography benefits, see earlier in this Section under Testing, Laboratory, and Radiology.

## **Maternity Length of Stay**

Covered, for up to:

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

### **Newborn Care**

Covered for the baby's routine non-surgical physician services and nursery care following birth. Benefits for a sick newborn are available when you add the child to your coverage within 31 days of birth.

### **Nurse Midwives**

Covered. Services provided by nurse midwives will be covered at the same benefit levels as similar services provided by other providers within the scope of their license.

### **Pap Smears (routine)**

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

### **Pregnancy Termination**

Covered.

### **Total Maternity Care**

Covered, including prenatal, false labor, delivery, and postnatal services. Benefit payment occurs following delivery and includes the treatment of routine gynecological conditions during scheduled prenatal visits. If benefit payments are made separately prior to delivery, payments will be considered an advance and we will deduct the amount from the benefit payment for total maternity care.

### **Tubal Ligation**

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

### **Well Woman Exam**

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

## **SPECIAL BENEFITS for PARTICIPANT and COVERED SPOUSE**

### **In Vitro Fertilization**

Covered. But coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are an HMA Participant. Additionally, coverage is limited to Participants who meet the following criteria:

- The in vitro fertilization is for you or your spouse. In vitro fertilization services are not covered when a surrogate is used.
- Either of the following two statements is true:
  - You and your spouse have a history of infertility for at least five years; or
  - The infertility is associated with one or more of the following medical conditions: endometriosis; exposure in utero to diethylstilbestrol (DES); blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or abnormal male factors contributing to the infertility.
- You have been unable to attain a successful pregnancy through other covered infertility treatments.
- The in vitro procedures are performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

**Please note:** these services require prior authorization. See *Section 5: Prior Authorization*.

**Please note:** exclusions or limitations which may relate to this benefit are described in *Section 6: Services Not Covered* in the section labeled *Fertility and Infertility*.

## **SPECIAL BENEFITS for HOMEBOUND, TERMINAL, or LONG-TERM CARE**

### **Home Health Care**

Covered, but only when all of the following statements are true:

- Services are prescribed in writing by a physician for the treatment of illness or injury when you are homebound. Homebound means that due to an illness or injury, you are unable to leave home, or if you do leave home, doing so requires a considerable and taxing effort.
- Part-time skilled health services are required.
- Services are not more costly than alternate services that would be effective for diagnosis and treatment of your condition.
- Without home health care, you would require inpatient hospital or skilled nursing facility care.
- 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.
- Services do not exceed 150 visits per calendar year.

### **Hospice Services**

Covered. A **Hospice Program** provides care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. We follow Medicare

guidelines in determining benefits, level of care and eligibility for hospice services. In addition, we cover:

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

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

Hospice services must be received from a hospice that is currently under contract with us to provide hospice benefits. You are not covered for hospice services provided by a hospice not under contract with us.

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

### **Integrated Case Management**

Covered, when approved by us. Integrated Case Management is a special program to assist Participants with certain medical conditions that require costly, long-term, care and when a hospital may not be the most appropriate setting for your treatment. If you meet HMA's criteria, your coverage provides you with alternate benefits to help meet health care needs resulting from extreme illness or injury (providing costs do not exceed inpatient facility costs). You, your physician, and the hospital can work with our case managers to identify and arrange alternate treatment plans to meet your special needs and to assist in preserving your health care benefits.

Conditions and treatments for which benefits management might be appropriate are: AIDS, coma, traumatic brain injury, respirator dependency, spinal cord injury, and long-term intravenous therapy.

### **Approval for Alternate Treatment Plans**

Before benefits are available for alternate treatment plans, approval must be received. Without approval, no benefits for alternate treatment plans are available. Physicians usually contact us on your behalf to identify and arrange alternate treatment plans. If you are not sure if your provider has contacted us, you should talk with your physician, or call us at: (808) 951-4621 or Neighbor Islands can call (866) 377-3977.

### **BEHAVIORAL HEALTH - Mental Health and Substance Abuse**

Covered, if:

- You are diagnosed with a condition found within the most current Diagnostic and Statistical Manual of the American Psychiatric Association.

- The services are provided by a licensed psychiatrist, psychologist, clinical social worker, or advanced practice registered nurse.

**Please note:** Epilepsy, senility, mental retardation, or other developmental disabilities and addiction to or abuse of intoxicating substances, alone do not constitute a mental disorder. You are not covered for educational programs or other services performed by mutual self-help groups, even if you are referred to such a group by the judicial system.

### **Serious Mental Illness**

Services for serious mental illness, as defined by Hawaii law such as schizophrenia, schizo-affective disorder, and bi-polar types I and II, and services for delusional disorder, dissociative disorder, major depressive disorder, and obsessive-compulsive disorder are not subject to the mental health inpatient and outpatient benefit limitations described below.

### **Benefit Limitations**

- **Outpatient Sessions.** Benefits for outpatient mental health and/or substance abuse services by a psychiatrist, psychologist, clinical social worker or advanced practice registered nurse. Sessions are limited to no more than 50 minutes per day for individual sessions and 90 minutes per day for group sessions. Please note: Except for serious mental illness, mental health sessions are limited to 24 outpatient sessions per calendar year. Each outpatient psychological testing session counts as one session against the outpatient mental health session maximum.
- **Inpatient Sessions.** Benefits for inpatient mental health and/or substance abuse sessions by a psychiatrist, psychologist, clinical social worker, or advanced practice registered nurse. Sessions are limited to no more than 50 minutes per day. Please note: Except for serious mental illness, mental health sessions are limited to 30 inpatient sessions per calendar year. Each inpatient psychological testing session counts as one session against the inpatient mental health session maximum.
- **Inpatient Days.** Benefits for inpatient mental health and/or substance abuse services are limited to room and care and inpatient ancillary service charges. No additional benefits are available for intensive or special-care psychiatric units. Please note: Except for serious mental illness, mental health conditions are limited to 30 inpatient days per calendar year.
- **Psychological Testing.** Each outpatient psychological testing session counts as one session against the outpatient mental health session maximum. Each inpatient psychological testing session counts as one session against the 30-day inpatient mental health session maximum.

### **Inpatient Mental Health Benefit Substitutions**

Each inpatient mental health hospital day may be exchanged for:

- Two days of *nonhospital residential services*.
- Two days of partial hospitalization.

- Two days of day treatment services in a qualified treatment facility, but only if the care includes three or more hours of treatment per day. A physician, clinical social worker, registered nurse, or licensed psychologist must prescribe and supervise day treatment services. Services require *a minimum of three hours of care in any one day but less than 24 hours of care.*
- *Two outpatient visits.* You may only exchange two outpatient visits for one inpatient hospital day if outpatient services would reasonably preclude hospitalization.

## **Definitions**

*Alcohol Dependence* means any use of alcohol that produces a pattern of pathological use causing impairment in social or occupational functioning or produces physiological dependency evidenced by physical tolerance or withdrawal.

*Day Treatment Services* means that treatment services are provided by a hospital, mental health outpatient facility, or nonhospital facility to patients who, because of their conditions, require more than periodic hourly service.

*Drug Dependence* means any pattern of pathological use of drugs causing impairment in social or occupational functioning and producing psychological or physiological dependency or both, evidenced by physical tolerance or withdrawal.

*Nonhospital Residential Services* mean the provision of medical, psychological, nursing, counseling, or therapeutic services by a nonhospital residential facility to patients suffering from alcohol dependence, drug dependence, or mental illness, according to individualized treatment plans.

*Psychological Testing* means a standardized task used to assess some aspect of a person's cognitive, emotional, or adaptive functioning.

*Substance Abuse Services* means medical, psychological, nursing, counseling, or therapeutic services in response to a treatment plan for alcohol or drug dependence or both. Services include, as appropriate, a combination of aftercare and individual, group and family counseling services.

