HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Option Plus *one*

Medical Plan Schedule of Benefits 2025

Annual Deductible $100 per person / $300 maximum per family

Out-of-Pocket Maximum (per calendar year, includes deductibles and copayments)

Participating Provider $600 per person / $1,800 per family

Non-Participating Provider $1,100 per person / $3,300 per family

Lifetime Maximum Unlimited

Benefit	Coinsurance/Copayment	
	Participating	Non-Participating
Hospital and Facility Services		
Ambulatory Surgical Center (ASC)	10%	20%
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Facilities)	10%	$200 (per first confinement in calendar year) + 20%*
Hospital Ancillary Services	10%	20%*
Hospital Room and Board	10%	$200 (per first confinement in calendar year) + 20%*
Outpatient Facility	10%	20%
Emergency Services and Urgent Care		
Emergency Room	10%	10%
Physician Visits	10%	10%
Urgent Care	$25	$50
Physician Services		
Physician Visits	10%	$10 + 20%
Hospital Visits	10%	$10 + 20%
Immunizations (standard, including travel)	None	30%
Online and Telephonic Care via HMAA's HiDoc® Service	None	Not Covered
Telehealth Services	Your deductible and copayment/coinsurance amounts vary depending on the type of service or supply. See copayment/coinsurance amounts listed in this chart for the service or supply you receive.	
Testing, Laboratory and Radiology		
Allergy Testing	$15 + 10%*	$25 + 20%*
Allergy Treatment Materials	$15 + 10%*	$25 + 20%*
Diagnostic Testing	10%	20%*
Laboratory and Pathology	10%	20%*
Radiology	10%	20%*
Chemotherapy and Radiation Therapy		
Chemotherapy — Infusion/Injections	10%*	20%*
Radiation Therapy	10%	20%*
Other Medical Services and Supplies		
Acupuncture, Chiropractic, Massage, and Naturopathic Services	10%	20%*
Ambulance (air or ground)	20%*	20%*
Blood and Blood Products	10%*	20%*
Dialysis and Supplies	10%*	20%*
Durable Medical Equipment and Supplies	10%*	20%*
Evaluations for Hearing Aids	10%*	20%*
Growth Hormone Therapy	10%*	20%*
Home IV Therapy	$5 + 10%	30%
Inhalation Therapy	10%*	20%*
Injections	10%*	20%*
Medical Foods	10%	20%
Orthotics and External Prosthetics	10%*	20%*
Vision and Hearing Appliances	10%*	20%*

* = Annual Deductible Applies | % = Coinsurance (Percentage based on eligible charge) | $ = Copayment (Fixed dollar amount)

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Benefit	Coinsurance/Copayment	
	Participating	Non-Participating
Rehabilitation Therapy		
Physical and Occupational Therapy		
Inpatient	10%	20%*
Outpatient	$5 + 10%*	30%*
Speech Therapy Services		
Inpatient	10%	20%*
Outpatient	$5 + 10%*	30%*
Special Benefits – Disease Management and Preventive Services		
Disease Management	None	Not Covered
Preventive Services — Laboratory	None	20%*
Preventive Services — Physical Exam	None	$10 + 20%*
Screening and Preventive Counseling	None	20%*
Special Benefits for Children		
Newborn Care	10%	20%*
Well Child Care Immunizations	None	None
Well Child Care Laboratory Tests	None	20%
Well Child Care Physician Office Visits	None	$10 + 20%
Special Benefits for Men		
Prostate Specific Antigen Test (screening)	10%	20%
Special Benefits for Women		
Breast Pump	None	None
Chlamydia Screening	None	20%*
Contraceptive Implants (generic)	None	30%
Contraceptive Injectables (generic)	None	30%
Contraceptive IUD (generic)	None	30%
In Vitro Fertilization	10%	20%
Mammography (screening)	None	20%
Maternity Care	10%	20%*
Pap Smears (screening)	None	20%
Pregnancy Termination	10%	20%
Tubal Ligation	None	20%
Well Woman Exam	None	20%
Special Benefits for Homebound, Terminal, or Long-Term Care		
Home Health Care	None	30%
Hospice Services	None	None*
Behavioral Health – Mental Health and Substance Abuse		
Hospital and Facility Services		
Inpatient	10%	$200 (per first confinement in calendar year) + 20%*
Outpatient	10%	20%
Physician Services		
Inpatient	10%	20%*
Outpatient	10%	$10 + 20%
Psychological Testing	10%	20%*

Special Offers

Employee Assistance Program (EAP)	Up to 6 fully-covered visits to assist subscribers with personal or family issues
Health and Wellness Programs	A variety of solutions for healthy living including Active&Fit®, Flu Prevention, Colorectal Cancer Screening, Baby & Me (our free maternity incentive program), and more
Member Plus Discount Program	Discounted prices and special offers from HMAA member groups and other participating merchants

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* = Annual Deductible Applies | % = Coinsurance (Percentage based on eligible charge) | $ = Copayment (Fixed dollar amount)

Note: Reimbursement is based on a percentage of HMAA's eligible charges, not the billed charges. Eligible charges may be based on a procedure fee schedule, a percentage of billed charges, per day (per diem) fees, per case fees, per treatment fees, or other methods. This document is intended to provide a condensed explanation of benefits. Please refer to the Description of Coverage (DOC) for details. In the case of a discrepancy between this document and the language contained within the DOC, the latter will take precedence.

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Option Plus One

Description of Coverage (DOC)

January 2025

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www.hmaa.com

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Summary of Plan Changes

Effective January 1, 2025

Questions? Contact our Customer Service Center at 808.941.HMAA or toll-free 888.941.HMAA 8 am to 4 pm HST Mon-Fri, or at hmaa.com/contact-us.

Change	Description of Change
General Changes (for clarification, practicality, consistency, and Federal/State compliance)	
Verbiage/Exception added for Clarification and Compliance with Federal Law (No Surprises Act ("NSA"))	Chapter 1: Important Information; Questions We Ask When You Receive Care; **From What Provider Category Did You Receive Care?** **Exception:** For certain out-of-network services that may be subject to the No Surprises Act of 2021, your cost-share may be different based on the requirements of the law. Chapter 2: Payment Information; Eligible Charge **Exception:** For services included in the No Surprises Act of 2021 rendered by an out-of-network provider, you will not have to pay the difference between the actual charge and the maximum allowable fee, but your cost-share may be different based on the requirements of the law.
Expanded/Separated benefit for clarification and consistency	Chapter 3: Summary of Benefits and Your Payment Obligations; **Prescription Drugs and Supplies; Chemotherapy – Oral Drugs** Oral Chemotherapy — Non-Specialty Drugs Oral Chemotherapy — Specialty Drugs
Verbiage revised throughout section to be consistent with Prepaid Health Care Act requirements	Chapter 4: Description of Benefits; **Prescription Drugs and Supplies** Please refer to the above-referenced section of your DOC for specific revisions.
Verbiage revised for clarification and consistency	Chapter 9: Coordination of Benefits and Third Party Liability; **What Coordination of Benefits Means** If you are covered under this plan and another group medical plan or Medicare, the benefits of this plan and those of the other plan will be coordinated and adjusted so that you do not receive more than 100% of the eligible expenses incurred. In order to coordinate benefits, it is important to understand which plan is primary (pays first) and which plan is secondary (pays second) for each family member. This will assist the provider of service in the proper filing of claims.
Verbiage deleted for compliance with federal law (Mental Health Parity and Addiction Equity Act ("MHPAEA")	Chapter 4: Description of Benefits, section: Rehabilitation Therapy, subsection: **Speech Therapy Services** Covered, for the treatment of communication impairments and swallowing disorders but only when all of the following statements are true: ▪ **[DELETED]** The therapy is not for developmental delay/developmental learning.
Benefit Changes (Additions and Exclusions)	
Revised "Intra-uterine Insemination" to "Artificial Insemination"	Chapter 3: Summary of Benefits and Your Payment Obligations; and Chapter 4: Description of Benefits, Special Benefits for Women **Artificial Insemination** Covered. Coverage for other related services such as office visits, labs and radiology are described in other sections of this DOC.

Change	Description of Change
Benefit Changes (Additions and Exclusions), *continued*	
Affected plans' Air Ambulance benefit revised specific to plan for Compliance with federal law (No Surprises Act ("NSA")).	Ambulance benefit separated into Air and Ground categories and Air Ambulance benefit revised to be the same benefit level for par and non-nor providers pursuant to the NSA. Please refer to your DOC to identify specific changes to affected plan benefits.
Contraceptives revised per plan to be consistent with Prepaid Health Care Act requirements	Chapter 3: Summary of Benefits and Your Payment Obligations; **Prescription Drugs and Supplies** Please refer to the above-referenced section of your DOC for specific revisions to affected benefits.
Revised "Orthodontic Treatment for Orofacial Anomalies"	Chapter 3: Summary of Benefits and Your Payment Obligations; and Chapter 4: Description of Benefits, Other Medical Services and Supplies. **Orthodontic Treatment for Orofacial Anomalies** Medically necessary orthodontic services for the treatment of orofacial anomalies resulting from birth defects or syndromes are covered in accordance with Hawaii Law and HMAA's medical policies subject to a maximum benefit of **$6,930** per treatment phase. The number of visits to an orthodontist is excluded from the maximum benefit, which will be adjusted annually for inflation.
Exclusion revised for clarification	Chapter 6: Services Not Covered, Fertility and Infertility **Contraceptives** You are not covered for contraceptives services, or contraceptives including diaphragms, cervical caps, oral contraceptives, and other contraceptive methods, except as described in *Chapter 3: Summary of Benefits and Your Payment Obligations* and *Chapter 4: Description of Benefits under Special Benefits for Women and Drugs and Supplies.*
Added exclusion	Chapter 6: Services Not Covered, Miscellaneous Exclusions **Recreational Therapy** You are not covered for recreational therapy and/or programs such as: • wilderness therapy, • health resorts, • swimming with dolphins, • outdoor skills programs, • relaxation or lifestyle programs, and • any other services provided in conjunction or related to (or as part of) those programs.

Par = Participating Provider

Non-Par = Non-Participating Provider

Refer to your Description of Coverage (DOC) for definitions and further information. **This is only a summary**. In the case of a discrepancy between this document and the language contained within the DOC, the latter will take precedence.

Table of Contents

What You Should Know About This Description of Coverage (DOC)

Accessibility and Readability

Thank you for choosing HMAA. If you need help understanding this book, please call our customer service center at 808-941-4622 or toll-free at 888-941-4622. HMAA offers interpreter services at no charge. If you need an interpreter, please tell our representative when you contact us.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-941-4622.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-941-4622.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-941-4622.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-941-4622.

Third-Party Administration

HMAA is your Insurer and utilizes Hawaii-Western Management Group ("HWMG") as its third-party administrator to provide administrative services, such as claims processing and customer service, to HMAA members.

About Your PPO Program

Your health care coverage is a ***Preferred Provider Organization***. This means you have medical benefits for your health care needs including office visits, inpatient facility services, outpatient facility services, and other provider services. This coverage offers you flexibility in the way you get medical benefits. Your opportunity to take an active role in your health care decisions makes this coverage special. In general, to get the best benefits possible, you should seek services from HMAA ***Participating Providers***.

HMAA Participating Providers have agreed to render required services at negotiated rates. The member is not responsible for the difference between the negotiated rate and the billed charges, except for deductible, copayments, coinsurance and non-covered items. Benefits shall be automatically assigned for Participating Providers. Some services rendered by ***Non-Participating Providers*** may be paid directly to the Member with all non-covered charges being the responsibility of the Member.

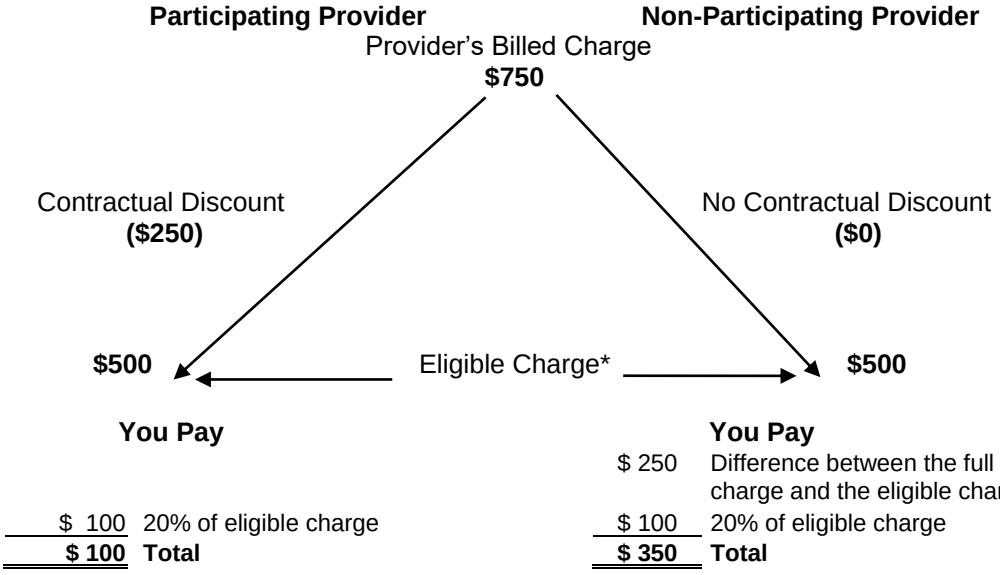
The Plan pays benefits at two levels: (1) a higher level for Participating Providers and (2) a lower level for Non-Participating Providers. **By using participating providers, you are assured of receiving the maximum benefits of the plan.**

Before you visit your doctor or receive other healthcare services, please verify whether your provider is participating with HMAA through one of the following:

- Ask your provider's office
- View our provider directory at hmaa.com
- Contact our Customer Service Center at 808-941-4622, toll-free at 888-941-4622, or via e-mail at CustomerService@hmaa.com

Pay Less by Choosing a Participating Provider

The following illustrates an example of your out-of-pocket expense if you receive services from a participating vs. non-participating provider.



* The eligible charge is not equal to the billed charge. The eligible charges shown above are for illustration purposes only. Such charges may vary, depending on the provider and type of service performed. Taxes are not covered and are the sole responsibility of the member. Payment may vary by health plan.

As illustrated, using a non-participating provider or facility will result in substantially higher out-of-pocket expenses. You will be responsible for all non-covered charges, copayments, coinsurance and any remaining balances over the eligible charge, up to the full billed amount. As a result, your out-of-pocket expense could be substantial. The provider or facility may require you to pay the entire bill at the time you receive services, and to file your claim directly with us. When allowed, HMAA reserves the right to make payment directly to the member, regardless of whether assignment of benefits is requested (in other words, regardless of whether you ask us to pay your provider directly).

Enrollment Periods

HMAA must permit a qualified small employer to purchase coverage at any point during the year, provided that the small employer meets minimum contribution and group participation requirements.

Open Enrollment Periods

An initial enrollment period is a specific time when an individual is first eligible, according to your employer's rules for eligibility. If you do not apply for coverage when you first become eligible or by the first day of the month immediately following the first four consecutive weeks of employment, your enrollment form will not be accepted until the next open enrollment period. However, if you show us to our satisfaction that there was unusual and justifiable cause for submitting your enrollment application late, you may enroll sooner.

Open enrollment is a specific time each year when a current subscriber can make changes to their coverage. The annual open enrollment period for employer groups varies, and the number of days allotted for open enrollment may also differ between groups. Employees should check with their Human Resources department to find out their company's open enrollment period.

Terminology

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

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

Definitions

Throughout this Description of Coverage (DOC), terms appear in ***Italics*** the first time they are defined. Terms are also defined in *Chapter 12: Glossary*.

Questions

If you have any questions, please call us. More details about plan benefits will be provided free of charge. We list our telephone numbers on the front cover of this DOC.

Summary of Provider Categories

This chart shows how the various provider categories impact your benefits.

	HMAA Participating Provider	Mainland Participating Provider	Centers of Excellence Provider	Non-Participating Provider (in or out-of-state)
Does your provider contract with HMAA's networks?	Yes	No, contract with Cigna PPO network	Yes, contracts with HMAA for transplant services	No, does not contract with HMAA or Cigna PPO networks.
Does your provider always file claims for you?	Yes	Yes	Yes	No, you may have to file your own claims.
Does your provider accept eligible charge as payment in full? If so, you do not pay for any difference between actual charge and eligible charge.	Yes	Yes	Yes	Perhaps, in some cases you pay the difference between the actual charge and the eligible charge. See *From what Provider Category Did You Receive Care?* later in this chapter.
Do you pay the provider deductibles, copayments and coinsurance? If so, we send benefit payment directly to the provider.	Yes	Yes	Yes	Perhaps, or you may need to pay the provider in full if we send benefit payments to you.
Is your coinsurance percentage lower?	Yes	Yes	Yes	No, your coinsurance percentage is higher except when mandated by law to be the same as for services rendered by participating providers.
Does your provider get precertification approvals for you?	Yes	No, you are responsible for getting approval.	Yes	No, you are responsible for getting approval.

Care While You Are Away From Home

Participating Providers Outside Hawaii

We provide access to medical services on the U.S. Mainland by participating with the Cigna PPO Network. This enables members to obtain medical services from participating providers while traveling outside our service area, the state of Hawaii. If you obtain services from a Cigna PPO Network provider, you enjoy advantages similar to those available when you receive health care from participating providers in Hawaii.

We do not guarantee the availability of Mainland participating providers in all areas.

Whenever you access covered healthcare services outside Hawaii and the claim is processed through Cigna, the amount you pay for covered healthcare services is based on the negotiated price that Cigna makes available to HMAA.

Finding Participating Providers

The Cigna PPO Network can provide you with information on participating providers outside the state of Hawaii. To locate a medical provider on the Mainland, visit www.myCigna.com, or contact our Customer Service Center at the phone numbers listed on the front cover of this DOC.

Non-Participating Providers

Depending on the situation, you may be liable for the difference between the amount the non-participating healthcare provider bills and the payment we make for the covered services as set forth in this paragraph.

In certain situations, we may base payment on items such as billed covered charges, the highest eligible charge of the most prevalent reimbursement agreement of an identical participating provider, a Qualifying Payment Amount or a special negotiated payment to determine the amount we pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount the non-participating healthcare provider bills and the payment we make for covered services as set forth in this paragraph.

Benefit payments for covered emergency services provided by non-participating providers are a "reasonable amount" as defined by federal law at 45 CFR§ 147.138(b).

Carry Your Member Card

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

Questions We Ask When You Receive Care

Is the Care Covered?

To receive benefits, the care you receive must be a covered treatment, service, or supply. See *Chapter 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:

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

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

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

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.

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

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

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

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

Is the Care Consistent with HMAA's Medical Policies?

To be covered, the care you get must be consistent with the provider's scope of practice, state licensure requirements, and HMAA's medical policies. These are policies drafted by HMAA's Chief Medical Officer, who is a licensed physician. Each policy provides detailed coverage criteria for when a specific service, drug, or supply meets payment determination criteria. If you have questions about the policies or would like a copy of a policy related to your care, please call us at one of the telephone numbers on the front cover of this DOC.

From What Provider Category Did You Receive Care?

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

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

Exception: For certain out-of-network services that may be subject to the No Surprises Act of 2021, your cost-share may be different based on the requirements of the law.

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

Please note: Your participating provider may refer services to a non-participating provider and you may incur a greater out-of-pocket expense.

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

Is the Service or Supply Subject to a Benefit Maximum?

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

Is the Service or Supply Subject to Precertification?

Certain services require our prior approval. HMAA participating providers get approval for you, but other providers may not. If you receive services from a non-participating provider and approval for certain services is not obtained, benefits may be denied. In some cases, benefits are denied entirely. For services subject to approval, read *Chapter 5: Precertification.*

Did You Receive Care From a Provider Recognized 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 non-participating providers are recognized and approved. To find out if your physician is a participating provider, refer to our Directory of Participating Providers. If you need a copy, call us and we will send one to you, or visit www.hmaa.com. To find out if a non-participating provider is recognized and approved, call us at one of the telephone numbers on the front cover of this DOC.

Did a Provider Order the Care?