## **ORGAN and TISSUE TRANSPLANTS**

### **Organ and Tissue Transplants**

Covered, but only as described in this section and subject to all other conditions and provisions including that the transplant meets payment determination criteria. For a definition of payment determination criteria, see Section 1: Important Information under Questions We Ask When You Receive Care. In addition, transplants (with the exception of corneal, kidney, small bowel and multivisceral transplants) must:

- receive our approval. Without approval for the specified transplants, benefits are not available. See *Section 5: Prior Authorization.*
- be received from a facility that:

- is under contract with us for that type of transplant; and
- accepts you as a transplant candidate.

Small bowel and multivisceral transplants must receive our approval. See *Section 5: Prior Authorization*.

Benefits are not available for any of the following:

- Artificial (mechanical) organs.
- Non-human organs.
- Organ or tissue transplants not listed in this section.

### **Transplant Evaluations**

Covered, for bone marrow, heart, heart-lung, liver, lung, simultaneous kidney/pancreas, or small bowel and multivisceral transplants, but only with our approval. Transplant Evaluation means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations that a facility uses in evaluating a potential transplant candidate. For information about donor screening benefits, see in this Section under Organ Donor Services.

### **Bone Marrow Transplants**

Covered, but only with approval. See *Section 5: Prior Authorization*. Also, benefits for bone marrow transplants are limited to autologous and allogeneic bone marrow transplants for the specified diseases or conditions described in this section. Benefits are not available for autologous and allogeneic bone marrow transplants for any other diseases or conditions.

The limited benefits specified below for allogeneic and autologous bone marrow transplants are an exception to the exclusion for experimental or investigative procedures. This limited exception is not intended to, and does not operate as, a waiver of the exclusion for experimental or investigative procedures. The limited benefit is subject to all other conditions and provisions of this plan.

### **Important Bone Marrow Transplant Definitions**

Allogeneic and Autologous Bone Marrow Transplants mean medical and/or surgical procedures composed of several steps or stages including, without limitation:

- The harvest of stem cells from the blood or bone marrow of a third-party donor (“allogeneic”) or from the patient (“autologous”)
- Processing and/or storage of harvested stem cells.
- The administration of high dose chemotherapy and/or high dose radiation therapy. High Dose Chemotherapy and High Dose Radiation Therapy are forms of therapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a bone marrow transplant is required or warranted.
- The infusion of harvested stem cells.

- Hospitalization, observation, and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities, and low blood counts.

This definition specifically includes transplants when the transplant component is derived from circulating blood instead of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, high dose chemotherapy and/or high dose radiation therapy.

### **Allogeneic Bone Marrow Transplants**

Covered, but only with our approval. See *Section 5: Prior Authorization*. Allogeneic bone marrow transplants are available only for treatment prescribed for the following conditions:

- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia.

This definition specifically includes transplants when the transplant component is derived from circulating blood instead of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, high dose chemotherapy and/or high dose radiation therapy.

### **Allogeneic Bone Marrow Transplants**

Covered, but only with our approval. See *Section 5: Prior Authorization*. Allogeneic bone marrow transplants are available only for treatment prescribed for the following conditions:

- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia.
- Advanced stage Hodgkin's disease.
- Advanced stage, intermediate-grade, or high-grade non-Hodgkin's lymphoma.
- Advanced stage neuroblastoma.
- Chronic myelogenous leukemia that is in blast crisis or chronic phase.
- Gonadal germ cell tumors.
- Homozygous beta-thalassemia.
- Infantile malignant osteopetrosis.
- Lysosomal storage diseases.
- Myelodysplastic syndrome.
- Severe aplastic anemia.
- Severe combined immunodeficiency syndrome.
- Wilm's tumor.
- Wiskott-Aldrich syndrome.

### **Autologous Bone Marrow Transplants**

Covered, but only with our approval. See *Section 5: Prior Authorization*. Also, benefits for autologous bone marrow transplants are limited to treatment prescribed for the following conditions:

- Acute lymphocytic and non-lymphocytic (i.e., myelogenous) leukemia.
- Advanced stage intermediate-grade or high-grade non-Hodgkin's lymphoma.
- Advanced stage Hodgkin's disease.
- Advanced stage neuroblastoma.
- Breast cancer.
- Gonadal germ cell tumors.
- Multiple myeloma if in accord with our criteria, the disease is newly diagnosed or responsive to previous treatment for multiple myeloma.
- Wilms' tumor.

### **Corneal Transplants**

Covered.

### **Heart Transplants**

Covered, but only with our approval. See *Section 5: Prior Authorization*.

### **Heart and Lung Transplants**

Covered, but only with our approval. See *Section 5: Prior Authorization*.

### **Kidney Transplants**

Covered.

### **Liver Transplants**

Covered, but only:

- with our approval; and
- if contraindicators used by HMA are not present; and
- for patient's with end-stage liver disease due to:
  - intrinsic disease of the liver;
  - diseases caused by external agents; or
  - systemic disease.

### **Lung Transplants**

Covered, but only with our approval. See *Section 5: Prior Authorization*.

### **Organ Donor Services**

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

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

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

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

### **Simultaneous Kidney/Pancreas Transplants**

Covered, but only with our approval. See *Section 5: Prior Authorization*.

### **Small Bowel and Multivisceral Transplants**

Covered, for small bowel (small intestine) and the small bowel with liver or small bowel with multiple organs such as the liver, stomach and pancreas, but only with our approval. See *Section 5: Prior Authorization*.

## **Section 5: Prior Authorization**

### **PRIOR AUTHORIZATION REQUIREMENTS**

Prior Authorization is required to ensure that certain medical treatments, procedures, or devices meet payment determination criteria prior to the service being rendered.

A table listing treatments, procedures and devices which require prior authorization appears later in this Section.

### **Changes to this Summary's List of Services and Supplies Which Require Prior Authorization**

From time to time, it is necessary to change the list of services and supplies which require prior authorization. Changes are necessary so that your plan benefits remain current with changes to the way therapies are delivered and may occur at any time during your plan year. If you would like to know if a treatment, procedure or device has been added or deleted from the list in this Summary, call us at (808) 951-4621 or Neighbor Islands may call (866) 377-3977.

### **When to Request Prior Authorization**

If you are under the care of:

- an HMA participating physician or contracting physician, he or she will:
- obtain approval for you; and
- accept any penalties for failure to obtain approval.

## **How to Request Prior Authorization**

Request prior authorization by writing to us at:

HMA, INC.  
Attn: Health Services Department  
P.O. Box 135005  
Honolulu, HI 96801

or faxing us at (808) 951- 4620

If you would like to check on the status of the prior authorization, call our HMA office at (808) 951-4621 or Neighbor Islands may call (866) 377-3977.

## **Our Response to Your Request for Prior authorization of Urgent Care**

Your care is urgent if application of the time periods applicable to non-urgent care:  
Could seriously jeopardize your life or health or your ability to regain maximum function, or  
In the opinion of your treating physician, would subject you to severe pain that cannot be adequately managed without the care that is the subject of the request for prior authorization.  
HMA will respond to your request for prior authorization of urgent care as soon as possible given the medical circumstances of your case but not later than 72 hours after our receipt of the request.

If you do not provide sufficient information for us to determine whether or to what extent the care you request is covered, we will notify you within 24 hours of our receipt of your request.

We will let you know what information we need to respond to your request and provide you a reasonable time but not less than 48 hours to provide the information.

## **Appeal of Our Prior Authorization Decision**

If you disagree with our prior authorization decision, you may appeal our decision. See *Section 8: Dispute Resolution*.

## **Payment Determination Criteria**

Providers may bill or collect charges for services or supplies that do not meet payment determination criteria.

## TYPES OF CARE REQUIRING APPROVAL

Approval Required For:	Action Required:
Specific Type of Care or Procedure	
<p><b>Autologous Chondrocyte Implants</b>  <b>Biological Therapeutics and Biopharmaceuticals</b> for the first year of its FDA-approved release date  <b>Bone Density Test</b>  <b>Computed Tomography (CT) – Outpatient</b> (not required for emergency room)</p> <p><b>Genetic Testing – if predictive in asymptomatic individuals with the following:</b></p> <ul style="list-style-type: none"> <li>• Family history of breast cancer</li> <li>• Family history of ovarian cancer</li> <li>• Familial adenomatous polyposis</li> <li>• Hereditary nonpolyposis colorectal cancer</li> </ul> <p><b>Growth Hormone Therapy</b>  <b>High Dose Rate Brachytherapy</b>  <b>Home IV Therapy</b></p> <ul style="list-style-type: none"> <li>• Albumin Therapy</li> <li>• Inotropic Therapy</li> <li>• Intravenous Immune Gamma Globulin (IVIG) Therapy</li> <li>• Pain Management Infusion Therapy</li> <li>• Parenteral Nutrition Therapy</li> </ul> <p><b>In Vitro Fertilization</b></p> <ul style="list-style-type: none"> <li>• Injectable Drugs</li> <li>• Avastin</li> <li>• Enbrel (for treatment of psoriasis)</li> <li>• Erbitux</li> <li>• Forteo</li> </ul> <ul style="list-style-type: none"> <li>• Lupron (for therapy beyond 11 years for girls and 12 years for boys for central precocious puberty, for off-label use in the palliative treatment of advanced breast cancer.)</li> <li>• Raptiva</li> </ul>	<p>Call HMA:  (808) 951-4621</p> <p>For neighbor islands:  (866) 377-3977</p> <p><b>PLEASE NOTE:  If services do not meet payment determination criteria, no benefits are available</b></p>

Approval Required For:	Action Required:
Specific Type of Care or Procedure	
<ul style="list-style-type: none"> <li>• Synagis</li> <li>• Velcade</li> <li>• Xolair</li> <li>• Zevalin</li> </ul> <p><b>Intensity Modulated Radiation Therapy (IMRT)</b>  <b>Kyphoplasty</b>  <b>Lung Volume Reduction Surgery</b>  <b>Magnetic Resonance Angiography (MRA) – Outpatient</b> (not required for emergency room)  <b>Magnetic Resonance Imaging (MRI) – Outpatient</b> (not required for emergency room)  <b>Nuclear Cardiology – Outpatient</b> (not required for emergency room)  <b>Physical and Occupational Therapy Visit</b> (beyond the benefit maximums stated in Section 4)  <b>Positron Emission Tomography (PET)</b>  <b>Routine Care Associated With Clinical Trials</b>  <b>Stereotactic Radiosurgery Utilizing Particle Beams</b>  <b>Surgery for Hyperhidrosis</b>  <b>Surgery to Correct Morbid Obesity</b>  <b>Surgeries, therapies or procedures employing new technology or representing a new application of existing technology</b>  <b>Treatment of Hepatitis C with combined Interferon (including Peginterferon) and Ribavirin Therapy</b></p> <p><b>ORGAN AND TISSUE TRANSPLANTS</b> (<i>your provider may contact HMA for you to obtain authorization</i>)  <b>Transplant Evaluations</b>  <b>Allogeneic Bone Marrow Transplant</b>  <b>Autologous Bone Marrow Transplant</b>  <b>Heart Transplant</b>  <b>Heart/Lung Transplant</b>  <b>Liver Transplant</b>  <b>Lung Transplant</b>  <b>Simultaneous Kidney/Pancreas Transplant</b></p> <p><b>Small Bowel and Multivisceral Transplant</b> (<i>call HMA</i>)</p>	<p>Call HMA: (808) 951-4621</p> <p>For neighbor islands: (866) 377-3977</p> <p><b>PLEASE NOTE: If services do not meet payment determination criteria, no benefits are available</b></p>

## Section 6: Services Not Covered

### **ABOUT THIS SECTION**

Your health care coverage does not provide benefits for certain procedures, services or supplies that are listed in this Section. For your convenience, we divided this Section with category headings. These category headings will help you find the information you are looking for. Actual exclusions are listed below category headings.

***Please note:*** Even if a service or supply is not specifically listed as an exclusion, it will not be covered unless it is described in *Section 4: Description of Benefits*, and it meets all of the criteria described in *Section 1: Important Information under Questions We Ask When You Receive Health Care*.

If you are unsure if a specific procedure, service or supply is covered or not covered, please call us, and we will assist you. For your convenience, we list our telephone numbers on the front cover of this Summary.

### **COUNSELING SERVICES – Not Covered**

#### **Bereavement Counseling**

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

#### **Genetic Counseling**

You are not covered for genetic counseling.

#### **Marriage or Family Counseling**

You are not covered for marriage and family counseling or other training services.

#### **Sexual Identification Counseling**

You are not covered for sexual identification counseling.

### **COVERAGE UNDER OTHER PROGRAMS OR LAWS – Not Covered**

#### **Payment Responsibility**

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

#### **Military**

You are not covered for treatment of illness or injury related to military service when you receive treatment in a hospital operated by an agency of the United States government. You are not

covered for services or supplies that are required to treat an illness or injury received while you are on active status in the military service.

### **Third Party Reimbursement**

Except as outlined in *Section 9: Third Party Liability Rule*, you are not covered for an injury or illness: caused or alleged to be caused by a third party; or for which you have or may have a right to receive payment, or recover damages, with or without regard to fault, from a person or entity other than the Plan.

### **DENTAL, DRUG, and VISION – Not Covered**

#### **Dental Care**

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

- Orthodontics.
- Dental splints and other dental appliances.
- Dental prostheses.
- Maxillary and mandibular implants (osseointegration) and all related services.
- Removal of impacted teeth.
- Any other dental procedures involving the teeth, gums and structures supporting the teeth.
- Any services in connection with the treatment of TMJ (temporomandibular joint) problems or malocclusion of the teeth or jaws. The initial visit to diagnose TMJ disorder will be covered.

#### **Drugs**

You are not covered for prescription drugs except as stated in *Section 4: Description of Benefits*. Benefits are never available for prescription drugs that have an over-the-counter equivalent.

#### **Eyeglasses and Contacts**

You are not covered for the following:

- Sunglasses.
- Prescription inserts for diving masks or other protective eyewear.
- Nonprescription industrial safety goggles.
- Nonstandard items for lenses including tinting and blending.
- Oversized lenses, and invisible bifocals or trifocals.
- Repair and replacement of frame parts and accessories.
- Eyeglass lenses and contact lenses, except as described in *Section 4: Description of Benefits* under *Other Medical Services and Supplies, Prosthetics and Orthotics*.

- Exams for a fitting or prescription (including vision exercises).
- Frames.

### **Vision Services**

You are not covered for:

- Refractive eye surgery to correct visual acuity problems.
- Replacement of lost, stolen or broken lenses, contact lenses or frames.
- Vision training.
- Aniseikonic studies and prescriptions.
- Reading problem studies or other procedures determined to be special or unusual.

### **Experimental or Investigative Treatment**

You are not covered for medical treatments, procedures, drugs, devices, or care, and all related services or supplies (except for routine care described as covered in Section 4 of this Summary), that are experimental or investigational. A medical treatment, procedure, drug, device, or care is experimental or investigative if:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and FDA approval for marketing for the proposed use has not been given at the time the drug or device is furnished, unless the off-label use is listed as an approved/accepted indication in the USPDI (United States Pharmacopeial Drug Information), AHFS (American Hospital Formulary Service Drug Information), or the Participant demonstrates that the weight of the scientific evidence establishes the medical necessity of the drug for treatment of the Participant's condition; or
- The drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
- Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is for the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy compared with a standard means of treatment or diagnosis.

***Reliable Evidence*** shall mean only:

- published reports and articles in authoritative medical and scientific literature;
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or

- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

## **FERTILITY and INFERTILITY – Not Covered**

### **Contraceptives**

You are not covered for contraceptive foams, creams, condoms, or other non-prescription substances or supplies used individually or in conjunction with any other prescribed drug or device.