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

What You Can Do to Maintain Good Health

Be Passionate About Your Health

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

Take Charge of your Health

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

Take time to read and understand your ***Explanation of Benefits*** *(EOB).* This report shows how we applied benefits. You may receive copies of your EOB through Online for Members at hmaa.com or by mail. Make sure you are billed only for those services you received.

Interpreting This Description of Coverage

Agreement

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

- This Description of Coverage (DOC).
- Any riders and/or amendments.
- The enrollment form submitted to us (if applicable).
- The agreement between us and your employer or group sponsor.

Our Rights to Interpret this Document

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

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

Our determinations and interpretations, and our decisions on these matters are subject to *de novo* review by an impartial reviewer as provided in this DOC or as allowed by law. If you do not agree with our interpretation or determination, you may appeal. See *Chapter 8: Dispute Resolution.*

No oral statement of any person shall modify or otherwise affect the benefits, limits and exclusions of this Description of Coverage, convey or void any coverage, or increase or reduce any benefits under this Agreement.

Chapter 2: Payment Information

Eligible Charge

Definition

For most medical services, except for emergency and air ambulance services provided by non-participating providers, and certain services provided by non-participating providers in participating facilities, the ***Eligible Charge*** is the lower of either the provider's *actual charge* or the amount we establish as the *maximum eligible fee.* HMAA's payment and your coinsurance are based on the eligible charge. Exception: For services provided by participating facilities, HMAA's payment is based on the maximum eligible fee and your coinsurance is based on the lower of the actual charge or the *maximum eligible fee.* Your copayment is a fixed dollar amount that does not change based on the eligible charge.

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

Participating providers agree to accept HMAA's payment plus your deductible, copayment and/or coinsurance as payment in full for covered services. Non-participating providers generally do not. If you receive services from a non-participating or non-contracted provider, you are responsible for the deductible, copayment and/or coinsurance plus potentially any difference between the actual charge and the eligible charge.

Exception: For services included in the No Surprises Act of 2021 rendered by an out-of-network provider, you will not have to pay the difference between the actual charge and the *maximum allowable fee*, but your cost-share may be different based on the requirements of the law.

Please note: The eligible charge does not include excise or other tax. You are responsible for all taxes related to the medical care you receive.

Coinsurance

Definition

Coinsurance applies to most covered services. It is a fixed percentage of the eligible charge. Exception: For services provided at a participating facility, your coinsurance is based on the lower of the facility's actual charge or the maximum eligible fee. You owe coinsurance even if the facility's actual charge is less than the maximum eligible fee.

Please note: If you receive services from a non-participating or non-contracted provider, you are responsible for the deductible, copayment and/or coinsurance, plus potentially any difference between the actual charge and the eligible charge.

Amount

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

Examples

Here are two examples of how coinsurance works:

Let's say you have an outpatient surgery and go to a participating physician for the service.

- The physician's bill or actual charge = $150
- HMAA's eligible charge = $70
- Your coinsurance = $7 (10% of $70)

If you go to a non-participating physician, your out-of-pocket cost will be higher.

- The physician's bill or actual charge = $150
- HMAA's eligible charge = $70
- Your coinsurance = $21 (30% of $70)
- The difference between the actual charge and the eligible charge = $80
- You owe $101 (your coinsurance plus the difference between the actual charge and the eligible charge).

Copayment

Definition

A ***copayment*** is a fixed dollar amount paid in addition to your coinsurance. All copayments apply to the Out-Of-Pocket Maximum. The copayment does not apply to all services. Please refer to *Chapter 3: Summary of Benefits and Your Payment Obligations* for details.

Please note: If you receive services from a non-participating or non-contracted provider, you are responsible for the deductible, copayment and/or coinsurance, plus potentially any difference between the actual charge and the eligible charge.

Examples

Here is one example of how the copayment works:

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

- The physician's bill or actual charge = $150
- HMAA's eligible charge = $70
- Your copayment = $10
- Your coinsurance = $12 (20% of $60)
- The difference between the actual charge and the eligible charge = $80
- You owe $102 (your copayment and coinsurance, plus the difference between the actual charge and the eligible charge).

Annual Deductible

Definition

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

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

- Copayments and Coinsurance for services that are not subject to the annual deductible.
- Payments for services subject to a maximum once you reach the maximum. See *Benefit Maximum* later in this chapter.
- The difference between the actual charge and the eligible charge that you pay when you get services from a non-participating provider.
- Payments for non-covered services.
- Any amounts you owe in addition to your copayment and/or coinsurance for covered services.

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

Amount

$100 per person
$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 always go to a participating 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 $80. You are responsible for the entire amount because you have not met the annual deductible.
- In June, you receive physical therapy from a non-participating provider for your leg. The eligible charge is $100. You owe $20 to meet the remaining deductible balance, plus a $16 coinsurance (20% of the remaining $80 balance).

Here is an example of how your maximum per family deductible works:

- In February, your daughter is tested for allergies at the doctor's office. The eligible charge is $80. 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 $400. You are responsible for $100 (because you have not met the per person annual deductible), plus applicable coinsurance and copayments.
- In June, your spouse falls down the stairs and is prescribed outpatient physical therapy. Your spouse sees a non-participating provider. The eligible charge for the covered sessions is $300. You are responsible for $100 (because your spouse has not met the per person annual deductible), plus applicable coinsurance and copayments.
- In July, your daughter requires inhalation therapy. The eligible charge is $125. You are responsible for $20 (because you have previously paid $280 in per person deductibles), plus applicable coinsurance and copayments.
- For the remainder of the year, you will pay no per person deductibles.

Annual Coinsurance Maximum

Definition

The ***Annual Coinsurance Maximum,*** *also known as Out-Of-Pocket Maximum,* is the maximum deductible, copayment and coinsurance amounts you pay in a calendar year. Once you meet the coinsurance maximum you are no longer responsible for deductible, copayment, or coinsurance amounts.

Charges for participating providers will apply towards both the participating and non-participating Annual Coinsurance Maximums. Charges for non-participating providers will only apply towards the non-participating Annual Coinsurance Maximum.

Amount

Participating Providers: $600 per person/$1,800 per family

Non-Participating Providers: $1,100 per person/$3,300 per family

When You Pay More

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

- Coinsurance payments for Prescription Drugs and Supplies.
- Payments for services subject to a maximum once you reach the maximum. See *Benefit Maximum* later in this chapter.
- The difference between the actual charge and the eligible charge that you pay when you receive services from a non-participating provider.
- Any payments made to a pharmacy as a result of a pharmaceutical manufacturer's assistance program for covered drugs under this benefit plan will not count towards a member's out-of-pocket maximum.
- Any payments made to a pharmacy as a result of a pharmaceutical manufacturer's assistance program for covered drugs under this benefit plan will not count towards a member's copayment.
- Payments for non-covered services.

Maximum Eligible Fee

Definition

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

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

- For most services, supplies, or procedures, we consider:
  - Increases in the cost of medical and non-medical services in Hawaii over the last year.
  - The relative difficulty of the service compared to other services.
  - Changes in technology.
  - Payment for the service under federal, state, and other private insurance programs.
  - Negotiated reimbursement levels with participating providers.
  - Prevalent negotiated reimbursement levels with non-participating providers
  - The Qualifying Payment Amount.
- For some facility-billed services, we use a per case, per treatment, or per day fee (per diem) rather than an itemized amount (fee for service). This does not include practitioner-billed facility services. For non-participating hospitals, our maximum eligible fee for all-inclusive daily rates established by the hospital will never exceed more than if the hospital had charged separately for services.
- For services billed by participating providers outside of Hawaii, we use the negotiated price passed on to us by Cigna.
- For prescription drugs and supplies, we use nationally recognized pricing sources and other relevant information. The allowable fee includes a dispensing fee. Any discounts or rebates that we receive will not reduce the charges that your coinsurance is based on. We apply discounts and rebates to reduce prescription drugs and supplies coverage rates.

Benefit Maximum

Definition

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

- Service. For example, alternative care benefits are limited to a combined maximum of $1,000 per calendar year.
- 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 Limitations

See *Chapter 4: Description of Benefits.*

Chapter 3: Summary of Benefits and Your Payment Obligations

Benefit and Payment Chart

About this Chart

This benefit and payment chart:

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

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

* = An asterisk next to a service or supply means a service dollar maximum may apply.

** = A double asterisk next to a service or supply means a visit maximum may apply.

\# = A pound sign next to a service means a copayment per confinement applies.

Certain Services require precertification from HMAA. Please refer to *Chapter 5: Precertification* for details.

	More info on page:	Annual Deductible Applies?		% = Coinsurance (Percentage based on eligible charge) $ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating	Participating	Non-Participating
Hospital and Facility Services					
Ambulatory Surgical Center (ASC)	17	No	No	10%	20%
**#Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Facilities)	17	No	Yes	10%	$200 (per 1st confinement in cal. yr.) + 20%
Hospital Ancillary Services	17	No	Yes	10%	20%
#Hospital Room and Board	17	No	Yes	10%	$200 (per 1st confinement in cal. yr.) + 20%
#Intensive Care Unit/Coronary Care Unit	18	No	Yes	10%	$200 (per 1st confinement in cal. yr.) + 20%
#Intermediate Care Unit	18	No	Yes	10%	$200 (per 1st confinement in cal. yr.) + 20%
#Isolation Care Unit	18	No	Yes	10%	$200 (per 1st confinement in cal. yr.) + 20%
Operating Room	18	No	Yes	10%	20%
Outpatient Facility	18	No	No	10%	20%
Emergency Services					
Emergency Room	18	No	No	10%	10%
All Other Services and Supplies	18	No	No	10%	10%
Urgent Care					
All services and Supplies	18	No	No	$25	$50
Online and Telephonic Care via HMAA's HiDoc® Service					
All Services	19	No	Not Covered	None	Not Covered
Telehealth					
Telehealth Services	19	Your Deductible and copayment/coinsurance amounts vary depending on the type of service or supply. See copayment/coinsurance amounts listed in this chart for the service or supply you receive			

* = See page 10 ** = See page 10 # = See page 10		More info on page:	Annual Deductible Applies?		% = Coinsurance (Percentage based on eligible charge) $ = Copayment (Fixed dollar amount)	
			Participating	Non-Participating	Participating	Non-Participating
Physician Services						
Anesthesia	Inpatient	19	No	Yes	10%	20%
	Outpatient		No	No		
Consultation Services		19	No	No	10%	$10 + 20%
Immunizations (standard, including travel)		19	No	No	None	30%
Physician Visits		19	No	No	10%	$10 + 20%
Physician Visits – Emergency Room		20	No	No	10%	10%
Surgical Services						
Assistant Surgeon Services	Inpatient	20	No	Yes	10%	20%
	Outpatient		No	No		
Bariatric Surgery		20	No	Not Covered	10%	Not Covered
Colonoscopy (screening)		20	No	No	None	20%
Cutting Surgery	Inpatient	20	No	Yes	10%	20%
	Outpatient		No	No		
Non-cutting Surgery	Inpatient	21	No	Yes	10%	20%
	Outpatient		No	No		
Oral Surgery	Inpatient	21	No	Yes	10%	20%
	Outpatient		No	No		
Reconstructive Surgery	Inpatient	21	No	Yes	10%	20%
	Outpatient		No	No		
Sigmoidoscopy (screening)		21	No	No	None	20%
Surgical Supplies	Inpatient	21	No	Yes	10%	20%
	Outpatient		No	No		
Testing, Laboratory and Radiology						
Allergy Testing		21	Yes	Yes	$15 + 10%	$25 + 20%
Allergy Treatment Materials		21	Yes	Yes	$15 + 10%	$25 + 20%
Diagnostic Testing — Inpatient		21	No	Yes	10%	20%
Diagnostic Testing — Outpatient		21	No	Yes	10%	20%
Fecal Occult Blood Test (FOBT) (screening)		21	No	Yes	None	20%
Genetic Testing, Screening, and Counseling		21	No	Yes	10%	20%
Laboratory and Pathology — Inpatient		22	No	Yes	10%	20%
Laboratory and Pathology — Outpatient		22	No	Yes	10%	20%
Radiology — Inpatient		22	No	Yes	10%	20%
Radiology — Outpatient		22	No	Yes	10%	20%
Tuberculin Test (screening)		22	No	No	10%	20%

* = See page 10 ** = See page 10 # = See page 10	More info on page:	Annual Deductible Applies?		% = Coinsurance (Percentage based on eligible charge) $ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating	Participating	Non-Participating
Chemotherapy and Radiation Therapy					
Chemotherapy — Infusion/Injections	22	Yes	Yes	10%	20%
Radiation Therapy — Inpatient	22	No	Yes	10%	20%
Radiation Therapy— Outpatient	22	No	Yes	10%	20%
Other Medical Services and Supplies					
*Acupuncture, Chiropractic, Massage, and Naturopathic Services	22	No	Yes	10%	20%
Advance Care Planning	22	No	Yes	None	20%
Ambulance (air)	22	Yes	Yes	20%	20%
Ambulance (ground)	22	Yes	Yes	20%	20%
Blood and Blood Products	22	Yes	Yes	10%	20%
Dialysis and Supplies	22	Yes	Yes	10%	20%
Durable Medical Equipment and Supplies	22	Yes	Yes	10%	20%
Evaluations for Hearing Aids	23	Yes	Yes	10%	20%
Gender Identity Services	23	Your Deductible and copayment/coinsurance amounts vary depending on the type of service or supply. See copayment/coinsurance amounts listed in this chart for the service or supply you receive.			
Growth Hormone Therapy	23	Yes	Yes	10%	20%
Home IV Therapy	23	No	No	$5 + 10%	30%
Implanted Internal Items/Implants – Outpatient	23	Yes	Yes	None	30%
Inhalation Therapy	23	Yes	Yes	10%	20%
Injections	24	Yes	Yes	10%	20%
Medical Foods	24	No	No	10%	20%
Medical Nutrition Therapy	24	No	Yes	None	30%
*Orthodontic Treatment for Orofacial anomalies	24	No	No	None*	None*
Orthotics and External Prosthetics	24	Yes	Yes	10%	20%
Outpatient IV Therapy	25	Yes	Yes	10%	20%
Parking Fees	25	Covered when tied to the diagnosis/treatment of cancer. Maximum daily allowance of $25			
Private Duty Nursing	43	Not Covered	Not Covered	Not Covered	Not Covered
*Vision and Hearing Appliances	25	Yes	Yes	10%	20%
Rehabilitation Therapy					
Physical and Occupational Therapy— Inpatient	26	No	Yes	10%	20%
**Physical and Occupational Therapy— Outpatient	25	Yes	Yes	$5 + 10%	30%
Pulmonary Rehabilitation – Outpatient	26	Yes	Yes	10%	20%
Speech Therapy Services — Inpatient	26	No	Yes	10%	20%
**Speech Therapy Services — Outpatient	26	Yes	Yes	$5 + 10%	30%

* = See page 10 ** = See page 10 # = See page 10	More info on page:	Annual Deductible Applies?		% = Coinsurance (Percentage based on eligible charge) $ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating	Participating	Non-Participating
Special Benefits – Disease Management and Preventive Services					
Disease Management	26	No	Not covered	None	Not covered
Gonorrhea (screening)	26	No	Yes	None	20%
Preventive Services — Laboratory	26	No	Yes	None	20%
Preventive Services — Physical Exam	26	No	Yes	None	$10 + 20%
Screening Services and Preventive Counseling	26	No	Yes	None	20%
Special Benefits for Children					
Newborn Care	27	No	Yes	10%	20%
Newborn Circumcision — Inpatient	27	Yes	Yes	10%	20%
Newborn Circumcision — Outpatient	27	No	No	10%	20%
Well Child Care Immunizations	27	No	No	None	None
Well Child Care Laboratory Tests	27	No	No	None	20%
Well Child Care Physician Office Visits	27	No	No	None	$10 + 20%
Special Benefits for Men					
Erectile Dysfunction	28	Your Deductible and copayment/coinsurance amounts vary depending on the type of service or supply. See copayment/coinsurance amounts listed in this chart for the service or supply you receive.			
Prostate Specific Antigen (PSA) Test (screening)	28	No	No	10%	20%
Vasectomy	28	No	Yes	10%	20%
Special Benefits for Women					
Artificial Insemination	28	No	Yes	10%	30%
*Breast Pump	28	No	Not Covered	None	Not Covered
Chlamydia Screening	28	No	Yes	None	20%
Contraceptive Implants (generic)	28	No	No	None	30%
Contraceptive Injectables (generic)	28	No	No	None	30%
Contraceptive IUD (generic)	28	No	No	None	30%
In Vitro Fertilization	28	No	No	10%	20%
Mammography (screening)	29	No	No	None	20%
Maternity Care	29	No	Yes	10%	20%
Pap Smears (screening)	29	No	No	None	20%
Pregnancy Termination	29	No	No	10%	20%
Tubal Ligation	29	No	No	None	20%
Well Woman Exam	29	No	No	None	20%

* = See page 10 ** = See page 10 # = See page 10	More info on page:	Annual Deductible Applies?		% = Coinsurance (Percentage based on eligible charge) $ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating	Participating	Non-Participating
Special Benefits for Homebound, Terminal, or Long-Term Care					
**Home Health Care	29	No	No	None	30%
**Hospice Services	30	No	Yes	None	None
Behavioral Health – Mental Health and Substance Abuse					
Autism — Applied Behavioral Analysis, Treatment and Diagnosis	30	No	Yes	10%	30%
#Hospital and Facility Services— Inpatient	30	No	Yes	10%	$200 (per 1st confinement in cal. yr.) + 20%
Hospital and Facility Services— Outpatient	30	No	No	10%	20%
Physician Services — Inpatient	30	No	Yes	10%	20%
Physician Services — Outpatient	30	No	No	10%	$10 + 20%
Psychological Testing — Inpatient	30	No	Yes	10%	20%
Psychological Testing — Outpatient	30	No	Yes	10%	20%

You must receive services from a provider that is an approved Center of Excellence for Transplants or is under contract with us for the specific type of transplant you will receive for these benefits to apply.

* = See page 10 ** = See page 10 # = See page 10	More info on page:	Annual Deductible Applies?		% = Coinsurance (Percentage based on eligible charge) $ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating	Participating	Non-Participating
Organ and Tissue Transplants					
Corneal Transplants	32	No	Yes	10%	30%
Kidney Transplants	32	No	Yes	10%	30%
Organ Donor Services	32	Yes	Yes	20%	30%
Transplant Evaluation	32	No	Not covered	None	Not covered
*Transportation, Lodging and Meal Allowance	32	Transportation, Lodging and Meal Allowance for patient and companion. The maximum daily allowance for Lodging & Meals is $150. The maximum Benefit per Transplant from the date of the Pre-transplant Evaluation through one year of Post-Transplant Follow-up is $7,500.			
Other Organ and Tissue Transplants					
Heart Transplants	32	No	Not covered	None	Not covered
Heart and Lung Transplants	32	No	Not covered	None	Not covered
Liver Transplants	32	No	Not covered	None	Not covered
Lung Transplants	32	No	Not covered	None	Not covered
Pancreas Transplants	32	No	Not covered	None	Not covered
Simultaneous Kidney/Pancreas Transplants	32	No	Not covered	None	Not covered
Small Bowel and Multivisceral Transplants	33	No	Not covered	None	Not covered
Stem-Cell Transplants (including Bone Marrow Transplants)	33	No	Not covered	None	Not covered

Prescription Drugs and Supplies

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

* = See page 10 ** = See page 10 # = See page 10	More info on page:	Annual Deductible Applies?		% = Coinsurance (Percentage based on eligible charge) $ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating	Participating	Non-Participating
Autism Spectrum Disorder Drugs					
Generic Drugs	33	No	No	None	None
Preferred Drugs	33	No	No	None	None
Non-Preferred Drugs	33	No	No	None	None
Mail Order Generic Drugs	35	No	Not Covered	None	Not Covered
Mail Order Preferred Drugs	35	No	Not Covered	None	Not Covered
Mail Order Non-Preferred Drugs	35	No	Not Covered	None	Not Covered
Chemotherapy – Oral Drugs		*If you have an HMAA or freestanding drug plan with benefits for oral chemotherapy drugs, the HMAA or freestanding drug plan benefits will apply. Outpatient medications over $1,000 require precertification.*			
Oral Chemotherapy — Non-Specialty Drugs	33	No	No	None	None
Oral Chemotherapy — Specialty Drugs	33	No	Not Covered	None	Not Covered
Mail Order Chemotherapy — Oral	35	No	Not Covered	None	Not Covered
Contraceptives		*If you have an HMAA or freestanding drug plan with benefits for contraceptives, the HMAA or freestanding drug plan benefits will apply. Contraceptives are not covered for group health plans offered by religious organizations that have qualified for an exemption from the federal requirement.*			
Contraceptive Diaphragms/Cervical Caps	33	No	No	None	$10 per device
Contraceptive Oral (Generic)	33	No	No	None	20%
Contraceptive Oral (Preferred)	33	No	No	20%	20%
Contraceptive Oral (Non-Preferred)	33	No	No	30%	30%
Contraceptive — Other Methods (Generic)	33	No	No	None	20%
Contraceptive — Other Methods (Preferred)	33	No	No	20%	20%
Contraceptive — Other Methods (Non-Preferred)	33	No	No	30%	30%
Contraceptive – Over-the-Counter (OTC)	33	No	No	None	20%
Mail Order Contraceptive Diaphragms/Cervical Caps	35	No	Not Covered	None	Not Covered
Mail Order Contraceptive Oral (Generic)	35	No	Not Covered	None	Not Covered
Mail Order Contraceptive Oral (Preferred)	35	No	Not Covered	20%	Not Covered
Mail Order Contraceptive Oral (Non-Preferred)	35	No	Not Covered	30%	Not Covered

* = See page 10 ** = See page 10 # = See page 10	More info on page:	Annual Deductible Applies?		% = Coinsurance (Percentage based on eligible charge) $ = Copayment (Fixed dollar amount)	
		Participating	Non-Participating	Participating	Non-Participating
Contraceptives (Continued)		*Outpatient medications over $1,000 require precertification. Contraceptives are not covered for group health plans offered by religious organizations that have qualified for an exemption from the federal requirement.*			
Mail Order Contraceptive — Other Contraceptive Methods (Generic)	35	No	Not Covered	None	Not Covered
Mail Order Contraceptive — Other Contraceptive Methods (Preferred)	35	No	Not Covered	20%	Not Covered
Mail Order Contraceptive — Other Contraceptive Methods (Non-Preferred)	35	No	Not Covered	30%	Not Covered
Mail Order Contraceptive – Over-the-Counter (OTC)	35	No	Not Covered	None	Not Covered
Diabetic Drugs, Supplies, and Insulin		*If you have an HMAA or freestanding drug plan with benefits for diabetic drugs, supplies, and insulin, the HMAA or freestanding drug plan benefits will apply.*			
Diabetic Supplies — Preferred	33	No	No	None	None
Diabetic Supplies — Non-Preferred	33	No	No	10%	20%
Diabetic Drugs— Generic	33	No	No	10%	20%
Diabetic Drugs— Preferred	33	No	No	10%	20%
Diabetic Drugs — Non-Preferred	33	No	No	10%	20%
Insulin — Generic Drugs	33	No	No	10%	20%
Insulin — Preferred	33	No	No	10%	20%
Insulin — Non-Preferred	33	No	No	10%	20%
Mail Order Diabetic Supplies — Preferred	35	No	Not Covered	None	Not Covered
Mail Order Diabetic Supplies — Non-Preferred	35	No	Not Covered	10%	Not Covered
Mail Order Diabetic Drugs— Generic	35	No	Not Covered	10%	Not Covered
Mail Order Diabetic Drugs— Preferred	35	No	Not Covered	10%	Not Covered
Mail Order Diabetic Drugs — Non-Preferred	35	No	Not Covered	10%	Not Covered
Mail Order Insulin — Generic Drugs	35	No	Not Covered	10%	Not Covered
Mail Order Insulin — Preferred	35	No	Not Covered	10%	Not Covered
Mail Order Insulin — Non-Preferred	35	No	Not Covered	10%	Not Covered
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs		*If you have an HMAA or freestanding drug plan with benefits for U.S. Preventive Services Task Force recommended drugs, the HMAA or freestanding drug plan benefits will apply. Outpatient medications over $1,000 require precertification.*			
USPSTF recommended drugs	34	No	No	None	20%
Mail Order — USPSTF recommended drugs	35	No	Not Covered	None	Not Covered

Reimbursement percentages are based on participating pharmacy negotiated charges. Any payments made to a pharmacy as a result of a pharmaceutical manufacturer's assistance program for covered drugs under this benefit plan will not count towards a member's copayment or coinsurance. If you go to a non-participating pharmacy, member pays the total amount up front and is reimbursed based upon the wholesale price minus the applicable copayments. The member will be responsible for any remaining balance over the eligible charge up to the full billed amount.

Chapter 4: Description of Benefits

About This Chapter

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

Additional Coverage Mandated by Law

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

Precertification

Certain Services require precertification from HMAA. Please refer to *Chapter 5: Precertification* for details.

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 we inform you that you do not meet payment determination criteria for acute inpatient care but you meet payment determination for skilled nursing care, you must transfer to the first available skilled nursing facility bed. If you do not transfer to the skilled nursing bed, you must pay all acute inpatient charges beginning on the day we informed you that you no longer meet acute inpatient payment determination criteria and a skilled nursing bed become available.

All inpatient admissions require approval. If payment determination criteria are not met, our nurse reviewer will discuss your case with a physician consultant. If more information is needed, 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 lab and x-ray related to surgery. ***Ambulatory Surgical Center*** is an outpatient facility that provides surgical services without an overnight stay. This facility may be in a hospital or it may be a separate independent facility.

Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Facilities)

Covered in accord with HMAA's medical policies. Room and board is covered, but only for semi-private rooms when all of the following are true:

- You are admitted by your physician.
- Care is ordered and certified by your physician.
- Care is for skilled nursing care, sub-acute care, or long-term acute care rendered in an extended care facility.
- Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care.
- The Confinement is not for custodial care.

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

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

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 coinsurance is based on the facility's medical/surgical semi-private room rate. If you are hospitalized at a non-participating facility, your coinsurance is based on HMAA's maximum eligible fee for semi-private rooms. Also, you owe the difference between the non-participating hospital's room charge and HMAA's maximum eligible fee for semi-private rooms.

- Private Rooms.
  - At Participating Hospitals:
    - If you are hospitalized in a participating facility with private rooms only, your coinsurance is based on HMAA's maximum eligible fee for semi-private rooms.
    - If you are hospitalized in a participating facility with semi-private and private rooms, your coinsurance is based on the facility's medical/surgical semi-private room rate. Also, you owe the difference between the facility's charges for private and semi-private rooms. Exception: If you are hospitalized for conditions identified by HMAA as conditions that require a private room, your coinsurance is based on the facility's medical/surgical private room rate.
  - At Non-Participating Hospitals:
    - If you are hospitalized in a non-participating facility, you have a $200 copayment per 1st confinement in any calendar year. Your coinsurance is based on HMAA's maximum eligible fee for semi-private rooms. Also, you owe the difference between the facility's private room charge and HMAA's maximum eligible fee for semi-private rooms. Exception: If you are hospitalized for conditions identified by HMAA as conditions that require a private room, your coinsurance is based on HMAA's maximum eligible fee for private rooms. Also, you owe the difference between the facility's private room charge and HMAA's maximum eligible fee for private rooms.

Intensive Care Unit/Coronary Care Unit

Covered.

Intermediate Care Unit

Covered.

Isolation Care Unit

Covered.

Operating Room

Covered.

Outpatient Facility

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

Emergency Services

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

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

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

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

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

Urgent Care

Urgent care defined as services rendered at an Urgent Care Facility requiring urgent attention and cannot reasonably be postponed is covered when a member cannot wait to visit a personal care provider for an unexpected illness or injury that is not life-threatening. These conditions include, but are not limited to:

- Coughs, colds, sore throats
- Fractures and sprains
- Minor burns
- Ear, nose and throat infections
- Stomachaches
- Headaches or dizziness
- Allergic reactions
- Animal bites

Online and Telephonic Care via HMAA's HiDoc® Service

Covered exclusively through MD Care dba HiDoc. Consultations available through telephone or video conferencing via computer or mobile application. Member must be 18 years old to initiate an online consultation. Pediatric consultations available with the accompaniment of a parent or legal guardian. Regular and extended consultations are covered for primary and specialty physicians. Consultations covered in all 50 states. All services rendered through HiDoc are considered to be in-network. Visit HiDocOnline.com to see a doctor online or call (808) 400-4113.

Please Note: Online services not intended to substitute care in emergency situations.

Telehealth

Covered in accord with Hawaii law and HMAA's medical policy for "Telehealth Services". Telehealth is the use of telecommunications services to transmit medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis when the parties are separated by distance. Telecommunications services include:

- Store and forward technologies.
- Remote monitoring
- Live consultation
- Mobile health

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

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

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

Physician Services

Anesthesia

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

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

Consultation Services

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

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

Immunizations (Standard and Travel)

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

Please note: The list of ACIP recommended immunizations may change. If you would like information about the ACIP recommended immunizations or high-risk criteria, call our Customer Service Center and we will help you. Our phone number is listed on the front cover of this DOC.

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 and routine newborn care. Benefits for a sick newborn are available when you add the child to your coverage within 31 days of birth. See *Chapter 10: General Provisions* under *Eligibility for Coverage.*

Physician Visits – Emergency Room

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

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

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

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

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

Surgical Services

Participating Providers have agreed to comply with HMAA's payment policies and so will not bill you for services or added charges HMAA does not cover unless specifically requested by you.

When you see a non-participating provider you will owe any copayment and coinsurance that applies to the service plus the difference between HMAA's eligible charge and the provider's actual charge. This may include services or added charges not covered by HMAA.

Approval for Certain Surgical Procedures

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

Please note: This list of procedures changes periodically. To ensure your surgical procedure is covered, call us or go online at www.hmaa.com and we will check if it requires approval before you receive the surgery.

If you are under the care of a:

- *Participating* physician, the physician will get approval for you.
- *Non-participating* physician, the physician may not get approval for you. Getting approval is your responsibility. See *Chapter 5: Precertification.*

Assistant Surgeon Services

Covered, but only when:

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

Bariatric Surgery

Covered, but only if you meet HMAA's criteria and when the facility is located in the state of Hawaii, has a contract with HMAA to perform bariatric surgery, and has a comprehensive weight management program.

Colonoscopy (screening)

Covered in accord with HMAA's medical policies.

Cutting Surgery

Covered, including preoperative and postoperative care.

Please note: Non-participating 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. Examples also include orthopedic castings; destruction of localized lesions by chemotherapy (excluding silver nitrate), cryotherapy or electrosurgery; and acne treatment.

Oral Surgery

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

Bone grafts, dental implants and the extraction of teeth for orthodontic purposes are not covered.

Please Note: If you have an HMAA dental plan with a similar benefit, there shall be no duplication or coordination of benefits between this plan and your HMAA dental plan and this medical plan will be primary.

Reconstructive Surgery

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

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

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

Sigmoidoscopy (screening)

Covered in accord with HMAA's medical policies.

Surgical Supplies

Covered.

Testing, Laboratory, and Radiology

Allergy Testing

Covered.

Allergy Treatment Materials

Covered.

Diagnostic Testing

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

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

Fecal Occult Blood Test (FOBT) (screening)

Covered in accord with HMAA’s medical policies.

Genetic Testing, Screening and Counseling

Covered, but only if you meet HMAA’s criteria. Call us for more information.

Laboratory and Pathology

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

Radiology

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

Tuberculin Test (screening)

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

Chemotherapy and Radiation Therapy

Chemotherapy — Infusion/Injections

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

Radiation Therapy

Covered.

Other Medical Services and Supplies

Acupuncture, Chiropractic, Massage and Naturopathic Services

Covered, up to a combined annual maximum of $1,000.

Advance Care Planning

Covered, once a year as a doctor's visit, assists members in making decisions about advance care directives, actionable medical orders, living wills, and surrogate decision makers.

Ambulance

Covered, emergency transportation within the United States, if services are provided:
- By a professional ambulance to and from a hospital; or
- By a regularly scheduled airline, railroad, or by air ambulance or chartered aircraft if an air ambulance is not available, from the city or town in which the covered person becomes disabled, to and from the nearest hospital qualified to provide hospital treatment to such injury or illness in any one accidental bodily injury, or on account of any illness.

Blood and Blood Products

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

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

Dialysis and Supplies

Covered.

Durable Medical Equipment and Supplies

Covered, but only when prescribed by your treating provider. The equipment must meet all of the following criteria:
- FDA-approved for the purpose that it is being prescribed.
- Able to withstand repeated use.
- Primarily and customarily used to serve a medical purpose.

- Appropriate for use in the home. *Home* means the place where you live other than a hospital or skilled or intermediate nursing facility.
- Necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body part. It should not be useful to a person in the absence of illness or injury.

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

Supplies and accessories necessary for the effective functioning of the equipment are covered subject to certain limitations and exclusions. Please call our office listed on the front cover of this DOC for details.

Repair and replacement of DME is covered subject to certain limitations and exclusions. Please call our office listed on the front cover of this DOC.

Examples of DME include oxygen equipment, hospital beds, mobility assistive equipment (wheelchairs, walkers, power mobility devices), and insulin pumps.

Please note: Benefits of insulin pump tubing can be found in *Prescription Drugs and Supplies* Section.

Evaluations for Hearing Aids

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

Gender Identity Services

Covered, in accord with the Gender Affirming Treatment Act and HMAA's medical policy for "Gender Identity Services" which can be found at http://www.hmaa.com/gender-identity-services-medical-policy. The services listed below are covered, but only when deemed medically necessary to treat gender dysphoria. Your coinsurance and/or copayment may vary depending on the type of service or supply you receive. Additional benefit information about the service or supply you receive can be found in other sections of this chapter.

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

Please note: Certain services must be precertified. See *Chapter 5: Precertification* and HMAA's medical policy for "Gender Identity Services" which can be found at http://www.hmaa.com/gender-identity-services-medical-policy.
Please note: Exclusions and limitations may apply. See *Chapter 6: Services Not Covered.*

Growth Hormone Therapy

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

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

Home IV Therapy

Covered, for services and supplies for home injections, biological therapeutics, biopharmaceuticals, or intravenous nutrient solutions needed for primary diet. Drugs must be FDA-approved.

Implanted Internal Items/Implants – Outpatient

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

Inhalation Therapy

Covered.

Injections – Other than Self-Administered

Covered, for outpatient services and supplies for the injection or intravenous administration of medication, biological therapeutics and biopharmaceuticals, or nutrient solutions needed for primary diet in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP). Injectable drugs must be FDA-approved.
If you have an HMAA drug plan with a similar benefit, there shall be no duplication or coordination of benefits between this plan and your HMAA drug plan.

Injections – Self-Administered

Covered, for FDA-approved injectable drugs.

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

Medical Foods

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

Medical Nutrition Therapy

Covered to treat medical conditions, such as chronic kidney disease, in accord with Hawaii law and HMAA's medical policies. If you are diagnosed with an eating disorder by a qualified provider, medical nutrition therapy must be rendered by a recognized licensed dietitian.

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

Orthodontic Treatment for Orofacial Anomalies

Medically necessary orthodontic services for the treatment of orofacial anomalies resulting from birth defects or syndromes are covered in accordance with Hawaii Law and HMAA's medical policies subject to a maximum benefit of $6,930 per treatment phase. The number of visits to an orthodontist is excluded from the maximum benefit which will be adjusted annually for inflation.

Orthodontic treatment of orofacial anomalies is covered (subject to Limitations and Administrative Guidelines) when all of the following criteria are met:

- The patient has been diagnosed with an orofacial defect that falls into one of the following types:
  - Cleft lip;
  - Cleft palate;
  - Cleft palate with alveolar ridge involvement; or
  - Other orofacial defect resulting from a birth defect or a birth defect syndrome if a physical functional impairment exists.
- Orthodontic services being requested are medically necessary to improve a functional impairment in at least one of the following areas:
  - Chewing;
  - Swallowing;
  - Speech; or
  - Respiration.
- Orthodontic services must be prescribed by an interdisciplinary team as part of a comprehensive individualized treatment plan to ensure that care is provided in a coordinated and consistent manner with the proper sequencing of evaluations and treatments within the framework of the patient's overall developmental and medical needs. The interdisciplinary team must complete an external evaluation and demonstrate compliance with the standards for team care as established by the American Cleft Palate-Craniofacial Association (ACPA) and the Cleft Palate Foundation (CPF).

Orthodontic services to alter or reshape normal structures of the body in order to improve appearance are considered cosmetic and will not be covered. Orthodontic services to correct developmental maxillofacial conditions that result in overbite, crossbite, underbite, malocclusion or similar developmental irregularities of the teeth; or temporomandibular joint disorder will not be covered.

Orthotics and External Prosthetics

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

Supplies necessary for the effective functioning of an orthotic are covered subject to certain limitations and exclusions. Please call our office listed on the front cover of this DOC for details.

Examples of orthotics include braces, orthopedic footwear, and shoe inserts.

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

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

Supplies necessary for the effective functioning of a prosthetic are covered subject to certain limitations and exclusions. Please call our office listed on the front cover of this DOC for details.

Repair and replacements are covered subject to certain limitations and exclusions. Please call our office listed on the front cover of this DOC for details.

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

Outpatient IV Therapy

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

Parking Fees

Covered, for services tied to the diagnosis/treatment of cancer. Maximum daily allowance of $25.

Routine Care Associated With Clinical Trials

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

Vision and Hearing Appliances

Vision appliances, which include eyeglasses and contact lenses are covered when required because of intraocular surgery or accidental eye injury only. Please call our office listed on the front cover of this DOC for details.

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

Hearing aids are covered for severe sensorineural hearing loss and is limited to one hearing aid per ear every 60 months. Severe hearing loss is defined as a bilateral hearing threshold of 40 decibels (dB.) or more. Fitting, adjustment, maintenance, repairs and batteries are not covered. Exclusions or limitations apply.

Rehabilitation Therapy

Physical and Occupational Therapy

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

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

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

Pulmonary Rehabilitation

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

Benefits are not provided for maintenance programs.

Participants must meet HMAA's eligibility criteria and guidelines.

Speech Therapy Services

Covered, for the treatment of communication impairments and swallowing disorders but only when all of the following statements are true:

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

Speech therapy services include speech/language therapy, swallow/feeding therapy, aural rehabilitation therapy and augmentative/alternative communication therapy.

Special Benefits – Disease Management and Preventive Services

Disease Management

Covered, for programs available through HMAA for members with diseases such as asthma, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and behavioral health conditions (mental health and substance abuse). The programs offer services to help you and your physician manage your care and make informed health decisions.

Gonorrhea (screening)

Covered.

Preventive Services – Laboratory

Covered.

Preventive Services – Physical Exam

Covered.

Screening Services and Preventive Counseling

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

- Preventive Counseling Services
- Preventive Services
- Screening Laboratory Services:
  - Screening for Lipid Disorders in Adults
  - Screening for Asymptomatic Bacteriuria in Adults
  - Screening for Gonorrhea
  - Screening for Hepatitis B Virus Infection
  - Screening for HIV
  - Screening for Syphilis Infection
  - Screening for Type 2 Diabetes Mellitus in Adults
  - Screening for Iron Deficiency Anemia
  - Screening for Rh (D) Incompatibility
  - Screening for Congenital Hypothyroidism

    - Screening for Phenylketonuria (PKU)
    - Screening for Sickle Cell Disease in Newborns
- Screening Radiology Services:
    - Screening for Abdominal Aortic Aneurysm
    - Screening for Osteoporosis in Postmenopausal Women

Please Note: The list of U.S. Preventive Services Task Force (USPSTF) recommended screening may change. If you need more information about the USPSTF recommended screenings, including a current list of recommendations, please visit our website at http://www.hmaa.com/USPSTF-Recommendations-List or call us at our telephone numbers on the front cover of this DOC.