### **Infertility Diagnosis**

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

### **Infertility Treatment**

Except as described in *Section 4: Description of Benefits* under Special Benefits for Employee and Spouse, you are not covered for services or supplies related to the treatment of infertility, including but not limited to:

- Collection, storage and processing of semen.
- In vitro fertilization benefits when services of a surrogate are used.
- Cost of donor oocytes and donor semen.
- Any donor-related services, including but not limited to collection, storage and processing of donor oocytes and donor semen.
- Ovum transplants.
- Gamete intrafallopian transfer (GIFT).
- Zygote intrafallopian transfer (ZIFT).
- Services related to conception by artificial means, including prescription drugs related to such services except as described in *Section 4: Description of Benefits* under *Special Benefits for Employee and Spouse*.

### **Sterilization Reversal**

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

## **PREVENTIVE and ROUTINE – Not Covered**

### **Immunizations**

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

### **Routine Foot Care**

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

## **PROVIDER TYPE – Not Covered**

### **Complementary and Alternative Medicine Provider**

You are not covered for services or supplies provided by complementary and alternative medicine providers, including but not limited to naturopathic and homeopathic care providers, acupuncturists, and massage therapists.

### **Chiropractor**

You are not covered for services or supplies provided by a chiropractor.

### **Hospice (Nonparticipating)**

You are not covered for hospice services provided by a nonparticipating hospice agency.

### **Provider Is an Immediate Family Member**

You are not covered for professional services or supplies when furnished to you by a provider who is within your immediate family. Immediate Family means a parent, child, spouse, or yourself.

### **Physician Assistant**

You are not covered for services and supplies received from a physician assistant unless he or she is employed by a medical group, M.D. or D.O.

### **Private Duty Nursing**

You are not covered for private duty nursing.

### **Social Worker**

You are not covered for services and supplies received from a social worker. This exclusion does not apply to covered mental health or substance abuse services.

## **TRANSPLANTS – Not Covered**

### **Living Organ Donor Services**

You are not covered for organ donor services if you are the organ donor.

### **Living Donor Transport**

You are not covered for expenses of transporting a living donor.

### **Mechanical or Non-Human Organs**

You are not covered for mechanical or non-human organs.

### **Organ Purchase**

You are not covered for the purchase of any organ.

### **Transplant Services or Supplies**

You are not covered for transplant services or supplies or related services or supplies other than those described in *Section 4: Description of Benefits* under Organ and Tissue Transplants. Related Transplant Supplies are those that would not meet payment determination criteria but for your receipt of the transplant, including, and without limitation, all forms of bone marrow or peripheral stem cell transplants.

## **MISCELLANEOUS EXCLUSIONS**

### **Act of War**

You are not covered for services received for injuries or illnesses due to an act of war

### **Acupuncture**

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

### **Airline Oxygen**

You are not covered for airline oxygen.

### **Biofeedback**

You are not covered for biofeedback and any related diagnostic testing.

### **Bionic Devices**

You are not covered for bionic services or devices.

### **Blood**

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

### **Carcinoembryonic Antigen (CEA)**

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

### **Cardiac Rehabilitation**

You are not covered for cardiac rehabilitation services.

### **Cosmetic Services, Surgery or Supplies**

You are not covered for cosmetic services or supplies that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function.

### **Chemotherapy (High-dose)**

You are not covered for high-dose chemotherapy except as described in *Section 4: Description of Benefits* under *Bone Marrow Transplants*.

### **Complications of a Non-Covered Procedure**

You are not covered for complications of a non-covered procedure.

### **Custodial Care**

You are not covered for custodial care, sanatorium care, or rest cures. Custodial Care consists of training in personal hygiene, routine nursing services, and other forms of personal care, such as help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Also excluded are supervising services by a physician or nurse for a person who is not under specific medical, surgical, or psychiatric treatment to improve that person's condition and to enable that person to live outside a facility providing this care.

### **Developmental Delay**

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

### **Ductal Lavage**

You are not covered for ductal lavage.

### **Effective Date**

You are not covered for services or supplies that you receive before the effective date of your coverage under this Plan.

### **Electron Beam Computed Tomography (EBCT or Ultrafast CT)**

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

### **Environmental Control Equipment and Supplies**

You are not covered for environmental control equipment 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.

### **Enzyme-potentiated Desensitization**

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

### **Erectile Dysfunction**

You are not covered for services and supplies (including prosthetic devices) related to erectile dysfunction except if due to an organic cause. This includes, but is not limited to, penile implants. You are not covered for drug therapies related to erectile dysfunction except certain injectables approved by us and only to treat erectile dysfunction due to an organic cause.

### **Extracorporeal Shock Wave Therapy**

You are not covered for extracorporeal shock wave therapy except for the treatment of kidney stones.

### **False Statements**

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

### **Foot Orthotics**

You are not covered for foot orthotics except for specific diabetic conditions.

### **Genetic Testing and Screening**

You are not covered for genetic testing and screening except as stated in *Section 4: Description of Benefits* under *Testing, Laboratory, and Radiology*.

### **Growth Hormone Therapy**

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

### **Hair Loss**

You are not covered for services or supplies, including hair transplants and topical medications, related to the treatment of baldness or hair loss regardless of condition.

### **Hypnotherapy**

You are not covered for hypnotherapy.

### **Intradiscal Electro Thermal Therapy (IDET)**

You are not covered for intradiscal electro thermal therapy.

### **Motor Vehicles**

This plan does not cover the cost of purchase or rental of motor vehicles such as cars and vans. You are also not covered for equipment and costs associated with converting a motor vehicle to accommodate a disability.

### **Personal Convenience Items and Supplies**

You are not covered for personal convenience items such as ramps, home remodeling, hot tubs, swimming pools, or personal convenience supplies such as surgical stockings and disposable underpads.

### **Radiation (Nonionizing)**

You are not covered for treatment with nonionizing radiation.

### **Radiation (High-dose)**

You are not covered for high-dose radiotherapy except as described in *Section 4: Description of Benefits* under *Bone Marrow Transplants*.

### **Self-Help or Self-Cure**

You are not covered for self-help and self-cure programs or equipment.

### **Sexual Transformation**

You are not covered for services and supplies related to sexual transformation regardless of cause. This includes, but is not limited to, sexual transformation surgery.

### **Stand-by Time**

You are not covered for a provider's waiting or stand-by time.

### **Supplies**

You are not covered for take home supplies or supplies billed separately by your provider when the supplies are integral to services being performed by your provider.

### **Thoracic Electric Bioimpedance (Outpatient)**

You are not covered for outpatient thoracic electric bioimpedance.

### **Topical Hyperbaric Oxygen Therapy**

You are not covered for topical hyperbaric oxygen therapy.

### **Travel or Lodging Cost**

You are not covered for the cost of travel or lodging.

### **Vertebral Axial Decompression (VAX-D)**

You are not covered for vertebral axial decompression.

### **Vitamins, Minerals and Food Supplements**

You are not covered for vitamins, minerals or food supplements except as described in *Section 4: Description of Benefits* under *Other Medical Services and Supplies*.

### **Weight Reduction Programs**

You are not covered for weight reduction programs and supplies (including dietary supplements, food, equipment, laboratory testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

### **Wigs**

You are not covered for wigs and artificial hairpieces.

## Section 7: Filing Claims

### **WHEN TO FILE CLAIMS**

#### **Submit within 90 Days**

All participating and most nonparticipating providers in the State of Hawaii file claims for you. If your nonparticipating provider does not file for you, please submit an itemized bill or receipt within 90 days of the last day on which you received services listing the services you received. No payment will be made on any claim received by us more than one year after the last day on which you received services. If you have any questions after reading this section, please contact your personnel department, or call us at (808) 951-4621 or Neighbor Islands may call (866) 377-3977.

### **HOW TO FILE CLAIMS**

#### **One Claim Per Person and Per Provider**

File a separate claim for each covered family member and each provider.

You should follow the same procedure for filing a claim for services received in- or out-of-state or out-of-country.

### **WHAT INFORMATION YOU MUST FILE**

#### Subscriber Number

The subscriber number which appears on your ID card.