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

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

- Breastfeeding Support and Counseling – but only when received from a trained physician or midwife during pregnancy and/or in the postpartum period.
- Contraceptive Counseling.
- Gestational Diabetes Screening.
- Human Papillomavirus (HPV) DNA Testing.
- Interpersonal and Domestic Violence Screening and Counseling.

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

Special Benefits for Children

Newborn Care

All newborns are covered for the baby's non-surgical physician services and nursery care after birth for the first 48 or 96 hours dependent upon the Newborn's Act requirements. Newborns are covered after the first 48 or 96 hours if added to your coverage within 31 days of birth. See *Chapter 10: General Provisions* under *Eligibility for Coverage.*

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

Newborn Circumcision

Covered.

Well Child Care

Covered, from birth through age twenty-one including office visits for history, physical exams, sensory screenings, developmental/behavioral assessments, anticipatory guidance, lab tests, and immunizations. ***Well Child Care*** means routine and preventive care for children through age twenty-one. If your child needs medical care as the result of an illness or injury, physician visit benefits apply (and not well child care benefits). See *Physician Services* earlier in this chapter.

Well Child Care Immunizations

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

Well Child Care Laboratory Tests

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

Well Child Care Physician Office Visits

Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) including routine sensory screening, and developmental/behavioral assessments according to the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care:

- Birth to one year: seven visits
- Age one year: three visits
- Age two years: two visits
- Age three years through twenty-one years: one visit per year

Special Benefits for Men

Erectile Dysfunction

Services, supplies, prosthetic devices, and injectables approved by us are covered to treat erectile dysfunction due to Organic diseases as defined by HMAA. See physician visits, supplies, prosthetic devices, and injectables for benefits.

Prostate Specific Antigen (PSA) Screening Test

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

Vasectomy

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

Special Benefits for Women

Artificial Insemination

Covered.

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

Breast Pump

Covered, for purchase of one device including attachments per pregnancy when purchased from a Participating Provider or Participating Medical Pharmacy that provides medical equipment and supplies.

Covered for the rental of a hospital-grade breast pump if the infant is unable to nurse directly on the breast due to a medical condition, such as prematurity, congenital anomaly and/or an infant is hospitalized.

Chlamydia Screening

Covered.

Contraceptive Implants

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. Contraceptives for birth control are not covered for group health plans offered by religious organizations that have qualified for an exemption from the federal requirement.

Contraceptive Injectables

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. Contraceptives for birth control are not covered for group health plans offered by religious organizations that have qualified for an exemption from the federal requirement.

Contraceptive IUDs

Covered.

Please note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. Contraceptives for birth control are not covered for group health plans offered by religious organizations that have qualified for an exemption from the federal requirement.

In Vitro Fertilization

Covered. Coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are an HMAA member. If you receive benefits for in vitro fertilization services under an HMAA plan, you will not be eligible for in vitro fertilization benefits under any other HMAA plan. In vitro fertilization services are not covered when a surrogate is used. The in vitro procedures must be performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine's minimal standards for programs of in vitro fertilization.

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

- You and your male partner have a history of infertility for at least five years; or infertility is related to 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);
  - abnormal male factors contributing to the infertility.
- You have been unable to attain a successful pregnancy through other covered infertility treatments.

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

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

Please note: Exclusions or limits that may apply.

Mammography (screening)

Covered according to the following schedule:

- Age 35 to 39, one baseline mammogram.
- Age 40 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 chapter under *Testing, Laboratory, and Radiology.*

Maternity Care

Covered, for routine prenatal visits, delivery, and one postpartum visit. HMAA pays physicians a global fee related to a bundle of maternity care. If benefit payments are made separately before delivery, payments will be considered an advance and we will deduct the amount from the global payment for maternity care.

Coverage for other maternity related services such as nursery care, labor room, hospital room and board, pregnancy termination, diagnostic tests, labs, and radiology are described in other sections of this document. See Physician Visits, Emergency Services and Laboratory and Pathology - Outpatient for benefits.

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.

Pap Smears (screening)

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

Pregnancy Termination

Covered.

Tubal Ligation

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

Well Woman Exam

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

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

Home Health Care

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

- Services are prescribed in writing by a physician to treat an illness or injury when you are homebound. ***Homebound*** means that due to an illness or injury, you are unable to leave home, or if you do leave home, doing so requires a considerable and taxing effort.

- Part-time skilled health services are needed.
- Services are not more costly than alternate services that would be effective to diagnose and treat your condition.
- Without home health care, you would need inpatient hospital or 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 an ongoing plan of treatment at the end of each 30-day period of care.
- Services do not exceed 150 visits per calendar year.

Hospice Services

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

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

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

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

Integrated Case Management

Covered, when approved by us. ***Integrated Case Management*** is a special program to help members with certain medical conditions that need costly, long-term, care and when a hospital may not be the most appropriate setting for your care. If you meet HMAA's criteria, your coverage provides you with alternate benefits to help meet health care needs that result 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 contact us for assistance.

Behavioral Health – Mental Health and Substance Abuse

Covered, if:

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

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

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

Alcohol or Drug Dependence Treatment

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

Autism

Covered, in accordance with Hawaii Law and HMAA's medical policies. Benefits shall exclude coverage for:

- Care that is custodial in nature;
- Services and supplies that are not clinically appropriate;
- Services provided by family or household members;
- Treatments considered experimental; and
- Services provided to an individual under any publicly funded program, an individualized family service plan, an individualized education program, or an individualized service plan.

Treatment for autism shall not be covered unless provided by an autism service provider that is licensed by a state licensure board. If a state licensure board that licenses providers to provide autism services is unavailable, the autism provider shall be certified by the Behavioral Analyst Certification Board, Inc. and meet credentialing requirements determined by HMAA.

Applied Behavioral Analysis (ABA) is covered, but only for autism spectrum disorders, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in accordance with Hawaii law and HMAA's medical policies, for ABA services defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Services must be provided in the state where you reside by Behavioral Analyst recognized by us.

The treatment & diagnosis of Autism is covered for the following care prescribed or ordered for an individual diagnosed with autism by a licensed physician, psychiatrist, psychologist, licensed clinical social worker, or registered nurse practitioner if the care is determined to be medically necessary in accord with HMAA's medical policies:

- Behavioral health treatment;
- Pharmacy care;
- Psychiatric care;
- Psychological care; and
- Therapeutic care.

ABA treatment may be covered for an individual with ASD when ALL of the following selection criteria are met:

1. A diagnosis of ASD has been made by a licensed medical professional or licensed psychologist as defined by the state mandate providing this coverage; and
2. ABA is considered an effective intervention for ASD based on consensus and evidence based practice guidelines from relevant professional societies and consistent with peer reviewed literature; and
3. The goals of intervention are appropriate for the individual's age and impairments; and
4. Documentation is provided which describes the individual-specific treatment plan that includes all of the following:
    a. The identified behavioral, psychological, family, and medical concerns; and
    b. Measurable goals in objective terms based on standardized assessments that address the behaviors and impairments for which the intervention is to be applied.

Continuation of ABA treatment may be covered for an individual with ASD when ALL of the following selection criteria are met:

1. The individual has met criteria for an initial course of ABA; and
2. The individual-specific treatment plan will be updated and submitted no less than every 6 months or as required by a state mandate; and
3. For each goal in the individual-specific treatment plan, the following is documented:
    a. Developmental testing is done no later than 2 months after the initial course of ABA treatment has begun in order to establish a baseline in the areas of social skills, communication skills, language skills, and adaptive functioning; and
    b. Progress to date; and
    c. Anticipated timeline for achievement of the goal based on both the initial assessment and subsequent interim assessments over the duration of the intervention; and
4. The individual-specific treatment plan includes age and impairment appropriate goals and measures of progress. Clinically significant progress in social skills, communication skills, language skills, and adaptive functioning must be documented as follows:
    a. Interim progress assessment at least every 6 months based on clinical progress toward treatment plan goals; and
    b. Developmental status as measured by standard scores using standardized assessments every 1 to 3 years.

ABA treatment will **not** be covered when the criteria above are not met or when there is no documentation of clinically significant developmental progress in any one of the following areas: social skills, communication skills, language skills, or adaptive functioning as measured by either a) interim progress assessment or b) developmental status as measured by standardized tests.

Treatment for autism shall not be covered unless the provider meets PPO network's credentialing requirements and is certified by the Behavior Analyst Certification Board, Inc.

Organ and Tissue Transplants

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

Also, all transplants must:

- Receive our approval. Without approval for the specified transplants, benefits are not available. *See Chapter 5: Precertification.*

- Be received from a facility that:
    - Accepts you as a transplant candidate, and
    - Is located in the State of Hawaii and has a contract with us to perform the transplant, or
    - Is an approved Center of Excellence for Transplants. You may call HMAA for a current list of providers.

Benefits are not available for:

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

Transportation, Lodging and Meal Allowance benefits are only available when utilizing a participating Centers of Excellence Provider. Lodging and Meal Allowance for patient and companion is limited to a daily dollar maximum. There is also a maximum dollar Benefit per Transplant for Transportation, Lodging and Meals from Pre-transplant Evaluation through one year of follow-up following the Transplant.

Transplant Evaluations

Covered, if we approve, for heart, heart-lung, liver, lung, pancreas, simultaneous kidney/pancreas, small bowel and multivisceral, or stem-cell transplants. See *Chapter 5: Precertification.* ***Transplant Evaluation*** means those procedures, including lab and diagnostic tests, consultations, and psychological evaluations that a facility uses in evaluating a potential transplant candidate. This coverage is limited to one evaluation per transplant request and must be rendered either at a facility that is located in the State of Hawaii and has a contract with us to perform the transplant or is an approved Center of Excellence for Transplants. For information about donor screening benefits, see in this chapter under *Organ Donor Services.*

Organ Donor Services

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

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

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

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

Corneal Transplants

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

Heart Transplants

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

Heart and Lung Transplants

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

Kidney Transplants

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

Liver Transplants

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

Lung Transplants

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

Pancreas Transplants

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

Simultaneous Kidney/Pancreas Transplants

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

Small Bowel and Multivisceral Transplants

Covered, for small bowel (small intestine) and the small bowel with liver or small bowel with multiple organs such as the liver, stomach and pancreas, but only if you meet HMAA's criteria and if we approve. See *Chapter 5: Precertification.*

Stem-Cell Transplants (including Bone Marrow Transplants)

Allogeneic stem-cell transplants, reduced intensity conditioning for allogeneic stem-cell transplants and autologous stem-cell transplants are available only for treatment prescribed in accord with HMAA's medical policies and with our approval. See *Chapter 5: Precertification.*

Prescription Drugs and Supplies

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

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

Autism Spectrum Disorders Drugs

Covered, in accord with Hawaii law and HMAA's medical policies.

Chemotherapy – Oral Drugs

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

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

Contraceptives

Covered, including diaphragms, cervical caps, oral contraceptives, other contraceptive methods, and over-the-counter contraceptives, but only with a written prescription for the contraceptive.

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

Diabetic Drugs, Supplies, and Insulin

Covered. Diabetic supplies are limited to coverage for:

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

U.S. Preventive Services Task Force (USPSTF)

Covered for drugs recommended by the U.S. Preventive Services Task Force (USPSTF).

Please note: The list of U.S. Preventive Services Task Force (USPSTF) recommended drugs may change. Examples of drugs recommended include, but are not limited to, aspirin and folic acid. If you need more information about the USPSTF recommended drugs, including a current list of recommendations please visit our website at www.hmaa.com or call us at our telephone numbers on the front cover of this DOC.

Please note: Benefits for drugs dispensed to a registered bed patient are listed under the section *Hospital and Facility Services* under *Hospital Ancillary Services.*

Please note: Some prescription drugs and supplies must have precertification. See *Chapter 5: Precertification.*

Please note: Coinsurance for Prescription Drugs and Supplies only apply toward meeting the Annual Coinsurance Maximum for Prescription Drugs and Supplies. Benefits for prescription drugs and supplies vary depending on whether the drug is a generic drug, a Preferred drug, or Non-Preferred drug.

Definitions

Biological products - Biological products, or biologics, are medical products. Many biologics are made from a variety of natural sources – human, animal, or microorganism – and may be produced by biotechnology methods and other cutting-edge technologies. Like drugs, some biologics are intended to treat diseases and medical conditions. Other biologics are used to prevent or diagnose diseases. Examples may include: vaccines, blood and blood products for transfusion and/or manufacturing into other products; allergenic extracts, which are used for both diagnosis and treatment (for example allergy shots); human cells and tissues used for transplantation (for example, tendons, ligaments and bone); gene therapies; cellular therapies; test to screen potential blood donors for infectious agents such as HIV.

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

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

Generic drugs are a drug, supply or insulin that is prescribed or dispensed under their commonly used generic name rather than a brand name and which are not protected by patent, or drugs identified by HMAA as "generic." Generic drugs include all single-source and multi-source generic drugs as set forth by a nationally recognized source selected and disclosed by HMAA.

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

Interchangeable biologic product – An interchangeable biologic product is an FDA-approved biologic product that meets the additional standards for interchangeability to an FDA-approved reference product included in:

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

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

Non-Preferred Formulary drugs, supplies, and insulin are brand name drugs, supplies, or insulin which are not identified as preferred on the HMAA Prescription Drug Formulary.

Non-Preferred Formulary Specialty Drugs are specialty drugs that are not identified as a Preferred Formulary Specialty Drug on the HMAA Prescription Drug Formulary.

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

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

Preferred Formulary drugs, supplies and insulin are brand name drugs, supplies or insulin identified as preferred on the HMAA Prescription Drug Formulary.

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

Reference product – A reference product refers to the original FDA-approved biologic product on which a biosimilar is based.

Specialty Drugs – Drugs with one or more of the following characteristics:

- High in cost ($1,000 or more).
- Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.
- Coordination of care is required prior to drug therapy initiation and/or during therapy.
- Unique patient compliance and safety monitoring requirements.
- Unique requirements for handling, shipping, and storage.
- Restricted access or limited distribution.

Benefit Limitations

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

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

- You must pay an additional coinsurance for each 30-day supply or fraction thereof, and
- The pharmacy will fill the prescription in the quantity specified by your Provider up to a 12-month supply for contraceptives.

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

Diabetic supplies
Diabetic supplies are limited to coverage for syringes, needles, lancets, lancet devices, test strips, acetone test tablets, insulin pump tubing, and calibration solutions.

Drug Benefit Management

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

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

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

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

Additional Amounts You May Owe When There is a Drug Generic Equivalent

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

You will be required to pay the entire cost of the brand name drug when you choose to obtain a brand name drug instead of the generic equivalent or the particular generic equivalent was out-of-stock or not available at the pharmacy. In this situation, you will be responsible for submitting a claim to us. In the event a generic equivalent is out-of-stock or not available, you may wish to purchase the generic equivalent from another pharmacy.

90-Day Retail Providers

Benefits for 90-day retail prescription drugs, supplies, and insulin are only available through a select network of contracted providers. Log onto our website at HMAA.com for a list of these providers. If you receive a 90-day supply of prescription retail drugs and supplies from a non-participating provider, no benefits will be paid.
Coinsurance amounts are for a maximum 90-day supply or fraction thereof. A 90-day supply means a supply that will last you 90 consecutive days or a fraction thereof. You must pay a 90-day coinsurance even if the prescription is written for less than a 90-day supply or the pharmacy dispenses less than 90 doses or less than a 90-day supply. Situations in which this would occur include, but are not limited to:

- You are prescribed a drug in pill form that must be taken only on the last five days of each month. A 90-day supply would be fifteen pills, the number of pills you must take during a three-month period.
- You are prescribed a 30-day supply of a drug that is packaged in less than 30-day quantity.

Mail Order Providers

Benefits for mail order prescription drugs, supplies, and insulin are only available through contracted providers. Log onto our website at HMAA.com for a list of these providers. If you receive mail order prescription drugs and supplies from a non-participating provider, no benefits will be paid.
The contracted provider will fill the prescription in the quantity specified by the Provider up to a 12-month supply for contraceptives. For all other drugs or supplies, coinsurance amounts are for a maximum 90-day supply or fraction thereof. A 90-day supply means a supply that will last you 90 consecutive days or a fraction thereof. You must pay a 90-day coinsurance even if the prescription is written for less than a 90-day supply or the pharmacy dispenses less than 90 doses or less than a 90-day supply. Situations in which this would occur include, but are not limited to:

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

- You are prescribed a 30-day supply with two refills. The mail order pharmacy will fill the prescription in the quantity specified by the Provider, in this case 30 days, and will not send you a 90-day supply. You owe the 90-day coinsurance payment even though a 30-day supply has been dispensed.
- You are prescribed a 30-day supply of a drug that is packaged in less than 30-day quantity, for example, a 28-day supply. The pharmacy will fill the prescription by providing you a 28-day supply. You owe the 90-day coinsurance payment. If you are prescribed a 90-day supply, the pharmacy would fill the prescription by giving you three packages each containing a 28-day supply of the drug. Again, you would owe a 90-day coinsurance payment for the 84-day supply.

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

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

Refills

Except for certain drugs managed under Drug Benefit Management, refills will be paid if indicated on your original prescription and only after two-thirds of your prescription has already been used.

Chapter 5: Precertification

Definition

Precertification is a special approval process to make sure that certain medical treatments, procedures, or devices meet payment determination criteria before the service is rendered. **If you do not receive approval and receive any of the services, benefits may be denied.**

Changes to the List of Services and Supplies Which Require Precertification

From time to time, we need to update the list of services and supplies that require precertification. Changes are needed so that your plan benefits remain current with the way therapies are delivered. Changes 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, call us at the telephone number on the front cover of this DOC.

A table with a list of the treatments, procedures and devices that need precertification is available on our website at www.hmaa.com, or contact us to obtain a copy.

When to Request Precertification

If you are under the care of:

- An HMAA participating physician or contracting physician, he or she will:
  - Get approval for you; and
  - Accept any penalties for failure to get approval.
- A Cigna PPO Network participating provider or non-participating provider, you are responsible for getting the approval. If you do not receive approval and receive any of the services, benefits may be denied.

How to Request Precertification

Ask for precertification by writing or faxing us at:

HMAA - Health Management Department	On Oahu (808) 791-7505
220 South King Street, Suite 1200	Toll-Free (888) 941-4622 ext. 302
Honolulu, HI 96813	Fax (808) 535-8398

If you would like to check on the status of the precertification, call us at the phone numbers shown above.

Our Response to Your Request for Precertification or Non-Urgent Care

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

Our Response to Your Urgent Precertification Request

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

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

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

If you do not provide enough details for us to determine if or to what extent the care you request is covered, we will notify you within 24 hours after we receive your request. We will let you know what information we need to respond to your request and you will have three (3) business days to provide the information.

Appeal of Our Precertification Decision

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

About This Chapter

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

Please note: Even if a service or supply is not specifically listed as an exclusion in this chapter, there are additional exclusions as described by the limitations in Chapter 4. If that service or supply is not specifically listed as an exclusion in this chapter or as a limitation exclusion in Chapter 4, it will not be covered unless it is described in *Chapter 4: Description of Benefits,* and meets all of the criteria, circumstances or conditions described, and it meets all of the criteria described in *Chapter 1: Important Information* under *Questions We Ask When You Receive Care.* If a service or supply does not meet the criteria described in Chapter 4, then it should be considered an exclusion or service that is not covered. This chapter should be read in conjunction with Chapter 4 in order to identify all items that are excluded from coverage.

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

Counseling Services

Bereavement Counseling

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

Genetic Counseling

You are not covered for genetic counseling, except as identified on the U.S. Preventive Services Task Force list of Grade A and B Recommendations. If you need more information about USPSTF recommended counseling, including a current list of recommendations, please visit our website or call us at our telephone numbers on the front cover of this DOC.

Marriage or Family Counseling

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

Nutritional Counseling

You are not covered for nutritional counseling, except as described in *Chapter 4: Description of Benefits. See Other Medical Services and Supplies, Nutritional Counseling,* or *Special Benefits –Disease Management and Preventive Services, Screening Services and Preventive Counseling.*

Sexual Orientation Counseling

You are not covered for sexual orientation counseling.

Coverage Under Other Programs or Laws

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

Third Party Reimbursement

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

Dental, Drug and Vision

Dental Care

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

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

Drugs

You are not covered for:

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

Eyeglasses and Contacts

You are not covered for:

- Sunglasses.
- Prescription inserts for diving masks or other protective eyewear.
- Non-prescription industrial safety goggles.
- Non-standard 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 *Chapter 4: Description of Benefits* under *Other Medical Services and Supplies, Vision and Hearing Appliances.*
- 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.

Fertility and Infertility

Contraceptives

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

You are not covered for contraceptives if your group health plan is offered by a religious organization that has qualified for an exemption from the federal requirement.

Infertility Treatment

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

- Collection, storage and processing of semen.
- Cryopreservation of oocytes, semen and embryos.
- 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 and supplies related to such services except as described in *Chapter 4: Description of Benefits* under *Special Benefits for Women.*

Sterilization Reversal

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

Preventive and Routine

Health Appraisal

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

Immunizations

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

Preventive Services - Physical Examination

You are not covered for physical or health exams and any associated screening procedures except as described in *Chapter 4: Description of Benefits* under the *Special Benefits* sections.

Routine Circumcision

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

Routine Foot Care

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

Provider Type

Provider Nondiscrimination

To the extent an item or service is a Covered Service under this Plan, and consistent with reasonable medical management techniques specified under this Plan with respect to the frequency, method, treatment or setting for an item or service, HMAA shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope or the provider's license or certification under Hawaii law. HMAA is not required to accept all types of providers into its network and has discretion governing provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

Provider as an Immediate Family Member

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

Social Worker

You are not covered for services and supplies from a social worker. This exclusion does not apply to covered mental health or substance abuse services or Covered Services within the scope of the social worker's professional license issued in Hawaii.

Please note: Social workers are not Participating Providers under this plan except as noted above. You will be responsible for your copayment/coinsurance, if any, plus the difference between HMAA's eligible charge and the social worker's billed charge.

Transplants

Living Donor Transport

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

Liver Organ Donor Services

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

Mechanical or Non-Human Organs

You are not covered for mechanical or non-human organs, except for artificial hearts when used as a bridge to a permanent heart transplant.

Organ Purchase

You are not covered for the purchase of any organ.

Transplant Services or Supplies

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

Transportation of Organs or Tissue

You are not covered for the transportation of organs or tissues.

Miscellaneous Exclusions

Act of War

To the extent allowed by law, you are not covered for services needed to treat an injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists.

Airline Oxygen

You are not covered for airline oxygen.

Biofeedback

You are not covered for biofeedback and any related tests.

Blood

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

Carcinoembryonic Antigen (CEA)

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

Complications of a Non-Covered Procedure

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

Convenience Treatments, Services or Supplies

You are not covered for treatments, services or supplies that are prescribed, ordered or recommended primarily for your comfort or convenience, or the comfort or convenience of your provider or caregiver. Such items may include ramps, home remodeling, hot tubs, swimming pools, deluxe/upgraded items, or personal supplies such as surgical stockings.

Cosmetic Services, Surgery or Supplies

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

Custodial Care

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

Developmental Delay

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

Ductal Lavage

You are not covered for ductal lavage.

Duplicate Item

You are not covered for duplicate durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances that are intended to be used as a back-up device, for multiple residences, or for traveling, e.g., a second wheeled mobility device specifically for work or school use or a back-up manual wheelchair when a power wheelchair is the primary means of mobility.

Effective Date

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

Electron Beam Computed Tomography (EBCT or Ultrafast CT)

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

Enzyme-Potentiated Desensitization

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

Erectile Dysfunction

You are not covered for services and supplies (including prosthetic devices) related to erectile dysfunction except if due to an organic cause or to treat gender dysphoria as described in *Chapter 4: Description of Benefits* under *Other Medical Services and Supplies, Gender Identity Services.*

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 fraudulent statement or other intentional misrepresentation that you or your employer made on an enrollment form for membership or in any claims for benefits. If we pay benefits to you or your provider before learning of any false statement, you or your employer are responsible for reimbursing us.

Foot Orthotics

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

- Foot orthotics for persons with specific diabetic conditions per Medicare guidelines;
- Foot orthotics for persons with partial foot amputations;
- Foot orthotics that are an integral part of a leg brace and are necessary for the proper functioning of the brace, and;
- Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.

Genetic Testing and Screening

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

Growth Hormone Therapy

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

Hair Loss

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

Hypnotherapy

You are not covered for hypnotherapy.

Incontinence Supplies

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

Intradiscal Electro Thermal Therapy (IDET)

You are not covered for intradiscal electro thermal therapy.

Microprocessor (Upper/Lower Prostheses)

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

Motor Vehicles

This plan does not cover the cost to buy or rent motor vehicles such as cars and vans. You are also not covered for equipment and costs related to converting a motor vehicle to accommodate a disability

Non-Medical Items

You are not covered for durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances that are not primarily medical in nature, e.g., environmental control equipment or supplies (such as air conditioners, humidifiers, dehumidifiers, air purifiers or sterilizers, water purifiers, vacuum cleaners, or supplies such as filters, vacuum cleaner bags and dust mite covers); hygienic equipment; exercise equipment; items primarily for participation in sports or leisure activities, and educational equipment.

Non-Related Items Exclusion

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

Private Duty Nursing

You are not covered for private duty nursing.

Radiation (High-Dose)

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

Radiation (Nonionizing)

You are not covered for treatment with nonionizing radiation.

Recreational Therapy

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

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

Repair/Replacement

You are not covered for the repair or replacement of durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances covered under the manufacturer or supplier warranty or that meet the same medical need as the current item but in a more efficient manner or is more convenient, when there is no change in your medical condition.

Reversal of Gender Reassignment Surgery

You are not covered for reversal of gender reassignment surgery, except in the case of a serious medical barrier to completing gender reassignment or the development of a serious medical condition requiring a reversal.

Self-Help or Self-Cure

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

Standby Time

You are not covered for a provider's waiting or standby time.

Supplies

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

Thoracic Electric Bioimpedance (Outpatient/Office)

You are not covered for outpatient thoracic electric bioimpedance in an outpatient setting which includes a physician's office.

Topical Hyperbaric Oxygen Therapy

You are not covered for topical hyperbaric oxygen therapy.

Travel or Lodging Cost

You are not covered for the cost of travel or lodging except as described in *Chapter 4: Description of Benefits* under *Organ and Tissue Transplants.*

Vertebral Axial Decompression (VAX-D)

You are not covered for vertebral axial decompression.

Vitamins, Minerals, Medical Foods and Food Supplements

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

Weight Reduction Programs

You are not covered for weight reduction programs and supplies, whether or not weight reduction is medically appropriate. This includes dietary supplements, food, equipment, lab tests, exams, and prescription drugs and supplies.

Wigs

You are not covered for wigs and artificial hairpieces.

Chapter 7: Filing Claims

When to File Claims

All participating and most non-participating providers in Hawaii file claims for you. If your non-participating provider does not file for you, please submit an itemized bill or receipt. The bill or receipt must be submitted within one year of the last day on which you received services. It must list 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. Our telephone numbers appear on the front cover of this DOC.

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 Identification Number (ID)

The subscriber ID number which appears on your member card.

Provider Statement

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

The provider statement must include:

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

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 Claims

Send your claim to the address listed on the front cover of this DOC.

Keep a Copy

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

Explanation of Benefits

Once we receive and process your claim, a report explaining your benefits will be provided no later than 30 days after we receive a claim you submit. You may receive copies of your report online at www.hmaa.com or by mail upon request. The ***Explanation of Benefits*** tells you how we processed the claim. It includes services performed, the actual charge, any adjustments to the actual charge, our eligible charge, the amount we paid, and the amount you owe.

If we require more information to make a decision about your claim or are unable to make a decision due to circumstances beyond our control, we will extend the time for an additional 15 days. We will let you know within the initial 30-day period why we are extending the time and when you can expect our decision. If we require more information, you will have at least 45 days to provide us the information.

If any of your claims are denied, our report will explain the denial.

If, for any reason, you believe we wrongly denied a claim or coverage request, please call us for help. Our phone numbers appear on the front cover of this DOC. 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 *Chapter 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, there may be a service charge.

Chapter 8: Dispute Resolution

Your Request for an Appeal

Writing Us to Request an Appeal

If you wish to dispute a decision made by HMAA related to coverage, reimbursement, this Agreement, or any other decision or action by HMAA you must ask for an appeal. Your request must be in writing unless you are asking for 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.

Send written requests to:

HMAA, Attn: Appeals Coordinator
220 South King Street, Suite 1200
Honolulu, HI 96813

Or, send us a fax at (808) 591-0463

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

If you have any questions about appeals, please contact our Customer Service Center.

Appeal of Our Precertification Decision

We will respond to your appeal as soon as possible given the medical circumstances of your case. It will be within 30 days after we receive your appeal.

Appeal of Any Other Decision or Action

We will respond to your appeal within 60 calendar days after we receive your appeal.

Expedited Appeal

You may ask for an expedited appeal if the time periods for appeals above may:

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

You may request expedited external review of our initial decision if you have requested an expedited internal appeal and the adverse benefit determination involves a medical condition for which the completion of an expedited internal appeal would meet the requirements above. The process for requesting an expedited external review is discussed below. You may ask for an expedited appeal by calling us at the phone number listed on the front cover of this DOC.

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

Who Can Request an Appeal

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

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

What Your Request Must Include

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

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

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

Information Available From Us

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

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

If You Disagree with Our Appeal Decision

If you are enrolled in a group plan and you would like to appeal HMAA's decision, you must do one of the following:

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

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

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

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

Your request must be in writing and include:

- A copy of HMAA's final internal appeal decision.
- A completed and signed authorization form releasing your medical records relevant to the subject of the IRO review. A copy of the authorization form is available on our website or by calling our Customer Service Center.
- A complete and signed conflict of interest form. Copies of the conflict of interest form are available on our website or by calling our Customer Service Center.
- A check for $15.00 made out to the Insurance Commissioner. It will be refunded to you if the IRO overturns HMAA's decision. You are not required to pay more than $60.00 in any calendar year.

You must send the request to the Insurance Commissioner at:

State of Hawaii Insurance Division
Attn: Health Insurance Branch — External Appeals
335 Merchant Street, Room 213
Honolulu, HI 96813
Telephone (808) 586-2804

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

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

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

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

Expedited IRO Review

You may request expedited IRO review if:

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

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

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

External Review of Decisions Regarding Experimental or Investigational Services

You may request IRO review of an HMAA determination that the supply or service is experimental or investigational. Your request may be oral if your treating physician certifies, in writing, that the treatment or supply would be significantly less effective if not promptly started.

Written requests for review must include, and oral requests must be promptly followed up with, the same documents described above for standard IRO review plus a certification from your physician that:

- Standard health care services or treatments have not been effective in improving your condition;
- Standard health care services or treatments are not medically appropriate for you; or
- There is no available standard health care service or treatment covered by your plan that is more beneficial than the health care service or treatment that is the subject of the adverse action.

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

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

Request Arbitration

If you are eligible for and choose arbitration, you must submit a written request for arbitration to HMAA, 220 South King Street, Suite 1200, Honolulu, Hawaii 96813. Your request for arbitration will not affect your rights to any other benefits under this plan. You must have fully complied with HMAA's appeals procedures described above and we must receive your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the issue. No other parties may be joined in the arbitration. The arbitration is binding and the parties waive their right to a court trial and jury.

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

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

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

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

HMAA waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.

Filing of Lawsuit

A member or dependent may not file a lawsuit or bring other legal action regarding the denial of eligibility or the denial of a claim for benefits under the Plan until the individual has timely filed a claim and has exhausted all the appeal rights made available under the Plan.

Any legal action described above must be filed no later than the earlier of (i) 180 days from the date the final decision on appeal is issued or should have been issued, or (ii) three years from the date that the claim was required to be submitted under the Plan.

A legal action regarding any matter pertaining to the Plan must be filed in the U.S. District Court for Hawaii, in Honolulu, Hawaii, which district court will have exclusive jurisdiction in regard to the matter.

Chapter 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 you are covered under this plan and another group medical plan or Medicare, the benefits of this plan and those of the other plan will be coordinated and adjusted so that you do not receive more than 100% of the eligible expenses incurred. In order to coordinate benefits, it is important to understand which plan is primary (pays first) and which plan is secondary (pays second) for each family member. This will assist the provider of service in the proper filing of claims.

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

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 benefit plans.
- Non-group 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 more information. If you do not give us the details we need to coordinate your benefits, your claims may be delayed or denied. To help us coordinate your benefits, you should:

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

What Will We Do

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

General Coordination Rules

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

No Coordination Rules

The coverage without coordination of benefits rules pays first.

Member Coverage

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

Active Employee Coverage

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

Earliest Effective Date

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

Dependent Children Coordination Rules

Birthday Rule

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

Court Decree Stipulates

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

Court Decree Does Not Stipulate

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

1. Custodial parent.
2. Spouse of custodial parent.
3. Other parent.
4. 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 the motor vehicle insurance law of your applicable State, then that motor vehicle coverage will pay before this coverage.

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

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

We will review the list of expenses to verify that the motor vehicle insurance coverage available under the motor vehicle insurance law of your applicable State is exhausted. After it is verified, you are eligible for covered services in accord with this DOC.

Please note that you are also subject to the Third Party Liability Rules at the end of this chapter: (1) if your injury or illness is caused or alleged to have been caused by someone else and you have or may have a right to recover damages or receive payment in connection with the illness or injury, or (2) if you have or may have a right to recover damages or receive payment without regard to fault other than coverage available under the motor vehicle insurance law of your applicable State.

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

Medicare Coordination Rules

Medicare as Secondary Payer

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

If You are Age 65 or Older

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

If You are Under Age 65 with Disability

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

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

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

Dual Medicare Eligibility

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

This Plan Secondary Payer to Medicare

If you 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. We will coordinate benefits under this plan up to the Medicare approved charge not to exceed the amount this plan would have paid if it had been your only coverage. If you are entitled to Medicare benefits, we will begin paying benefits after all Medicare benefits (including lifetime reserve days) are exhausted.

If you receive inpatient services and have coverage under Medicare Part B only or have exhausted your Medicare Part A benefits, we will pay inpatient benefits based on our eligible charge less any payments made by Medicare for Part B benefits (i.e., for inpatient lab, diagnostic and x-ray services).

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

Facilities or Providers Not Eligible or Entitled to Medicare Payment

When you receive services 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 Recovery, Subrogation and Reimbursement

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, worker's compensation, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant(s) is obligated to notify the Plan or its authorized representative within thirty (30) days of the date when the Participant(s) or his or her designee or representative provides notice to any party of the Participant's (or Participants') intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or any other condition sustained or suffered by the Participant(s). The Participant(s) or his or her designee or representative must provide all information to the Plan upon request, including but not limited to the full completion of any forms requested by the Plan. Further, the Participant(s) is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant(s) is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed. Failure to provide this information may result in the termination of health benefits for the Participant(s) or the institution of court proceedings against the Participant(s).

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:

1. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
2. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
3. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Member(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Member(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
8. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

By accepting benefits (whether the payment of such benefits is made to the Participant(s) or made on behalf of the Participant(s) to any provider) from the Plan, the Participant(s) agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Participant(s) hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Member(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Eligibility for Coverage

Nondiscrimination in Eligibility and Benefits

This plan allows individuals eligibility and continued eligibility regardless of any adverse health factor and uniformly provides benefits to participants and beneficiaries without directing any benefit restrictions at individual participants and beneficiaries based on a health factor.

When You Are Eligible For Coverage

You may enroll in this coverage when you are first eligible according to the Hawaii Prepaid Health Care Act, Chapter 393, HRS, and HMAA's rules for eligibility. If you do not enroll in this coverage by the first day of the month immediately following the first four consecutive weeks of employment, you will not be eligible to enroll until the next open enrollment period. ***Open Enrollment*** happens once a year. However, if you show us to our satisfaction that there was unusual and justifiable cause for submitting your enrollment form late, you may enroll sooner.

Enrollment Process

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

With the exception of the Form HC-5 Waiver, if you decline enrollment in this plan for yourself or your dependents (including your spouse) because of other health plan coverage, you may be able to enroll yourself or your dependents in this plan at a later date if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must enroll by complying with our usual enrollment process within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

What You Should Know About Enrolling Your Child(ren)

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

- The child is your son, daughter, stepson or stepdaughter, your legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian, or your eligible foster child (defined as an individual who is placed with you by an authorized placement agency or by judgment, decree or other court order).
- The child is under 26 years of age.

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

- Children with Special Needs
- Children who are Newborns or Adopted

Children With Special Needs

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

- Your child is incapable of self-sustaining support because of a physical or mental disability.
- Your child's disability existed before the child turned 26 years of age.
- Your child relies primarily on you for support and maintenance as a result of his or her disability.
- Your child is enrolled with us under this coverage or another HMAA coverage and has had continuous health care coverage with us since before the child's 26th birthday.

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

Children Who Are Newborns or Adopted

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

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

Qualified Medical Child Support Order (QMCSO)

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

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

If you would like more information about how HMAA handles QMCSOs, you may request a copy of HMAA's procedures governing QMCSO determinations. A copy will be mailed to you without charge.

When Coverage Begins

When You Are Eligible To Receive Benefits

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

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

If you are inpatient when this coverage begins, and you had no other insurance or coverage immediately prior, then coverage for services related to the hospitalization begins on the effective date of this coverage. If you had other insurance or coverage immediately prior, then coverage for any services related to the hospitalization either a) begins on the effective date of this coverage, or b) does not begin until the day after your discharge from the hospital or other inpatient facility. We will work with your prior insurer or coverage to determine which option applies to you. This limitation does not apply to you if you had medical coverage with us immediately prior to the effective date of this coverage. Please call us if this limit applies to you so that we can help you determine your rights to coverage.

When Coverage Ends

Reasons for Coverage Termination

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

- You choose to end this coverage. In this case, you must provide written notice of your intent to terminate 30 days before the termination date.
- You or your employer or group sponsor fails to make payments to us when due, or your employer or group sponsor decides to discontinue this coverage, and we have given 10-days advance written notice to your employer and the Director of the Hawaii Department of Labor and Industrial Relations.
- Your employer or group sponsor decides to replace this coverage with another coverage and there is no lapse in coverage.
- We end our agreement with your employer or group sponsor, and we have given 10-days advance written notice to your employer and the Director of the Hawaii Department of Labor and Industrial Relations.
- For the member, upon your retirement, termination of employment, severance from the group, or termination of this Agreement.
- For the member's spouse, upon your termination of coverage or upon the dissolution of the marriage.
- For the member's children, when any of the following occurs:
    - The member's coverage terminates; or
    - The child fails to meet the criteria outlined earlier in this chapter under *What You Should Know about Enrolling Your Child(ren).*

Notifying Us When Your Child’s Eligibility Ends

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

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

Termination for Fraud

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

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

If your coverage is terminated for fraud, intentional misrepresentation, or the concealment of material facts:

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

Continued Coverage

Continued Coverage Under Federal Law – COBRA Rights

When your coverage ends under this Agreement you may have the opportunity to continue your group coverage for a limited time under the Consolidated Omnibus Budget Reconciliation Act (COBRA). The act applies to employers with 20 or more employees. Refer to *Chapter 11: Required Notices and Disclosures* for further information about COBRA.

Qualifying Events

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

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

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

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

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

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

Payment of COBRA Premiums

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

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

What You Must Do

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

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

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

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

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

Adding Your Child

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

Length of Coverage Under COBRA

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

- The last day of the 18-, 29-, or 36-month maximum coverage period, whichever is applicable. If you or any of your dependents who has elected COBRA coverage is determined to be disabled under the Social Security Act during the first 60 days of continuation coverage, your COBRA coverage may continue for up to 29 months. The 29-month period will apply to you and your eligible dependents who elected COBRA coverage. You must provide notice of the disability determination to your employer within 60 days after the determination.
- The first day (including grace periods, if applicable) on which timely payment is not made by you.
- The date on which the employer ceases to maintain any group health plan (including successor plans).
- The date the qualified beneficiary enrolls in Medicare benefits. ***Qualified Beneficiary*** means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan:
    - as the spouse of the covered employee; or
    - as the dependent child of the covered employee.
- The first day on which a beneficiary is actually covered by any other group health plan. However, if the new group health plan contains an exclusion or limitation relating to any preexisting condition of the beneficiary, then coverage will end on the earlier of the satisfaction of the waiting period for preexisting conditions contained in the new group health plan, or the occurrence of any one of the other events stated in this chapter.