#### **Provider Statement**

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

The provider statement must include:

- Provider's full name and address.
- Patient's name.
- Date(s) you received service(s).
- Date of the injury or beginning of illness.
- The charge for each service in U.S. currency.
- Description of each service.
- Diagnosis or type of illness or injury.
- Where you received the service (office, outpatient, hospital, etc.).

- If applicable, information about other health coverage you may have.

### **Telephone Number**

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

### **Signature**

Make sure you sign the claim.

## **OTHER CLAIM FILING INFORMATION**

### **Where to Send Claim**

Send your claim to:

EUTF  
HMA, INC.  
P.O. Box 135005  
Honolulu, HI 96801

### **Keep a Copy**

You should keep a copy of the information provided to us for your records. Information provided to us may not be returned to you.

### **Explanation of Benefits**

Once we receive and process your claim, we will send you a report explaining your benefits. The *Explanation of Benefits* tells you how we processed the claim including services performed, the actual charge, and any adjustments to the actual charge, our eligible charge, the amount we paid, and the amount you owe.

If any part of your claim is denied, our report will provide an explanation for the denial.

If, for any reason, you believe we wrongly denied a claim or coverage request, please call us for assistance. For your convenience, our phone numbers appear on page 1 of this Summary. If you are not satisfied with the information you receive, and you wish to pursue a claim for coverage, you may request an appeal. See *Section 8: Dispute Resolution*.

### **Cash or Deposit any Benefit Payment in a Timely Manner**

If a check is enclosed with your Explanation of Benefits, you must cash or deposit the check before the check's expiration date. If you ask us to reissue the expired check, you will be assessed a service charge.

## Section 8: Dispute Resolution

### **YOUR REQUEST FOR AN APPEAL**

#### **Writing Us to Request an Appeal**

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

Address Written Requests to:

HMA, INC.  
Attn: Appeals Department  
P.O. Box 135005  
Honolulu, HI 96801

Or, send us a fax at:  
(808) 951-4620

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

We will respond to your appeal within 60 calendar days of our receipt of your appeal.

#### **Expedited Appeal**

You may request expedited appeal if application of the time periods for appeals above may:

- Seriously jeopardize your life or health, or
- Seriously jeopardize your ability to gain maximum functioning, or
- Subject you to severe pain that cannot be adequately managed without the care, or treatment that is the subject of the appeal.

We will respond to your request for expedited appeal as soon as possible taking into account your medical condition but not later than 72 hours of our receipt of your request.

#### **Who Can Request an Appeal**

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

- Any person you authorize to act on your behalf provided you follow our procedures which include filing a form with us. To obtain a form to authorize a person to act on your behalf, call us at:

(808) 951-4621 or toll free at (866) 377-3977

(Requests for appeal from an authorized representative who is a physician or practitioner must be in writing unless requesting expedited appeal.)

- A court appointed guardian or an agent under a health care proxy.

### **What Your Request Must Include**

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

- The date of your request.
- Your name.
- The date of the service we denied (in the case of prior authorization for a service or supply, the date of our denial of coverage for such service or supply), or the date of our action or decision that you dispute.
- The subscriber number from your ID card.
- The provider name.
- A description of facts related to your request and why you believe our action or decision was in error.
- Any other information relating to your appeal including written comments, documents, and records you would like us to review.

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

### **Requesting a Review of the Appeal**

If you disagree with HMA's appeal decision and would like to appeal, you must appeal the decision to the EUTF Board of Trustees by submitting a written request to:

EUTF Appeals  
201 Merchant Street, Suite 1520  
Honolulu, Hawaii 96813

Your written request should include the following information:

- Your name, mailing address, and telephone number,
- A description of the decision that you are appealing,
- A statement of all the facts relevant to your appeal,
- A statement of all the reasons that support your appeal and
- A description of the relief that you are seeking.

In your written request, you may request expedited review of your appeal, if a delay in review could:

- Seriously jeopardize your life or health
- Seriously jeopardize your ability to regain maximum functioning, or
- In the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the care of treatment that is the subject of your appeal.

Upon receiving your written request, the EUTF will advise you as to the procedures for further handling of your appeal. Your appeal initially may be handled by a hearing officer designated by the EUTF Board of Trustees.

If you disagree with the decision of the EUTF Board of Trustees and would like to appeal, you must appeal that decision to the Hawaii Circuit Court. If you file any appeal from the decision of the EUTF Board of Trustees in the Hawaii Circuit Court, on the date of filing that appeal, you shall notify HMA that your appeal has been filed by mailing a copy of your appeal to HMA at the following address: HMA, INC. Attn: Appeals Department, P. O. Box 135005, Honolulu, HI 96801.

The procedures set forth in this Section 8 on Dispute Resolution shall be the sole remedy for disputing a determination made by HMA related to coverage, reimbursement or any other decision or action by HMA, or any other matter related to this Plan. You shall not have any right of action against HMA in litigation or arbitration related to these disputes and any such claims shall be null and void. Any appeal filed by you pursuant to these procedures shall not name HMA as a party to the appeal.

## Section 9: Coordination of Benefits and Third Party Liability

### WHAT COORDINATION OF BENEFITS MEANS

#### Coverage that Provides Same or Similar Coverage

You may have other insurance coverage that provides benefits which are the same or similar to this plan. If so, the benefits payable under this plan, when combined with benefits paid under your other coverage, will not exceed the lesser of:

- 100 percent of eligible charge, or
- the amount payable by your other coverage plus any deductible and copayment you would owe if the other coverage were your only coverage.

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

The method we use to calculate our eligible charge may be different from the methods of other plans. For a description of how we determine our eligible charge, see *Section 2: Payment Information*.

#### What You Should Do

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

- group insurance.
- other group benefits plans.
- nongroup insurance.
- Medicare or other governmental benefits.
- the medical benefits coverage in your automobile insurance (whether issued on a fault or no fault basis).

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

You will receive a letter from us if we need additional information. If you do not give us information we need to coordinate your benefits, your claims may be delayed or denied.

To help us coordinate your benefits, you should:

- inform your provider by giving him or her information about the other coverage at the time services are rendered, and
- indicate that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form.

## **What We Will Do**

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

## **GENERAL COORDINATION RULES**

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

### **No Coordination Rules**

The coverage without coordination of benefits rules pays first.

### **Employee Coverage**

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

### **Active Employee Coverage**

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

### **Earliest Effective Date**

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

### **Limitation On Benefits**

After applying the coordination rules to determine which plan pays first and which plan pays second, if it is determined that this plan pays second, this plan's payment will not exceed the amount this plan would have paid if it had been your only coverage.

## **DEPENDANT CHILDREN COORDINATION RULES**

### **Birthday Rule**

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

### **Court Decree Stipulates**

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

## **Court Decree Does Not Stipulate**

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

- custodial parent.
- spouse of custodial parent.
- other parent.
- spouse of other parent.

## **Earliest Effective Date**

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

## **MOTOR VEHICLE INSURANCE RULES**

### **Automobile Coverage**

If your injuries or illness are due to a motor vehicle accident or other event for which we believe motor vehicle insurance coverage reasonably appears available under Hawaii Revised Statutes Chapter 431, Article 10C, then that motor vehicle coverage will pay before this coverage.

You are responsible for any cost sharing payments required under any such motor vehicle insurance coverage. We do not cover such cost sharing payments.

Before we pay benefits under this coverage for an injury covered by motor vehicle insurance, you must provide us a list of medical expenses paid by the motor vehicle insurance. The list must show the date expenses were incurred, the provider of service, and the amount paid by motor vehicle insurance.

We will review the list of expenses to verify that the motor vehicle insurance coverage available under Hawaii Revised Statutes Chapter 431, Article 10C is exhausted. Upon our verification of exhaustion, you are eligible for covered services in accord with this Summary of Benefits.

Please note that in the following two situations, you are also subject to the Third Party Liability Rules described at the end of this section: (1) if your injury or illness is or may have been caused by someone else and you have or may have a right to recover damages or receive payment in connection with the illness or injury, or (2) if you have or may have a right to recover damages or receive payment for the injury or illness without regard to fault (other than through coverage available under Hawaii Revised Statutes Chapter 431, Article 10C).

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

## **MEDICARE COORDINATION RULES**

### **Medicare as a Secondary Payer**

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

### **If You Are Age 65 or Older**

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

### **If You Are Under Age 65 With Disability**

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

### **If You Are Under Age 65 With End-Stage Renal Disease (ESRD)**

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

### **Dual Medicare Eligibility**

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

### **This Plan Secondary Payer to Medicare**

If you are covered under both Medicare and this plan, and Medicare is allowed by law to be the primary payer, coverage under this plan will be reduced by the amount of benefits paid by Medicare for the same covered services. Except as provided below, we will cover any remaining Medicare copayments and deductibles. Benefits under this plan will be paid up to either the Medicare approved charge for services rendered by a Medicare participating provider, or the lesser of our eligible charge or the limiting charge (as defined by Medicare) for services rendered by a provider that does not participate with Medicare.

## **Exhaustion of Medicare Benefits**

If you are entitled to Medicare benefits, we will begin paying benefits after all Medicare benefits (including all lifetime reserve days) are exhausted.

If your inpatient hospital stay is extraordinarily long and costly and some or all of the stay is not covered by Medicare because your Medicare inpatient hospital benefits (including lifetime reserve days) are exhausted, we will pay the lesser of:

- the eligible charge for the entire confinement less Medicare inpatient hospital payments and Medicare Part B payments for inpatient lab, diagnostic and x-ray services on those days; or
- total hospital charges for inpatient days for which Medicare rules permit the hospital to bill you less Medicare Part B payments for inpatient lab, diagnostic and x-ray services on those days.

## **Medicare Part B Only**

If you have coverage under Medicare Part B only, we will pay inpatient benefits based on our eligible charge less any Medicare Part B benefits for inpatient lab, diagnostic and x-ray services.

## **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 payer, we will limit payment to an amount that supplements the benefits that would have been payable by Medicare had the facility or provider been eligible or entitled to receive such payments, regardless of whether or not Medicare benefits are paid.

## **THIRD PARTY LIABILITY RULES**

### **What Third Party Liability Means**

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

- the illness or injury is caused or may have been caused by someone else and you have or may have a right to recover damages or receive payment in connection with the illness or injury; or
- you have or may have a right to recover damages or receive payment for the injury or illness without regard to fault.

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

## **If You Have Coverage Under Worker's Compensation Or Motor Vehicle Insurance**

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

- **Worker's Compensation Insurance.** If you have or may have coverage under worker's compensation insurance, such coverage will apply instead of the coverage under this Summary of Benefits. Medical expenses arising from injuries or illness covered under worker's compensation insurance are excluded from coverage under this Summary of Benefits.
- **Motor Vehicle Insurance.** If you are or may be entitled to medical benefits from your automobile coverage, you must exhaust those benefits first, before receiving benefits from us. Please refer to the section in this Chapter entitled "Motor Vehicle Insurance Rules" for a detailed explanation of the rules applicable to your automobile coverage.

## **What You Need To Do**

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

- **Give Us Timely Notice.** You must give us timely notice in writing of each of the following: (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. To give timely notice, your notice must be no later than 30 calendar days after the occurrence of each of the events stated above;
- **Sign Requested Documents.** You must promptly sign and deliver to us all liens, assignments, and other documents we deem necessary to secure our rights to recover payments, and 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 necessary to discharge your reimbursement obligations described above;
- **Provide Us Information.** You must promptly provide us any and all information reasonably related to our investigation of our liability for coverage and our determination of our rights to recover payments. We may ask you to complete an Injury/Illness report form, and provide us medical records and other relevant information.
- **Do Not Release Claims Without Our Consent.** You must not release, extinguish, or otherwise impair our rights to recover our payments, without our express written consent; and

- Cooperate With Us. You must cooperate in protecting our rights under these rules. This includes giving notice of our lien as part of any written claim or demand made against any third party or other source of recovery in connection with the illness or injury.

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

HMA, INC.  
Attn: TPL/Subrogation  
P.O. Box 135005  
Honolulu, HI 96801

or faxed to (808) 951- 4620

If you have any questions regarding these Rules, call the HMA office at (808) 951-4621 or Neighbor Islands may call (866) 377-3977.

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

### **Payment of Benefits Subject To Our Right To Recover Our Payments**

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

- settlement, judgment, or award;
- motor vehicle insurance including liability insurance or your underinsured or uninsured motorist coverage;
- workplace liability insurance;
- liability, property and/or casualty insurance;
- medical malpractice coverage; or
- any other applicable 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):

- do not specifically include medical expenses;
- are stated to be for general damages only;
- are for less than the actual loss or alleged loss suffered by you due to the injury or illness;

- are obtained on your behalf by any person or entity, including your estate, legal representative, parent, or attorney; are without any admission of liability, fault, or causation by the third party or payor.

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

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

To the extent that we are not reimbursed for the total benefits we pay or have paid related to your illness or injury, we have a right of subrogation (substituting us to your rights of recovery) for all causes of action and all rights of recovery you have against any third party or other source of recovery in connection with the illness or injury.

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

For any payment made by us under these rules, you are still responsible for your copayments, deductibles, timeliness in submission of claims, and other obligations under this Summary of Benefits.

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

## Section 10: General Provisions

### **WHEN COVERAGE ENDS**

#### **Notifying Us When Your Child's Eligibility Ends**

You must inform the Trust Fund, in writing, if a child covered under the Plan no longer meets the eligibility requirements. You must notify the Trust Fund on or before the first day of the month following the month the child no longer meets the requirements. For example, let's say that your child graduates from college on June 1. You would need to notify the Trust Fund by July 1.

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

#### **Notifying Us When Other Dependents' Eligibility Ends**

You must inform the Trust Fund, in writing, if other events occur that terminate coverage of other dependents covered by the Plan, such as divorce or the dissolution of a domestic partnership. If you fail to inform us that any of your dependents is no longer eligible, and we make payments for services on his or her behalf, you must reimburse us for the amount we paid.

#### **Termination for Fraud**

Your eligibility for coverage will terminate immediately if you use this coverage fraudulently or you misrepresent or conceal material facts. If your coverage is terminated for fraud, misrepresentation, or the concealment of material facts:

We will not pay for any services or supplies provided after the date the coverage is terminated. You agree to reimburse us for any payments we made under this coverage.

We will retain our full legal rights. This includes the right to initiate a civil action based on fraud, concealment or misrepresentation.

### **CONFIDENTIAL INFORMATION**

Your medical records and information about your care is confidential. HMA does not use or disclose your medical information except as permitted or required by law. You may be required to provide information to us about your medical treatment or condition. In accordance with law, we may use or disclose your medical information (including providing this information to third parties) for the purposes of payment activities and health care operations such as quality assurance, disease management, provider credentialing, administering the plan, complying with government requirements, and research or education.

## **TERMS OF COVERAGE**

### **Terms of Coverage**

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

### **Authority to Terminate, Amend, or Modify Coverage**

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

### **Governing Law**

To the extent not superseded by the laws of the United States, this coverage will be construed in accord with and governed by the laws of the State of Hawaii. Any action brought because of a claim against this coverage will be litigated in the state or federal courts located in the State of Hawaii and in no other.

### **Payment in Error**

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

### **Non-Assignment of Benefits**

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

### **Notice Address**

You may send any notice required by this section to:

HMA, INC.  
Attn: Enrollment Department  
P.O. Box 135005  
Honolulu, HI 96801

or fax to (808) 951-4620

Any notice from us will be acceptable when addressed to you at your address as it appears in our records.