If the new group health plan contains a preexisting condition exclusion, the preexisting condition exclusion period will be reduced by the qualified beneficiary's preceding aggregate periods of creditable coverage (if any). The creditable coverage is applicable to the qualified beneficiary as of the enrollment date in the new group health plan as long as there has been no interruption of coverage longer than 63 days. Creditable Coverage means any of the following:

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

You may request a certificate of creditable coverage by calling HMAA Customer Service. Our phone number is listed on the front cover of this DOC.

Confidential Information

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

Dues and Terms of Coverage

Dues

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

Timely Payment

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

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

Terms of Coverage

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

Authority to Terminate, Amend, or Modify Coverage

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

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

We are required to provide a 60 day advance notice to you before the effective date of any material modification, including changes in preventive benefits.

Assignment of Benefits

Without HMAA's prior written consent, the Plan Sponsor, the Group, any Employees, and any Plan Members are expressly prohibited from assigning to any person or entity any of the Plan Documents or any right, interest, claim for payment due, benefit, or obligation under any of the Plan Documents. Except as may be expressly prescribed in an agreement to which HMAA is a party, nothing contained in any written designation of coverage under the Plan will make the Parties liable to any third party to whom Employees or Plan Members may be liable for medical care, treatment, or services.

Governing Law

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

Payment in Error

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

Notice Address

You may send any notice required by this chapter to:

HMAA
220 South King Street, Suite 1200
Honolulu, Hawaii 96813

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

Health Care Reform

The following provisions will affect your HMAA health plan under the Affordable Care Act (ACA), federal health care reform legislation that was signed into law in March 2010.

Annual & Lifetime Maximums

HMAA health plans will not have annual or lifetime dollar limits for essential benefits.

Preexisting Conditions

No one will be denied coverage despite having a preexisting condition.

Guaranteed renewability of Coverage

HMAA will renew or continue in force coverage at the option of the group. HMAA will only non-renew or cancel group coverage for the following reasons:

- Nonpayment of premiums
- Fraud
- Market exit
- Movement outside of the service area
- Cessation of bona-fide association membership

Dependent Age

Dependents can stay on their parents' health plan until age 26, regardless of the child's marital status, financial dependency, or residency. "Child" for these purposes is defined as:

- An individual who is the son, daughter, stepson, or stepdaughter of the employee.
- A legally adopted individual.
- An individual who is placed with the employee for legal adoption by the employee.
- A child for whom the employee is the court-appointed guardian.
- An eligible foster child who is placed with the employee by an authorized placement agency or by judgment, decree, or other court order.

Emergency Care

HMAA members can receive coverage for emergency care without prior authorization. Copayments and coinsurance for out-of-network providers are no more than that for in network providers. However, members may be required to pay the difference between what the out-of-network provider charges and what HMAA is required to pay under federal regulations. For more on emergency care, please see *Chapter 4: Description of Benefits*.

Appeals

Members have available to them an internal and external appeals process that is consistent with health care reform rules. For more on appeals, please see *Chapter 8: Dispute Resolution.*

Preventive Services

HMAA members will have coverage without cost-sharing for the following services obtained from participating providers:

- Select services recommended by the U.S. Preventive Services Task Force.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- Preventive care and screenings for women and children supported by the Health Resources and Services Administration.
- For more on preventive services, please see *Chapter 4: Description of Benefits*

Rescissions

HMAA members will not be dropped from coverage retroactively except in cases of fraud, intentional misrepresentation, or failure to pay member dues on time.

Other Applicable Federal and State Laws

Genetic Information Nondiscrimination Act of 2008 (Effective May 21, 2009)

This plan complies with GINA's prohibition against group-based discrimination based on genetic information. Per CFR 2590.702-1(b)(1) a group health plan cannot adjust premium or contribution amounts for the plan, or any similarly situated individual under the plan, on the basis of genetic information.

This Act expands genetic nondiscrimination protections under the Plan such that HMAA will not engage in (1) using genetic information about an individual to adjust a group or individual plan's premiums, deny coverage, or impose a preexisting condition exclusion; (2) require or request genetic testing; and (3) request, require, or purchase genetic information for underwriting purposes prior to an individual's enrollment or in connection with enrollment.

Genetic information is defined as information about such individual's genetic tests (e.g., analysis of human DNA or RNA), the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. This Law amends the Employee Retirement Income Security Act of 1974 (ERISA).

Mental Health Parity and Addiction Equity Act of 2008 (Effective October 3, 2009)

This Act applies to mental health and substance use disorder benefits with respect to services, as defined under the terms of the Plan and in accordance with applicable Federal and State law. Financial requirements and treatment limitations of mental health and substance use disorder benefits must be the same as medical and surgical benefits. The criteria for medical necessity determinations under the Plan with respect to mental health or substance abuse disorder benefits will be made available to the Plan Administrator, employee, beneficiary, or participating provider upon request.

Coverage of Dependent Students on Medically Necessary Leave of Absence (cited as "Michelle's Law") (Effective October 9, 2009)

The following applies to medically necessary leaves of absence:

If a dependent student attending a postsecondary educational institution takes a medically necessary leave of absence that commences while such child is suffering from a serious illness or injury, is medically necessary and causes such child to lose student status for purposes of coverage under the terms of the Plan, coverage will not be terminated before the earlier of the date that is one year after the first day of the medically necessary leave of absence or the date on which such coverage would otherwise terminate under the terms of the Plan (e.g., child is 26 years of age). Proof of absence by means of a written certification by the dependent student's treating physician which supports the need for the medical leave is required.

If there is a change in coverage (e.g., change in health insurance coverage or issuer) within the coverage period in which the dependent student is on a medically necessary leave of absence, the dependent student will be covered under the changed Plan for the remainder of the medically necessary leave of absence coverage period in the same manner as it would have applied if the changed coverage had been the previous coverage. This Law amends the Employee Retirement Income Security Act of 1974 (ERISA).

Covered Oral Chemotherapy (Effective January 1, 2010)

In accordance with Hawaii State Law, orally administered chemotherapy will be covered at the same copayment percentage or relative coinsurance amount applied to intravenously administered chemotherapy as determined to be medically necessary and approved by the Plan's Utilization Review Department or Medical Director.

For members who have an HMAA prescription drug plan with benefits available for oral chemotherapy, the HMAA prescription drug plan benefits will apply. This Law amends Chapter 431:10A, Hawaii Revised Statutes.

Civil Unions, Dependent Coverage (Effective January 1, 2012)

In accordance with Chapter 572, Hawaii Revised Statutes, effective January 1, 2012, dependent coverage will be extended to partners to a civil union in the same manner and with the same eligibility criteria as afforded to a lawful spouse.

Cancer Treatment (Effective April 20, 2012)

In accordance with Section 431:10A-126, Hawaii Revised Statutes, a group health plan or health insurance issuer shall provide cost-sharing for generic and non-generic oral chemotherapy drugs at the same or lower rate as generic and non-generic intravenous chemotherapy drugs. In addition, insurers are prohibited from the following:

- Increasing the co-pays for intravenously administered chemotherapy in order to increase all rates.
- Increasing cost-sharing for non-generic medications to any greater extent than policies increase cost-sharing for other covered non-generic medication.

Telehealth (Effective 2013)

In accordance with Section 431:10A-116.3, Hawaii Revised Statutes, a group health plan or health insurance issuer shall provide coverage for telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the provider. Health care providers for the purposes of telehealth include primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians, advanced practice registered nurses, psychologists, and dentists.

A telehealth service will only be covered if a health care provider-patient relationship exists between the patient and one of the providers involved in the telehealth interaction, and the patient is accompanied by a treating provider at the time of the telehealth service, with the exception of behavioral health services in which case a second provider shall not be required to accompany the patient.

Services are covered to transmit medical information, including diagnostic-quality digital images and laboratory results, via telecommunications to parties separated by distance for purpose of providing medical interpretation and diagnosis. Telecommunications services include:

- Store and forward technologies.
- Remote monitoring.
- Live consultation.
- Mobile health.

In addition, services provided via telecommunications must be otherwise covered and not excluded by this plan.

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

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

Transgender Discrimination (Effective 2016)

In accordance with Chapter 431, Hawaii Revised Statutes, §431:10A, No individual and group accident and health or sickness policy, contract, plan or agreement that provides health care coverage shall discriminate with respect to participation and coverage under the policy, contract, plan, or agreement against any person on the basis of actual gender identity or perceived gender identity.

Contraceptives (Effective 2017)

In accordance with Section 432:1-604.5, Hawaii Revised Statutes, health insurers are required to cover FDA approved contraceptive supplies intended to last for up to twelve months when prescribed by a physician.

Non-Disclosure of Adolescent Mental Health Services (Effective 2021)

In accordance with Section 577-29, Hawaii Revised Statutes, an unlicensed mental health professional, working under the supervision of a licensed mental health professional, is permitted to provide mental health treatment or counseling services to minors (14 years or older) without parental or legal guardian consent, knowledge, or participation.

It further requires a mental health Professional to ensure that the covered entity (insurer) has been notified that minor-initiated mental health treatment or counseling services should not be disclosed.

Last, it requires a covered entity (insurer), upon notification that minor-initiated mental health treatment or counseling services should not be disclosed, to maintain the confidentiality minor-initiated mental health treatment or counseling services.

No Surprises Act (Effective January 1, 2022)

The No Surprises Act prevents surprise billing of patients who receive emergency services in the emergency department of a hospital, at an independent freestanding emergency department, and from air ambulances. In addition, the law protects patients who receive certain non-emergency services from an out-of-network provider at an in-network facility. There are some exceptions based on provider notice and member consent.

Gender Affirming Treatment Act (Effective June 16, 2022)

The Gender Affirming Treatment Act prohibits health insurers, mutual benefit societies, and health maintenance organizations from applying categorical cosmetic or blanket exclusions to gender affirming treatments or procedures when determined to be medically necessary pursuant to applicable law and specifies a process for appealing a claim denied on the basis of medical necessity. In addition, it requires those entities to provide applicants and insured persons with clear information about the coverage of gender transition services, including the process for appealing a claim denied on the basis of medical necessity.

ERISA Information

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

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

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

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

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

Under ERISA section 702(b) and 29 CFR 2590.702(c), plans may not require an individual to pay a premium or contribution that is greater than a premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health factor. For example, it would be impermissible for a plan to require certain full-time employees to pay a higher premium than other full-time employees based on their prior claims experience.

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice pertains to the privacy of health information created, received or maintained by HMAA (the "Plan"). The Plan is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. This notice has been revised to reflect regulations issued by the Department of Health and Human Services (DHHS).

How the Plan May Use and Disclose Your Health Information

- **For Payment.** The Plan may use and disclose your health information to pay claims for treatment, services or supplies you receive from health care providers. For example, the Plan may receive and maintain information regarding an office visit with a doctor so as to enable the Plan to process the doctor's request for payment for the services.
- **For Health Care Operations.** The Plan may use and disclose your health information to enable it to perform its operations or to facilitate the provision of benefits to persons covered under the Plan. For example, the Plan may use your health information to develop ways to arrange for medical review or to engage in general administrative activities, such as customer service or responding to questions or concerns.
- **For Treatment.** The Plan may disclose your health information to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise your treating physician about the types of prescription drugs that you currently take.
- **To the Company.** The Plan may disclose your health information to designated Company personnel so they can carry out their Plan-related administrative functions, including those described in this notice. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or permitted by law.
- **To a Business Associate.** The Plan may disclose health information to other persons or organizations, known as business associates, who provide services on the Plan's behalf. To protect your health information, the Plan requires its business associates to appropriately safeguard the health information disclosed to them.
- **Health-Related Benefits, Services and Treatment Alternatives.** The Plan may use and disclose your health information to inform you of health-related benefits, services or treatment options or alternatives that may be of interest to you.
- **Individual Involved in Your Care or Payment of Your Care.** The Plan may disclose health information to a close friend or family member involved in, or who helps pay for, your health care.
- **As Required by Law.** The Plan will disclose your health information when required by federal, state or local law.

The Plan may also use or disclose your health information under the special use and disclosure situations described below.

- **Judicial and Administrative Proceedings.** The Plan may disclose your health information in response to a court or administrative order, a subpoena, warrant, discovery request or other lawful process.
- **Law Enforcement.** The Plan may release your health information if asked to do so by a law enforcement official.
- **Workers' Compensation.** The Plan may disclose your health information as necessary to comply with applicable workers' compensation or similar laws.
- **To Avert Serious Threat to Health or Safety.** The Plan may use and disclose your health information when necessary to prevent a serious threat to the health and safety of yourself, another person, or the public.
- **Public Health Activities.** The Plan may disclose your health information for public health activities such as to an authorized public health authority for the purpose of preventing or controlling a disease, injury or disability.
- **Health Oversight Activities.** The Plan may disclose your health information to a health oversight agency for audits, investigations, inspections and licensure necessary for the government to monitor the health care system and government programs, or to ascertain compliance with applicable civil rights laws.
- **Specialized Government Functions.** In certain circumstances, federal regulations require the Plan to use or disclose your health information to facilitate government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.
- **Coroners and Medical Examiners.** The Plan may release your health information to a coroner or medical examiner. This may be necessary, for example, to identify the cause of a person's death.

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by laws that apply to the Plan will be made only with your written authorization. The law expressly restricts the use and disclosure of psychotherapy notes, the use or disclosure of health information for marketing purposes, or disclosures that constitute a sale of health information, unless authorized by you. If you authorize the Plan to use or disclose your health information, you may revoke the authorization in writing at any time and the Plan will no longer disclose or use your health information for the reasons covered by your written authorization. However, the Plan will not retract any uses or disclosures previously made as a result of a prior authorization.

Your Rights Regarding Health Information About You

You have the rights regarding your health information that are described below.

- **Protection of Genetic Information.** Genetic information about you or your family members may not be used or disclosed by the Plan for activities relating to the creation, renewal, or replacement of a health insurance contract of health insurance or health benefits, or for any other underwriting purpose.
- **Notification of Breach of Unsecured Health Information.** You will be promptly notified if the Plan or a business associate discovers a breach of unsecured health information that affects you.
- **Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your health information maintained by the Plan. Your request must be in writing. The Plan may charge a fee for the cost of copying and mailing your request. In limited circumstances, the Plan may deny your request. Generally, you may request a review of the denial.
- **Right to Amend.** If you feel that your health information maintained by the Plan is incorrect or incomplete, you may ask the Plan to amend it for as long as the information is maintained by the Plan. To request an amendment, you must send a detailed request in writing to the Plan and provide the reasons supporting your request. The Plan may deny your request if the information requested to be amended is in fact accurate and complete, not created by the Plan, not information maintained by the Plan, or not information that you are otherwise permitted to inspect and copy.
- **Right to an Accounting of Disclosures.** You have the right to request a list of your health information that has been disclosed by the Plan, other than disclosures made for treatment, payment or health operations; to you or to a person involved in your care; to a law enforcement custodial official or for national security purposes; or in a manner that removed information that identified you. The request must be made in writing and must specify the period for which you are requesting the information (for example, during the six months preceding the request date). The Plan is not required to provide an accounting for disclosures made more than six years prior to the request.
- **Right to Request Restrictions.** You may request restrictions on the Plan's use and disclosure of your health information for treatment, payment or health care operation purposes, and on the disclosure to someone involved in the payment of your care. For example, you may request that the Plan not disclose to a family member information regarding a surgery you had. The request must be made in writing; however, the Plan is not required to agree to it.
- **Right to Receive Confidential Communications.** You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, your request must be in writing, specify how or where you wish to be contacted, and include a statement that disclosure of all or part of the information to which the request pertains could endanger you. The Plan will attempt to honor reasonable requests for confidential communications.
- **Right to a Copy of This Notice.** You have a right to request and receive a paper copy of this notice at any time, even if you previously received it. Submit requests to the Plan's Contact Person, or you may obtain a copy at hmaa.com.

Changes to this Notice

The Plan reserves the right to change the terms of this notice at any time. If it is revised, we will distribute a copy of the revised notice to you. The provisions of the new notice will apply to all health information thereafter maintained by the Plan. Until such time as a notice is revised, the Plan is required by law to abide by the terms of the current version of the notice.

Complaints

Submit concerns or complaints about the Plan's safeguarding of your health information to the Plan's Contact Person. The Plan will not retaliate against you in any way for filing a complaint. Complaints must be submitted in writing. If you believe your privacy rights have been violated, you may also file a complaint with the Office of Civil Rights, DHHS.

Contact Person

If you have any questions or wish to make a request regarding the matters covered by this notice, please contact:

HMAA Privacy Officer, 220 South King Street, Suite 1200, Honolulu, Hawaii 96813
Phone (808) 941-4622 / Toll-Free (888) 941-4622

General Notice of COBRA Continuation Coverage Rights
Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** COBRA is only available if your employer employed twenty or more full-time employees in at least 50% of typical business days in the prior calendar year. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Description of Coverage or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: HMAA, Billing and Member Services Department, 220 South King Street, Suite 1200, Honolulu, HI 96813.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. A copy of the Social Security Disability Determination letter is required. **You must provide this letter to: HMAA, Billing and Member Services Department, 220 South King Street, Suite 1200, Honolulu, HI 96813.**

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

HMAA
Billing and Member Services Department
220 South King Street, Suite 1200
Honolulu, HI 96813

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Women's Health and Cancer Rights Act (WHCRA)

HMAA is required by the Women's Health and Cancer Rights Act of 1998 to provide you with this notice and to abide by the statements made in this notice.

Your plan may provide medical and surgical benefits in connection with a mastectomy and may also provide benefits for certain reconstructive surgery. Coverage may be provided for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications associated with all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

For the covered employee or their family member receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient. This plan complies with WHCRA by not providing impermissible incentives or penalties with respect to patients or attending providers.

This coverage may be subject to annual deductibles and coinsurance payments as may be deemed appropriate and as are consistent with those established for other benefits or coverages noted in your Plan. In addition, to the extent permitted by applicable law, this coverage may also be subject to benefit maximums and co-payment provisions that may apply under your Plan. You should review carefully the provisions of your Plan regarding any such applicable restrictions.

Special Enrollment Rights for Employees of ERISA Groups

If you are enrolled in a health plan governed by the Employee Retirement Income Security Act of 1974 (ERISA) and are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing toward your or your dependents' other coverage. However, you must request enrollment within thirty-one (31) days after your or your dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your plan administrator at your place of employment or HMAA directly.

For detailed information or if you have any questions about these policies or your rights, please contact HMAA:

HMAA
220 South King Street, Suite 1200
Honolulu, Hawaii 96813

Phone (808) 941-4622
Toll-Free (888) 941-4622
E-mail CustomerService@hmaa.com

Newborns' Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Accidental Injury	An injury, separate from a disease or bodily infirmity of any other cause, that happens by chance and needs medical care right away.
Actual Charge	The amount a provider bills for a covered service or supply.
Acute Care	Inpatient 24-hour hospital care that needs a physician and nursing care on a minute-to-minute, hour-to-hour basis.
Admission	The formal acceptance of a patient into a facility for medical, surgical, or obstetric care.
Agreement	The document made up of: This Description of Coverage; any riders or amendments; the enrollment application submitted to us; and the agreement between us and your employer or group sponsor.
Advance Care Planning	Advance care planning (ACP) prepares members in the event they become very sick. Members discuss with their doctor what matters the most to them and document the desired care. ACP becomes important when a member cannot communicate decisions.
Alcohol Dependence	Any use of alcohol that produces a pattern of pathological use that causes impairment in social or occupational functions or produces physiological dependence evidenced by physical tolerance or withdrawal.
Allogeneic Transplant	Transplant in which the tissue or organ for a transplant is obtained from someone other than the person receiving the transplant.
Ambulance Service	Air or ground emergency transportation within the United States to a hospital in the surrounding area where your transport began.
Ambulatory Surgical Center	A facility that provides surgical services on an outpatient basis for patients who do not need an inpatient, acute care hospital bed.
Ancillary Services	Facility charges other than room or board. For example, charges for inpatient drugs and biologicals, dressings, or medical supplies.
Anesthesia	The use of anesthetics to produce loss of feeling or consciousness, usually with medical treatment such as surgery.
Annual Coinsurance Maximum	The maximum amount you pay for most covered services in a benefit period. The coinsurance maximum is reached from copayment, deductible and coinsurance amounts you pay in any given calendar year. Also known as Out-of-Pocket Maximum.
Annual Deductible	The fixed dollar amount you pay each calendar year before benefits are available for certain services.
Applied Behavior Analysis	The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.
Arbitration	When one person (an arbitrator) reviews the positions of two parties who have a dispute and makes a decision to end the dispute.
Assisting Surgeon	A physician who actively assists the physician in charge during a surgical procedure.
Autologous Transplant	Transplant in which the tissue or organ for a transplant is obtained from the person receiving the transplant.
Benefit Maximum	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 coverage.