## Section 11: Glossary

Actual Charge	The amount a provider actually bills for a covered service or supply.
Acute Care	Inpatient 24-hour hospital care that requires physician and nursing observations on a minute-to-minute, hour-to-hour basis.
Admission	The formal acceptance of a patient into a facility for a medical, surgical, or obstetrical condition.
Alcohol Dependence	Any use of alcohol that produces a pattern of pathological use causing impairment in social or occupational functioning or produces physiological dependency evidenced by physical tolerance or withdrawal.
Allogeneic Transplant	Transplant in which the tissue or organ for a transplant is procured from someone other than the person receiving the transplant.
Ambulance Service	Local air or ground emergency transportation to a hospital or nursing facility in the surrounding area where your transportation began.
Ambulatory Surgical Center	A facility that provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed.
Anesthesia	The administration of anesthetics to produce loss of feeling or consciousness, usually in conjunction with forms of medical treatment such as surgery.
Ancillary Services	Facility charges other than room or board. For example, charges for inpatient drugs and biologicals, dressings, or medical supplies.
Annual Copayment Maximum	The maximum amount you pay for most covered services in a benefit period. The copayment maximum is reached from applicable deductible and copayment amounts you pay in any given calendar year.
Annual Deductible	The fixed dollar amount you pay each calendar year before benefits become available for certain services.
Autologous Transplant	Transplant in which the tissue or organ for a transplant is procured from the person receiving the transplant.
Benefit Maximum	The maximum benefit amount allowed for certain covered services. A benefit maximum may limit the dollar amount, the duration, or the number of visits for covered services.
Benefits	Those medically necessary services and supplies that qualify for payment under this Plan.
Biofeedback	Biofeedback is a technique in which a person uses information about a normally unconscious body function, such as blood pressure, to gain conscious control over that function. The condition to be treated must be a normally unconscious physiological function. A device or feedback monitoring equipment (i.e., external feedback loop) must be used in the treatment of the condition. The purpose of treatment is to exert control over that physiological function.

Biological Therapeutics and Biopharmaceuticals	Biological therapeutics and biopharmaceuticals are any biology-based therapeutics that structurally mimic compounds found within the body. This includes recombinant proteins, monoclonal and polyclonal antibodies, peptides, antisense oligonucleotides, therapeutic genes, and certain therapeutic vaccines.
Bionic Device	Electronic or electromechanical devices which replace missing body parts and/or which enhance one's existing strength and ability.
Blood Transfusion	Transferring blood products such as blood, blood plasma, and saline solutions into a blood vessel, usually a vein.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 which offers you and your eligible dependents continuation of this coverage if you lose coverage due to a qualifying event.
Calendar Year	The period beginning January 1 and ending December 31 of any year. The first calendar year for anyone covered by this plan begins on that person's effective date and ends on December 31 of that same year.
Chemotherapy	Treatment of infections or malignant diseases by drugs that act selectively on the cause of the disorder, but which may have substantial effects on normal tissue.
Child	Means any of the following: your natural child, your legally adopted child, your stepchild, a foster child, a child for whom you or your spouse or domestic partner is the court-appointed guardian, a minor child who has been adopted or placed with the Employee for adoption.
Chiropractor	A health care professional who practices the system of healing through spinal manipulation and specific adjustment of body structures.
Claim	A written request for payment of benefits for services covered by the Plan as described in this Summary of Benefits.
Consultation Services	A formal discussion (deliberation) between physicians on a case or its treatment.
Contact Lenses	Ophthalmic corrective lenses ground as prescribed by a physician or optometrist who fit the lenses directly to your eyes.
Contraceptive Services	Services intended to promote the effective use of prescription contraceptives supplies or devices to prevent pregnancy.
Contraceptives	Any oral contraceptives or contraceptive devices that prevent impregnation.
Coordination of Benefits (COB)	Applies when you are covered by more than one group coverage or commercial insurance policy providing benefits for like services.
Copayment	Applies to most covered services and is either a fixed percentage of the eligible charge or a fixed dollar amount. The amount you pay to help share the costs of your medical care. Your copayment applies each time you receive most covered services.
Cosmetic Services	Services that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function, or are prescribed for psychological or psychiatric reasons.
Covered Services	Services or supplies which meet payment determination criteria and are listed in this Summary in Chapter 4: Description of Benefits.

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.
Day Treatment Services	Treatment services provided by a hospital, mental health outpatient facility, or nonhospital facility to patients who, because of their condition, require more than periodic hourly service.
Deductible	The fixed dollar amount you pay for certain covered services before benefits are available in a calendar year.
Dependent	The Employee's spouse or domestic partner, and/or child(ren) who are eligible to enroll in the Plan under Chapter 87A, Hawaii Revised Statutes, and the Trust Fund's administrative rules, as the same may be amended from time to time.
Diagnosis	The medical description of the disease or condition.
Diagnostic Testing	A measure used to help identify the disease process and signs and symptoms.
Drug	Any chemical compound that may be used on or administered as an aid in the diagnosis treatment, or prevention of disease or other abnormal condition, for the relief of pain or suffering, or to control or improve any physiologic or pathogenic condition.
Drug Dependence	Any pattern of pathological use of drugs causing impairment in social or occupational functioning and producing psychological or physiological dependency or both, evidenced by physical tolerance or withdrawal.
Dues	The monthly premium amount for HMA participation.
Durable Medical Equipment	An item that meets the following criteria: It is durable enough to withstand repeated use. It is primarily and customarily manufactured to serve a medical purpose. It is not useful in the absence of illness or injury. Examples include wheelchairs, walkers, and crutches.
Effective Date	The date upon which you are first eligible to receive benefits under the coverage of this Plan.
Eligible Charge	The amount upon which your copayment is based. This amount is always the lower of the actual charge or the maximum allowable fee.
Emergency	When a prudent layperson could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child); 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ part.
Employee	An active employee or retiree who is eligible to enroll in the Plan under Chapter 87A, Hawaii Revised Statutes, and the Trust fund's administrative rules, as the same may be amended from time to time.
Experimental or Investigative Treatment	Services, supplies, devices, procedures, drugs or treatment that are not yet accepted as common medical practice. For a detailed definition, see Section 6: Services Not Covered.
Facility	Examples of facilities include hospitals, skilled nursing facilities, and ambulatory surgical facilities.

False Statement	Any misrepresentation that you made in any claims for benefits.
Family Member	The Retiree's spouse or domestic partner, and child(ren) who are eligible and enrolled in the Plan.
Frame	A standard plastic eyeglass frame or similar frame into which two lenses are fitted.
HMA	Health Management Associates.
HMA Directory of Participating Providers	A complete listing of HMA participating providers.
HMA Participating Provider	A provider that contracts with HMA, files claims for you, accepts eligible charge as payment in full, and handles prior authorization for you.
HMA Select Prescription Drug Formulary	A book published by HMA which contains a list of drugs by therapeutic category, cost and benefits.
High-Dose Chemotherapy	A form of chemotherapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a bone marrow transplant is required or warranted.
High-Dose Radiotherapy	A form of radiation therapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a bone marrow transplant is required or warranted.
Homebound	Homebound means that due to an illness or injury, you are unable to leave home or that if you do leave your home, doing so requires a considerable and taxing effort.
Hospice Program	A program that provides care in a comfortable setting (usually the home) for patients who are terminally ill and have a life expectancy of six months or less.
Hospital	An institution that primarily provides diagnostic and therapeutic services for surgical and medical diagnosis treatment and care of injured or sick persons.
ID Card	Your ID card issued to you by us. You must present this card to your provider at the time you receive services.
Illness or Injury	Any bodily disorder, bodily injury, disease or condition (includes pregnancy and complications of pregnancy).
Immediate Family Member	Your child, spouse, parent, or yourself.
Immunization	An injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.
In Vitro Fertilization	A method of treating infertility in women.
Inhalation Therapy	Therapy to treat conditions of the cardiopulmonary system.
Injection	The introduction of a drug, biological therapeutic, biopharmaceutical, or vaccine into the body by using a syringe and needle.
Integrated Case Management	A program that emphasizes the specialized care needs of patients with severe or chronic illnesses or injuries.