Bereavement Services

Services that focus on healing from emotional loss.

Biofeedback

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 to treat the condition. The purpose of treatment is to exert control over that physiological function.

Biological Products

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

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

Biological Therapeutics and Biopharmaceuticals

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

Blood Transfusion

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

Breast Prostheses (External)

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

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 which may offer you and your eligible dependents continuation of this coverage if you lose coverage due to a qualifying event.

Calendar Year

The period starting January 1 and ending December 31 of any year. The first calendar year for anyone covered by this plan begins on that person's effective date and ends on December 31 of that same year.

Chemotherapy

Treatment of infections or malignant diseases by drugs that act selectively on the cause of the disorder, but which may have substantial effects on normal tissue. Chemotherapy drugs must be FDA-approved.

Chemotherapy - Oral

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

Child

Means any of the following: your son, daughter, stepson or stepdaughter, your legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian, or your eligible foster child (defined as an individual who is placed with you by an authorized placement agency or by judgment, decree or other court order).

Chiropractor	A health care professional who practices the system of healing through spinal manipulation and specific adjustment of body structures.
Cigna PPO Network	A provider that contracts with the Cigna PPO Network that gives HMAA members access to preferred provider organizations on the U.S. Mainland. Cigna providers file claims for you and accept the eligible charge as payment in full.
Claim	A written request for payment of benefits for services covered by this coverage.
Coinsurance	The percentage of the covered expense payable by the Member. After the Calendar Year Deductible has been met and any required copayment has been made, you pay the percentage shown in *Chapter 3: Summary of Benefits and Your Payment Obligations.*
Consultation Services	A formal discussion between physicians on a case or its treatment.
Contact Lenses	Ophthalmic corrective lenses ground as prescribed by a physician or optometrist who fit the lenses directly to your eyes.
Contraceptives	Any oral medicine or device that prevents impregnation.
Contraceptive Services	Physician-delivered, physician-supervised, physician assistant-delivered, APRN-delivered, nurse-delivered, or pharmacist-delivered medical services or devices to prevent unwanted pregnancy.
Contraceptive Supplies	All U.S. FDA-approved contraceptive drugs or devices.
Coordination of Benefits (COB)	Applies when you are covered by more than one insurance policy providing benefits for like services.
Copayment	A fixed dollar amount that may be payable in addition to your coinsurance. Benefits requiring copayments are listed in *Chapter 3: Summary of Benefits and Your Payment Obligations.*
Cosmetic Services	Services that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function, or are prescribed for psychological or psychiatric reasons.
Covered Services	Services or supplies that meet payment determination criteria and are listed in this DOC in *Chapter 4: Description of Benefits*.
Creditable Coverage	Any of the following: a group health plan; health insurance coverage; Part A or B of Medicare; Medicaid; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5, United States Code; or a public health plan as defined in government regulations health benefit plan under section 5(e) of the Peace Corps Act.
Custodial Care	Care that helps you meet your daily living activities. This type of care does not need the ongoing attention and help from licensed medical or trained paramedical personnel.
Custom-Fabricated	Items which are individually made for a specific patient (no other patient would be able to use it) starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as vacuum forming, cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components but it involves more than trimming, bending, or making other modifications to a substantially prefabricated item.
Deductible	The fixed dollar amount you pay for certain covered services before benefits are available in a calendar year.

Deluxe/Upgraded Items

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

Dependent

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

Description of Coverage (DOC)

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

Detoxification Services

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

Diagnosis

The medical description of the disease or condition.

Diagnostic Testing

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

Drug

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

Drug Dependence

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

Dues

The monthly premium amount for HMAA membership.

Durable Medical Equipment

An item that meets these criteria:

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

Examples of durable medical equipment include oxygen equipment, hospital beds, mobility assistive equipment (wheelchairs, walkers, power mobility Examples of durable medical equipment include oxygen equipment, hospital beds, mobility assistive equipment (wheelchairs, walkers, power mobility devices) and insulin pumps.

ERISA

The Employee Retirement Income Security Act of 1974, a federal law that protects your rights under this coverage.

Effective Date

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

Eligible Charge

The Eligible Charge is the lower of either the provider's actual charge or the amount we establish as the maximum eligible fee. HMAA's payment, and your coinsurance, are based on the eligible charge. Exception: For services provided by participating facilities, HMAA's payment is based on the maximum eligible fee and your coinsurance is based on the lower of the actual charge or the maximum eligible fee.

Emergency

A medical condition accompanied by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson could reasonably expect the absence of immediate medical attention to result in: 1) serious risk to the health of the person (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.

Emergency Services

With respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

Explanation of Benefits (EOB)

The report you receive from us that notes how we applied benefits to a claim. You may receive copies of your report online at hmaa.com or by mail upon request.

Extended Care Facility

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

Facility

Examples include hospitals skilled nursing facilities, and ambulatory surgical facilities.

False Statement

Any fraudulent or intentional misrepresentation you or your employer made on your membership enrollment form or in any claims for benefits.

Family Coverage

Coverage for the member, his or her spouse, and each of his or her eligible children.

Family Member

The member's spouse and/or children who are eligible and enrolled for this coverage.

Foot Orthotics

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

Frame

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

Gender Dysphoria

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

Gender Identity

A person’s internal sense of being male, female, a gender different from the gender assigned at birth, a transgender person, or neither male or female.

Gender Transition	The process of a person changing the person's outward appearance, including sex characteristics, to accord with the person's gender identity.
Generic Drug	A drug that is prescribed or dispensed under its commonly used generic name rather than a brand name, is not protected by patent, or is identified by HMAA as "generic."
Group	Those members who share a common relationship such as employment or membership. The group has executed the group plan agreement with us and by getting health coverage through the group, you designate the group as your administrator.
Health Coaching	A coaching program that matches members with their own certified health coach who will help build a customized wellness plan designed to provide the motivation and support needed to meet your health goals.
High-Dose Radiotherapy	A form of radiation therapy in which the dose and/or manner of administration is expected to damage a person's bone marrow or suppress bone marrow function so that a stem-cell transplant is needed.
Homebound	Due to an illness or injury, you are unable to leave home, or leaving your home requires a large and taxing effort
Home Health Agency (HHA)	An approved agency that provides skilled nursing care in your home.
Home Infusion Therapy	Treatment in the home that involves giving nutrients, antibiotics and other drugs and fluids intravenously or through a feeding tube. Drugs must be FDA-approved.
Hospice Program	A program that provides care in a comfortable setting for patients who are terminally ill and have a life expectancy of six months or less. Care is normally provided in the patient's home.
Hospital	An institution that provides diagnostic and therapeutic services for surgical and medical diagnosis, treatment and care of injured or sick persons.
Illness or Injury	Any bodily disorder, injury, disease or condition, including pregnancy and its complications.
Immediate Family Member	Your child, spouse, parent, or yourself.
Immunization	An injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.
Implanted Internal Items/Implants (Surgical/Orthopedic)	Internal prosthetic devices used during surgery that are necessary for anatomical repair or reconstructive purposes. These devices remain in the body and replace a missing biological structure or support or enhance a damaged biological structure. Examples include, but are not limited to: cardiac pacemakers, defibrillators, heart valves and stents, breast implants for post-mastectomy reconstruction, hip and knee replacements, hardware necessary to anchor fractured bones, implanted cataract lenses, cochlear implants, adjustable gastric bands for bariatric surgery, and human tissue. The device must be FDA-approved for the purpose it is being used.
Inborn Error of Metabolism	A disease caused by an inherited abnormality of the body chemistry of a person that is characterized by deficient metabolism, originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat.
Incidental Procedure	A procedure that is an integral part of another procedure. Such procedures are not reimbursed separately.

Independent Freestanding Emergency Department	A health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.
Inhalation Therapy	Therapy to treat conditions of the cardiopulmonary system.
Injection	The introduction of a drug, biological therapeutic, biopharmaceutical, or vaccine into the body by using a syringe and needle. Injectable drugs must be FDA-approved.
Inpatient Admission	A stay in an inpatient facility, usually involving overnight care.
Integrated Case Management	A program that addresses the specialized care needs of patients with severe or chronic illnesses or injuries.
Intravenous Injection	An injection made into the vein.
In Vitro Fertilization	A way to treat infertility in women.
Laboratory Services	Services used to help diagnose, prevent, or treat disease.
Lenses	Ophthalmic corrective lenses ground as prescribed by a physician or optometrist for fitting into a frame.
Life Health Assessment (LHA)	Online portal that includes a risk assessment that evaluates your health and lifestyle.
Limited Services	Those covered services that are limited per service, per episode, per calendar year or per lifetime.
Long-Term Acute Care	A level of care for patients who no longer require care in an acute hospital, are chronically and severely ill, are felt to have the potential for improvement, and require an intensity and specialization of care that is beyond that provided in any other level of post-acute care. Examples include: skilled nursing facility, home healthcare, inpatient rehabilitation facility, and for a limited period until the condition is stabilized or a treatment course is completed.
Low-Protein Modified Food Product	A food product that: (1) Is specially formulated to have less than one gram of protein per serving; (2) Is prescribed or ordered by a physician or osteopathic physician as medically necessary for the dietary treatment of an inherited metabolic disease; and (3) Does not include a food that is naturally low in protein.
Mammogram	An x-ray exam of the breast using equipment dedicated specifically for mammography.
Mammography (screening)	An x-ray film that screens for breast abnormalities.
Maternity Services	Services for prenatal and postnatal care, complications, delivery, and to end a pregnancy.
Maximum Eligible Fee	The amount we establish as the maximum amount HMAA will pay for covered services and supplies.
Medicaid	A form of public assistance sponsored jointly by the federal and state governments providing medical assistance for eligible persons whose income falls below a certain level. The Hawaii Department of Human Services pursuant to Title XIX of the federal Social Security Act administers this program.
Medical Food	A food that is formulated to be consumed or administered internally under the supervision of a physician or osteopathic physician and is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation
Member	The person, and their dependents, who meets eligibility requirements of the Plan.

Member Card	Your member card issued to you by us. You must present this card to your provider at the time you receive services.
Mental Health Outpatient Facility	A mental health clinic, institution, center, or community mental health center that provides for the diagnosis, treatment, care or rehabilitation of people who are mentally ill.
Mental Health Illness/Disorder	A syndrome of clinically significant psychological, biological, or behavioral abnormalities that result in personal distress or suffering, impairment of capacity to function, or both. Mental illness and disorder are used interchangeably in this DOC and as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or in the International Classification of Disease.
Microprocessor-Controlled Prosthetic Device	Prosthetic devices that use feedback from sensors to adjust joint movement on a real-time as-needed basis.
Myoelectric Prosthetic Device	Prosthetic devices powered by electric motors with an external power source. For example, the movement of an upper limb prosthesis (e.g., hand, wrist, and/or elbow) is driven by micro-chip-processed electrical activity in the muscles of the remaining limb stump.
Newborn	A recently born infant.
Newborn Care	All routine non-surgical physician services and nursery care provided to a newborn during the mother's initial hospital stay.
Non-Assignment	When benefits for covered services and supplies cannot be transferred or assigned to anyone for use.
Non-Participating Providers	Providers that are not under contract with HMAA's networks.
Non-Preferred Drug, Supply, or Insulin	A brand name drug, supply, or insulin which are not identified as preferred on the HMAA Prescription Drug Formulary.
Nurse Midwife	A health care professional who provides services such as pre and post-natal care, normal delivery services, routine gynecological services, and any other services within the scope of his or her certification.
Occupational Therapy	A form of therapy involving the treatment of neurological and musculoskeletal dysfunction through the use of specific tasks or goal-directed activities designed to improve the functional performance of an individual.
Ophthalmologist	A physician specializing in the diagnosis and treatment of diseases and defects of the eye.
Optician	One who fits, adjusts and dispenses glasses and other optical devices, on the written prescription of a licensed physician or optometrist.
Optometrist	One who specializes in the examination, diagnosis, treatment and management of diseases and disorders of the visual system, the eye and related structures.
Oral Surgeon	A dentist licensed as a doctor of dentistry (D.M.D.) or dental surgery (D.D.S.) to diagnose and treat oral conditions that need surgery.
Organ Donor Services	Services related to the donation of an organ.
Orofacial Anomalies	Cleft lip or cleft palate and other birth defects of the mouth and face affecting functions such as eating, chewing, speech, and respiration.
Orthodontic Services	Direct or consultative services provided by a licensed dentist with a certification in orthodontics by the American Board of Orthodontics.

Orthotics/Orthotic Devices/Orthoses	Rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a diseased or injured part of the body. They must provide support and counterforce (i.e., a force in a defined direction of a magnitude at least as great as a rigid or semirigid support) on the limb or body part that it is being used to brace. An orthotic can be either prefabricated or custom-fabricated.
Osteopathy	Medicine that specializes in diseases of the bone.
Osteoporosis	The loss of minerals from the bone.
Other Providers	Health care providers other than facilities and practitioners. Examples include hospice agencies, ambulance services, retail pharmacies, home medical equipment suppliers, and independent labs.
Our	Reference to HMAA (Hawaii Medical Assurance Association).
Outpatient	Care received in a practitioner's office, the home, the outpatient department of a hospital or ambulatory surgery center.
Participating Medical Pharmacy	A participating retail pharmacy that also contracts with us to provide items that are covered under this plan such as medical equipment and supplies.
Participating Provider	A provider that participates with us.
Physical Therapy	A form of therapy involving treatment of disease, injury, congenital anomaly or prior therapeutic intervention through the use of therapeutic modalities and other interventions that focus on a person's ability to go through the functional activities of daily living and on alleviating pain.
Physician	A medical doctor (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.).
Physician Assistant	A practitioner who provides care under the supervision of a physician.
Physician Services	Professional services necessarily and directly performed by a doctor to treat an injury or illness.
Plan	This hospital and health benefits program offered to you as an eligible employee for purposes of ERISA.
Plan Administrator	Your employer or group sponsor for the purposes of ERISA.
Planned Admission	An admission that can be scheduled in advance because the condition, illness or injury is not immediately life-threatening.
Podiatrist	A health care professional who specializes in conditions of the feet.
Podiatry	Care and study of the foot.
Postoperative Care	Care given after a surgical operation.
Postpartum	The period of time after childbirth.
Precertification	The process of getting prior approval for specified services and devices. Failure to get our approval will result in a denial of benefits if the services or devices do not meet HMAA's payment determination criteria. HMAA participating providers agree to get approval for you. All other providers do not agree to get approval for you, therefore you are responsible.
Preferred Drug, Supply, or Insulin	A brand name drug, supply, or insulin identified as preferred on the HMAA Prescription Drug Formulary.
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 provider with statutory authority to prescribe 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.
Prosthetic Appliances	Devices used as artificial substitutes to replace a missing natural part of the body and other devices to improve, aid, or increase the performance of a natural function.
Provider	An approved physician or other practitioner, facility, or other health care provider, such as an agency or program.
Psychological Testing	A standard task used to assess some aspect of a person's cognitive, emotional, or adaptive function.
Psychologist	An approved provider who specializes in the treatment of mental health conditions.
Qualified Beneficiary	Qualified Beneficiary means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan: ▪ as the spouse of the covered employee; or ▪ as the dependent child of the covered employee.
Qualified Medical Child Support Order (QMSCO)	A Medical Child Support Order that creates or recognizes in the person specified in the order the existence of the right to enroll in the health benefit plan for which the plan member or his/her dependents are eligible. To be a Qualified Medical Child Support Order, the order cannot require a health benefit plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act with respect to a group plan.
Qualifying Payment Amount	Generally, the median of contracted rates for a specific service in the same geographic region
Radiology	The use of radiant energy to diagnose and treat 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 DOC.
Religious Employer	An entity for which each of the following is true: the inculcation of religious values is the purpose of the entity; the entity primarily employs persons who share the religious tenets of the entity; the entity is not staffed by public employees; the entity is a nonprofit per IRS definition.
Sexual Identification Counseling	Psychotherapy for a person with gender dysphoria.
Sexual Orientation Counseling	Treatment of an enduring pattern of emotional, romantic and/or sexual attractions to men, women or both sexes. Sexual orientation also refers to a person's sense of identity based on those attractions, related behaviors and membership in a community of others who share those attractions.
Single Coverage	Coverage for the member only.
Skilled Nursing Care	A level of care for patients who require skilled nursing and/or rehabilitation care, i.e., services that must be performed by or under the supervision of professional or technical personnel, on a daily basis.

Specialist	A provider who is specifically trained in a certain branch of medicine related to a service or procedure, body area or function, or disease.
Specialty Drugs	High-cost drugs that are used to treat chronic, potentially life-threatening diseases and are listed in the HMAA's Prescription Drug Formulary. Specialty Drugs are covered only when purchased from select providers.
Speech Therapy Services	Services for the diagnosis, assessment and treatment of communication impairments and swallowing disorders.
Spouse	Your husband or wife as the result of a marriage who is legally recognized in the state of Hawaii.
Standby Time	Any period of time that is used for waiting, or is idle.
Subcutaneous Implant	A medication that is surgically placed beneath the skin to release the drug in the bloodstream. An example is the Norplant contraceptive.
Subscriber ID Number	The number that appears on your HMAA member card.
Substance Abuse Services	Providing medical, psychological, nursing, counseling, or therapeutic services as part of a treatment plan for alcohol or drug dependence or both. Services may include aftercare and individual, group and family counseling services.
Surgical Services	Cutting, suturing, diagnostic, and therapeutic endoscopic procedures; debridement of wounds, including burns; surgical management or reduction of fractures and dislocations; orthopedic casting manipulation of joints under general anesthesia or destruction of localized surface lesions by chemotherapy cryotherapy, or electrosurgery.
Third Party Liability	Our rights to reimbursement when you or your family members receive benefits under this coverage for an illness or injury and you have a lawful claim against another party or parties for compensation, damages, or other payment.
Transplant	The transfer of an organ or tissue for grafting into another area of the same body or into another person.
Treatment	Management and care of the patient to combat a disease or disorder.
Treatment of Orofacial Anomalies	The care prescribed, provided, or ordered for an individual diagnosed with an orofacial anomaly by a craniofacial team that includes a licensed dentist, orthodontist, oral surgeon, and physician, and is coordinated between specialists and providers.
Tubal Ligation	A sterilization procedure for women.
Urgent Care Facility	A category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency room.
Us	HMAA (Hawaii Medical Assurance Association).
Vasectomy	A sterilization procedure for men.
Vision Services	Services that test eyes for visual acuity and identify and correct visual acuity problems with lenses and other equipment.
We	HMAA (Hawaii Medical Assurance Association).