Investigative or Experimental Treatment	Services, supplies, devices, procedures, drugs or treatment that is not yet accepted as common medical practice. For a detailed definition, see Section 6: Services Not Covered
Laboratory Services	Services used to help diagnose, prevent, or treat disease.
Lenses	Ophthalmic corrective lenses ground as prescribed by a physician or optometrist for fitting into a frame.
Mammogram	The x-ray examination of the breast using equipment dedicated specifically for mammography.
Mammography (screening)	An x-ray film that screens for breast abnormalities.
Maximum Allowable Fee	The amount we establish as the maximum amount HMA will pay toward covered services and supplies. HMA uses various methods to determine the maximum allowable fee.
Medicaid	A form of public assistance sponsored jointly by the federal and state governments providing medical assistance for eligible persons whose income falls below a certain level. The Hawaii Department of Human Services pursuant to Title XIX of the federal Social Security Act administers this program.
Medication	The treatment of disease by non-surgical means.
Medicine	The diagnosis and treatment of disease and maintenance of health.
Mental Health Outpatient Facility	A mental health establishment, clinic, institution, center, or community mental health center that provides for the diagnosis treatment, care or rehabilitation of mentally ill persons.
Mental Health Outpatient Facility	A mental health establishment, clinic, institution, center, or community mental health center that provides for the diagnosis treatment, care or rehabilitation of mentally ill persons.
Mental Illness/Disorder	A syndrome of clinically significant psychological, biological, or behavioral abnormalities that result in personal distress or suffering, impairment of capacity for functioning, or both. Mental illness and disorder are used interchangeably in this Summary and as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or in the International Classification of Disease.
Newborn	A recently born infant.
Newborn Care	All routine non-surgical physician services and nursery care provided to a newborn during the mother's initial hospitalization.
Non-Assignment	When benefits for covered services and supplies cannot be transferred or assigned to anyone for use.
Nonhospital Facility	A facility for the care or treatment of alcohol dependent, drug dependent, or mentally ill persons.
Nonhospital Residential Services	The provision of medical, psychological, nursing, counseling, or therapeutic services, by a nonhospital residential facility to patients suffering from alcohol dependence, drug dependence, or mental illness, according to individualized treatment plans.
Nonparticipating Providers	Providers that are not under contract with HMA.

Occupational Therapy	A form of rehabilitation therapy involving the treatment of neurological or musculoskeletal function through the use of specific tasks or goal-directed activities designed to improve the functional performance of an individual.
Optician	One who fits, adjusts and dispenses glasses and other optical devices, on the written prescription of a licensed physician or optometrist.
Optometrist	A practitioner who specializes in the examination, diagnosis, treatment and management of diseases and disorders of the visual system, the eye and associated structures.
Organ Donor Services	Services related to the donation of an organ.
Osteopathy	Medicine that specializes in diseases of the bone.
Osteoporosis	Demineralization of the bone.
Other Providers	Those health care providers other than facilities and practitioners. Examples include hospice agencies, ambulance services, retail pharmacies, home medical equipment suppliers, and independent labs.
Our	Refers to HMA (Health Management Associates).
Outpatient	Care received in a practitioner's office, the home, the outpatient department of a hospital or ambulatory surgery center.
Partial Hospitalization	Treatment services provided by a hospital or mental health outpatient facility to patients who, because of their condition, require more than periodic hourly service. A physician or licensed psychologist must prescribe partial hospitalization services.
Participant	An Employee and his or her Dependents who are eligible for and enrolled in the Plan.
Payment Determination Criteria	Care, treatment, service, or supply which is all of the following: 1) appropriate and necessary for the symptoms, diagnosis, and direct care or treatment of your illness or injury; 2) consistent with professionally recognized standards of health care in the United States, and given at the right time and in the right setting; 3) not primarily for your convenience or the convenience of your provider; and 4) the most appropriate supply or level of service that can safely be provided.
Physical Therapy	Therapy that helps restore a neurological or musculoskeletal function that was lost or impaired by injury or illness.
Physician	A medical doctor (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.).
Physician Assistant	A practitioner who provides care under the supervision of a physician.
Physician Services	Professional services necessarily and directly performed by a doctor in treatment of an injury or illness.
Plan	The health benefits plan, including hospital and medical coverage, described in this Summary to Benefits. The Plan is subject to Chapter 87A, Hawaii Revised Statutes, and the Trust Fund's administrative rules, as the same may be amended from time to time. The Trust Fund may modify or amend the terms and conditions of the Plan from time to time.
Postoperative Care	Care given following a surgical operation.

Postpartum	The period of time following childbirth.
Prior authorization	The process of obtaining approval for specified services and supplies. Failure to obtain our approval results in a penalty or denial of benefits. HMA participating providers agree to obtain approval for you. All other providers do not agree to obtain approval for you, you are responsible.
Preferred Provider Organization (PPO)	A health care program that offers you advantages when you receive services from contracting and participating providers.
Preoperative Care	Care that occurs, is performed, or is administered before, and usually close to, a surgical operation.
Prescription	The instructions written by a physician directing a pharmacist to dispense a particular drug in a specific dose.
Private Duty Nursing	24-hour nursing services by an approved nurse who is dedicated to one patient.
Provider	An approved physician or other practitioner, facility, or other health care provider such as an agency or program.
Psychological Testing	A standardized task used to assess some aspect of a person's cognitive, emotional, or adaptive functioning.
Psychologist	An approved provider who specializes in the treatment of mental health conditions.
Radiology	The use of radiant energy in the diagnosis and treatment of disease.
Registered Bed Patient	A person who is registered by a hospital or skilled nursing facility as an inpatient for an illness or injury covered by this Summary of Benefits.
Registered Dieticians	A health care professional who specializes in assessing and managing a person's diet in order to optimize a treatment program or to mitigate the effects of an illness or condition and holds the Registered Dietician (RD) credential issued by the Commission on Dietetic Registration.
Report to Participant	The report you receive in the mail from us that outlines how we applied benefits to a submitted claim.
Single Coverage	Coverage for the Employee only.
Skilled Nursing Facility	A facility that provides continuous skilled nursing services as ordered and certified by your attending physician.
Speech Therapy	Restoration of speech that was lost or impaired by injury or illness.
Spouse	Your husband or wife as the result of a marriage that is legally recognized in the State of Hawaii. For the purpose of this Summary of Benefits, "spouse" also includes an Employee's domestic partner who is eligible to enroll in the Plan under the Trust Fund's administrative rules, as same may be amended from time to time. Notwithstanding the terms of this Summary of Benefits, coverage of domestic partners is governed by Chapter 87A, Hawaii Revised Statutes, and the Trust Fund's administrative rules, as the same may be amended from time to time.

Stand by Time	Any period of time that is used for waiting, or is idle.
Subscriber Number	The number that appears on your HMA ID card.
Substance Abuse Services	The provision of medical, psychological, nursing, counseling, or therapeutic services in response to a treatment plan for alcohol or drug dependence or both. Services include, as appropriate, a combination of aftercare and individual, group and family counseling services.
Summary of Benefits	This document, along with any riders or amendments that provides a written description of your health care coverage. The terms of this Summary of Benefits is subject to Chapter 87A, Hawaii Revised Statutes, and the Trust Fund's administrative rules, as the same may be amended from time to time.
Third Party Liability	Our rights to reimbursement when you or your family members receive benefits under this coverage for an illness or injury and you have or may have a lawful claim against another party or parties for compensation, damages, or other payment.
Transplant	The transfer of an organ or tissue for grafting into another area of the same body or into another individual.
Treatment	Management and care of the patient for the purpose of combating disease or disorder.
Trust Fund	The Hawaii Employer-Union Health Benefits Trust Fund (EUTF). The Trust Fund has executed an agreement with HMA to administer the Plan covering Employees and Dependents.
Tubal Ligation	A sterilization procedure for women.
Us	HMA (Health Management Associates).
Vasectomy	A sterilization procedure for men.
Vision Services	Services that test eyes for visual acuity, and identify and correct visual acuity problems with lenses and other equipment.
We	HMA (Health Management Associates).
You and Your Family	You and your family members who are eligible for coverage under the Plan as described in this Summary of Benefits.