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Dental Plan B
Schedule of Benefits

Benefit	Plan Pays
Annual Maximum	**$1,000**
Basic Services	**100%**
• Oral Exams (twice per calendar year)	
• Bitewing X-rays (twice per calendar year)	
• Full Mouth X-rays (once per 3 calendar years)	
Preventive Services	**70%**
• Cleanings (twice per calendar year)	
• Fluoride Treatments (twice per calendar year through age 17)	
• All Other X-rays (as required)	
Restorative Services	**70%**
• Restorative Treatment	
• Palliative Treatment	
• Oral Surgery	
• Endodontics	
• Periodontics	
Major Services*	**50%**
• Crowns **	
• Bridges and Dentures ** (repairs and adjustments)	

*** Major dental services are available to members who have been enrolled continuously with the same HMAA group for the 12 months preceding the date of service.**

**** Replacements are covered if the existing crown, bridge, or denture is at least 5 years old.**

Note: The above reimbursement percentages are based on participating provider negotiated charges. If you go to a non-participating dental provider, benefits will be calculated on a lower eligible charge. The member is responsible for paying any remaining balance over the eligible charge up to the full billed amount. Exclusions and limitations apply. This document is intended to provide a condensed explanation of benefits. Please refer to the Dental Plan documents for details. In the case of a discrepancy between this document and the language contained within the Dental Plan documents, the latter will take precedence.

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Dental Plan B
$1,000 Annual Maximum

Please read the following material thoroughly for a description of your HMAA dental plan. Your member ID card will specify the dental plan in which you are enrolled.

Benefits

BASIC SERVICES / PREVENTIVE SERVICES:

- Routine Oral Examinations: twice per calendar year.
- Bitewing X-Rays: twice per calendar year.
- Panoramic Full Mouth X-Rays: once per 3 calendar years.
- Cleanings: twice per calendar year.
- Fluoride Treatments: twice per calendar year through age 17.
- All Other X-rays for preventive services: as required.

RESTORATIVE SERVICES:

- Office visits and Palliative Treatments.
- Amalgam Fillings (excluding gold)
- Fillings using composite resin (for anterior teeth only)
- Endodontics: Root Canal Therapy, Apicoectomies and Root Resection.
- Periodontics: Gingival curettage, once every 2 years; Osseous Surgery and Gingivectomies: once every 3 years.
- Following the completion of active Periodontal Surgery (which includes 6 months of follow-up care), 3 Prophylaxis treatments are allowed within the next 12-month period.
- Oral Surgery: Simple Extractions, Surgical Extractions of erupted or impacted teeth, and other Oral Surgical procedures.
- General anesthesia and intravenous sedation when medically necessary.

MAJOR SERVICES*:

- Crowns, Crown build-ups (when teeth cannot be restored with fillings): once every 5 years for the same tooth.**
- Complete Dentures, Partial Dentures (acrylic and cast chrome), Bridges: once every 5 years.**
- Complete and Partial Denture repairs and adjustments: twice per calendar year.

Pre-Determination of Benefits

HMAA recommends that the plan of treatment proposed by your dentist be approved by HMAA before treatment begins; however, in cases of emergency or brief routine procedures in which the total fee does not exceed $300, a treatment form need not be submitted before the dental services are performed.

Coordination of Benefits

The Plan will coordinate dual coverage for you by sharing the Dental expenses you might incur with the other plan.

Limitations

BENEFITS SHALL NOT BE PAYABLE FOR:

- **Any major services performed during the first year of continuous enrollment.**
- Taxes, broken appointments, completion of claim forms, oral hygiene or dietary instruction, plaque control programs, lost, stolen or damaged dentures or dental appliances, and incomplete dental treatments.
- Services started prior to the effective date of coverage and/or services started after termination of coverage date.
- Services relating to work-related injuries and automobile- related injuries or when the patient is not financially responsible.
- Desensitizing treatments, sealants, fixed bridgework or dentures for children under age 16, porcelain or plastic veneers placed for cosmetic reasons (including congenital malformations), porcelain crowns posterior to the second bicuspid, precision attachments for partial dentures, gold fillings and gold inlays.
- Composite restorations in posterior teeth (primary and permanent).
- Orthodontic services (including extraction of teeth in preparation of orthodontia).
- Experimental and/or investigational dental services; procedures, appliances, or restorations other than those for replacement of structure loss for caries, that are medically necessary to alter, restore or maintain occlusion. Such procedures include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting, restoration of tooth structure lost from attrition, restorations for tooth malalignment, gnathological rescorings, and treatments of disturbances of the temporomandibular joint.
- Services with respect to medically-related problems, congenital malformations, or cosmetic surgery or dentistry for purely cosmetic reasons including, but not limited to, cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, and anodontia.
- Hospitalization, including any emergency room visits, unless in conjunction with an authorized oral surgery procedure for treatment of fractures or dislocations.
- Implants or specialized technique to include, but not limited to, bone grafting, guided tissue regeneration, locally administered antibiotics or enzyme therapies and any other procedure that may be experimental in nature.
- Dental care rendered by a dentist or other licensed dental care professional beyond the scope of his license, or by unlicensed persons.
- When alternate treatments are available, The Plan will cover the most economical course of treatment. The patient is responsible for any difference in charges to upgrade the treatment.
- Charges in excess of participating provider's negotiated fees. The Plan has the exclusive right to determine eligible fees for Non-Participating Providers.

*** Major dental services are available to members who have been enrolled continuously with the same HMAA group for the 12 months preceding the date of service.**

**** Replacements are covered if the existing crown, bridge, or denture is at least 5 years old.**

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Dental Certificate

Dental Plan B

220 South King Street, Suite 1200
Honolulu, HI 96813

Phone (808) 941-4622
Toll-Free (888) 941-4622

www.hmaa.com

Table of Contents

Chapter 1: Important Information

What You Should Know About This Dental Certificate

Accessibility and Readability

Thank you for choosing HMAA. If you need help understanding this document, please call our Customer Service Center at 808-941-4622 or toll-free at 888-941-4622. HMAA offers interpreter services at no charge. If you need an interpreter, please tell our representative when you contact us.

Language Access Services

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-941-4622.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-941-4622.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-941-4622.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-941-4622.

About Your Dental Plan

This coverage offers you flexibility in the way you get dental benefits. Your opportunity to take an active role in your dental care decisions makes this coverage special. In general, to get the best benefits possible, you should seek services from HMAA ***Participating Providers***.

HMAA Participating Providers have agreed to render required services at negotiated rates. The member is not responsible for the difference between the negotiated rate and the billed charges, except for deductible, copayments, coinsurance and non-covered items. Benefits shall be automatically assigned for Participating Providers. Services rendered by ***Non-Participating Providers*** will be paid directly to the Member with all non-covered charges being the responsibility of the Member.

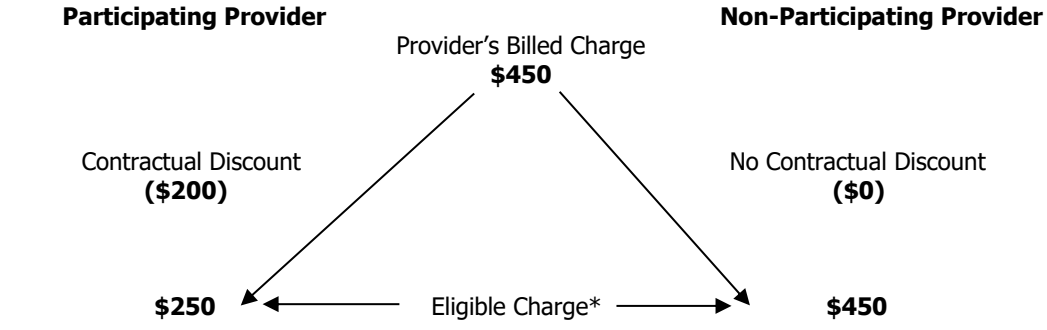
By using participating providers, you are assured of receiving the maximum benefits of the plan.

Before you visit your dentist or receive dental services, please verify whether your provider is participating with HMAA through one of the following:

- Ask your provider's office
- View our provider directory at hmaa.com
- Contact our Customer Service Center at (808) 941-4622, toll-free at 888-941-4622, or via e-mail at CustomerService@hmaa.com

Pay Less by Choosing a Participating Provider

The following illustrates an example of your out-of-pocket expense if you receive services from a participating vs. non-participating provider.



* The eligible charge is not equal to the billed charge. The eligible charges shown above are for illustration purposes only. Such charges may vary, depending on the provider and type of service performed. Taxes are not covered and are the sole responsibility of the member. Payment may vary by dental plan.

As illustrated, using a non-participating provider will result in substantially higher out-of-pocket expenses. You will be responsible for all non-covered charges, copayments, coinsurance and any remaining balances over the eligible charge, up to the full billed amount. As a result, your out-of-pocket expense could be substantial.

The provider may require you to pay the entire bill at the time you receive services, and to file your claim directly with us. Payment will always be made directly to the member, regardless of whether assignment of benefits is requested (in other words, regardless of whether you ask us to pay your provider directly).

Open Enrollment Periods

An initial enrollment period is a specific time when an individual is first eligible, according to your employer's rules for eligibility. If you do not apply for coverage when you first become eligible or by the first day of the month immediately following the first four consecutive weeks of employment, your enrollment form will not be accepted until the next open enrollment period. However, if you show us to our satisfaction that there was unusual and justifiable cause for submitting your enrollment application late, you may enroll sooner.

Open enrollment is a specific time each year when a current subscriber can make changes to their coverage. The annual open enrollment period for employer groups varies, and the number of days allotted for open enrollment may also differ between groups. Employees should check with their Human Resources department to find out their company's open enrollment period.

Terminology

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

The term ***Provider*** means an approved dental provider who provides you with health care services.

Definitions

Throughout this Dental Certificate, terms appear in ***Bold Italics*** the first time they are defined. Terms are also defined in *Chapter 10: Glossary.*

Questions

If you have any questions, please call us. More details about plan benefits will be provided free of charge. We list our telephone numbers on the front cover of this Certificate.

Participating Providers Outside Hawaii

There are no participating providers outside Hawaii. Services rendered outside Hawaii will be considered non-participating.

Non-Participating Providers

In these situations, you will be liable for the difference between the amount the non-participating healthcare provider bills and the payment we will make for the covered services. You will be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for covered services as set forth in this paragraph.

Carry Your Member Card

Always carry your HMAA Member Card. The card tells participating providers which Plan you belong to. It also includes information the provider needs to file your claim for you.

Questions We Ask When You Receive Care

Is the Care Covered?

To receive benefits, the care you receive must be a covered treatment, service, or supply. See *Chapter 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.

The fact that a dental provider 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.

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

Participating providers may, however, bill you for services or supplies that are excluded from coverage without getting a written acknowledgement of financial responsibility from you or your representative. See *Chapter 5: Services Not Covered.*
You may ask your physician to contact us to decide if the services you need meet our Payment Determination Criteria or are excluded from coverage before you receive the care.

Is the Care Consistent with HMAA's Dental Policies?

To be covered, the care you get must be consistent with HMAA's dental policies. Each policy provides detailed coverage criteria for when a specific service meets payment determination criteria. If you have questions about the policies or would like a copy of a policy related to your care, please call us at one of the telephone numbers on the front cover of this Certificate.

Is the Service or Supply Subject to a Benefit Maximum?

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

Interpreting This Dental Certificate

Agreement

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

- This Dental Certificate ("Certificate").
- Any riders and/or amendments.
- The enrollment form submitted to us (if applicable).
- The agreement between us and your employer or group sponsor.

Our Rights to Interpret this Document

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

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

Our determinations and interpretations, and our decisions on these matters are subject to *de novo* review by an impartial reviewer as provided in this Certificate or as allowed by law. If you do not agree with our interpretation or determination, you may appeal. See *Chapter 7: Dispute Resolution.*

No oral statement of any person shall modify or otherwise affect the benefits, limits and exclusions of this Dental Certificate, convey or void any coverage, or increase or reduce any benefits under this Agreement.

Chapter 2: Payment Information

Eligible Charge

Definition

The ***Eligible Charge*** is the lower of either the provider's *actual* charge or the amount we establish as the *maximum eligible fee.* HMAA's payment and your coinsurance are based on the eligible charge. Exception: For services provided by participating facilities, HMAA's payment is based on the maximum eligible fee and your coinsurance is based on the lower of the actual charge or the *maximum eligible fee.*

Participating providers agree to accept HMAA's payment plus your deductible, copayment and/or coinsurance as payment in full for covered services. Non-participating providers generally do not. If you receive services from a non-participating provider, you are responsible for the deductible, copayment and/or coinsurance plus any difference between the actual charge and the eligible charge.

Please note: The eligible charge does not include excise or other tax. You are responsible for all taxes related to the dental care you receive.

Coinsurance

Definition

Coinsurance is a fixed percentage of the eligible charge.

Please note: If you receive services from a non-participating or non-contracted provider, you are responsible for the copayment and/or coinsurance, *plus* any difference between *the actual charge and the eligible charge.*

Amount

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

Examples

Here are two examples of how coinsurance works:

Let's say you have a filling and go to a participating dentist for the service.

- The dentist's bill or actual charge = $150
- HMAA's eligible charge = $70
- Your coinsurance = $21 (30% of $70)

If you go to a non-participating physician, your out-of-pocket cost will be higher.

- The dentist's bill or actual charge = $150
- HMAA's eligible charge = $70
- Your coinsurance = $21 (30% of $70)
- The difference between the actual charge and the eligible charge = $80
- You owe $101 (your coinsurance plus the difference between the actual charge and the eligible charge).

Benefit Maximum

Definition

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

- Service. For example, dental benefits are limited to a combined maximum of $1,000 per calendar year.
- Calendar year. For example, you are eligible to receive benefits for up to two cleanings each calendar year.

Where to Look for Limitations

See *Chapter 4: Description of Benefits.*

Chapter 3: Summary of Benefits and Your Payment Obligations

Benefit and Payment Chart

About this Chart

This benefit and payment chart:

- Is a summary of covered services.
- Tells you if a covered service is subject to limits.

Annual Maximum	**$1,000**
Benefit	**Plan Pays**
Basic Services	**100%**
• Oral Exams (twice per calendar year)	
• Bitewing X-rays (twice per calendar year)	
• Full Mouth X-rays (once per 3 calendar years)	
Preventive Services	**70%**
• Cleanings (twice per calendar year)	
• Fluoride Treatments (twice per calendar year through age 17)	
• All Other X-rays (as required)	
Restorative Services	**70%**
• Restorative Treatment	
• Palliative Treatment	
• Oral Surgery	
• Endodontics	
• Periodontics	
Major Services*	**50%**
• Crowns **	
• Bridges and Dentures ** (repairs and adjustments)	

* *Major dental services are available to members who have been enrolled continuously with the same HMAA group for the 12 months preceding the date of service.*

** *Replacements are covered if the existing crown, bridge, or denture is at least 5 years old.*

Reimbursement percentages are based on participating provider negotiated charges. If you go to a non-participating dental provider, benefits will be calculated on a lower eligible charge. The member is responsible for paying any remaining balance over the eligible charge up to the full billed amount. Exclusions and limitations apply.

Chapter 4: Description of Benefits

About This Chapter

Your dental plan provides benefits for procedures, services or supplies that are listed in this chapter. You will note that some of the benefits have limitations. These limitations describe additional criteria, circumstances or conditions that are necessary for a procedure, service or supply to be a covered benefit. These limitations and benefits should be read in conjunction with *Chapter 5: Services Not Covered,* in order to identify all items excluded from coverage.

Benefits

Basic Services

- Routine Oral Examinations: twice per calendar year.
- Bitewing X-Rays: twice per calendar year.
- Panoramic Full Mouth X-Rays: once per 3 calendar years.

Preventive Services

- Cleanings: twice per calendar year.
- Fluoride Treatments: twice per calendar year through age 17.
- All Other X-rays for preventive services: as required.

Restorative Services

- Office visits and Palliative Treatments.
- Amalgam Fillings (excluding gold).
- Fillings using composite resin (for anterior teeth only).
- Endodontics: Root Canal Therapy, Apicoectomies and Root Resection.
- Periodontics: Gingival curettage, once every 2 years; Osseous Surgery and Gingivectomies: once every 3 years.
- Following the completion of active Periodontal Surgery (which includes 6 months of follow-up care), 3 Prophylaxis treatments are allowed within the next 12-month period.
- Oral Surgery: Simple Extractions, Surgical Extractions of erupted or impacted teeth, and other Oral Surgical procedures.
- General anesthesia and intravenous sedation when medically necessary.

Major Services*

- Crowns, Crown build-ups (when teeth cannot be restored with fillings): once every 5 years for the same tooth.**
- Complete Dentures, Partial Dentures (acrylic and cast chrome), Bridges: once every 5 years.**
- Complete and Partial Denture repairs and adjustments: twice per calendar year.

* *Major dental services are available to members who have been enrolled continuously with the same HMAA group for the 12 months preceding the date of service.*

** *Replacements are covered if the existing crown, bridge, or denture is at least 5 years old.*

Predetermination of Benefits

HMAA recommends the plan of treatment proposed by your dentist be approved by HMAA before treatment begins; however, in cases of emergency or brief routine procedures in which the total fee does not exceed $300, a treatment form need not be submitted before the dental services are performed.

Chapter 5: Services Not Covered

About This Chapter

Your dental care coverage does not provide benefits for certain procedures, services or supplies that are listed in this chapter or limited by this chapter or Chapter 4.

Please note: Even if a service or supply is not specifically listed as an exclusion in this chapter, there are additional exclusions as described by the limitations in Chapter 4. If that service or supply is not specifically listed as an exclusion in this chapter or as a limitation exclusion in Chapter 4, it will not be covered unless it is described in *Chapter 4: Description of Benefits,* and meets all of the criteria, circumstances or conditions described, and it meets all of the criteria described in *Chapter 1: Important Information* under *Questions We Ask When You Receive Care.* If a service or supply does not meet the criteria described in Chapter 4, then it should be considered an exclusion or service that is not covered. This chapter should be read in conjunction with Chapter 4 in order to identify all items that are excluded from coverage.

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

Exclusions and Limitations

- Any major services performed during the first year of continuous enrollment.
- Taxes, broken appointments, completion of claim forms, oral hygiene or dietary instruction, plaque control programs, lost, stolen or damaged dentures or dental appliances, and incomplete dental treatments.
- Services started prior to the effective date of coverage and/or services started after termination of coverage date.
- Services relating to work-related injuries and automobile-related injuries or when the patient is not financially responsible.
- Desensitizing treatments, sealants, fixed bridgework or dentures for children under age 16, porcelain or plastic veneers placed for cosmetic reasons (including congenital malformations), porcelain crowns posterior to the second bicuspid, precision attachments for partial dentures, gold fillings and gold inlays.
- Composite restorations in posterior teeth (primary and permanent).
- Orthodontic services (including extraction of teeth in preparation of orthodontia).
- Experimental and/or investigational dental services; procedures, appliances, or restorations other than those for replacement of structure loss for caries, that are medically necessary to alter, restore or maintain occlusion. Such procedures include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting, restoration of tooth structure lost from attrition, restorations for tooth malalignment, gnathological rescorings, and treatments of disturbances of the temporomandibular joint.
- Services with respect to medically-related problems, congenital malformations, or cosmetic surgery or dentistry for purely cosmetic reasons including, but not limited to, cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, and anodontia.
- Hospitalization, including any emergency room visits, unless in conjunction with an authorized oral surgery procedure for treatment of fractures or dislocations.
- Implants or specialized technique to include, but not limited to, bone grafting, guided tissue regeneration, locally administered antibiotics or enzyme therapies and any other procedure that may be experimental in nature.
- Dental care rendered by a dentist or other licensed dental care professional beyond the scope of his license, or by unlicensed persons.
- When alternate treatments are available, The Plan will cover the most economical course of treatment. The patient is responsible for any difference in charges to upgrade the treatment.
- Charges in excess of a participating provider's negotiated fees. The Plan has the exclusive right to determine eligible fees for Non-Participating Providers.

Non-Related Items Exclusion

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

Chapter 6: Filing Claims

When to File Claims

All participating and most non-participating providers in Hawaii file claims for you. If your non-participating provider does not file for you, please submit an itemized bill or receipt. The bill or receipt must be submitted within one year of the last day on which you received services. It must list 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. Our telephone numbers appear on the front cover of this Certificate.

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 Identification Number (ID)

The subscriber ID number which appears on your member card.

Provider Statement

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

The provider statement must include:

- Provider's full name and address.
- Patient's name.
- Date(s) you received service(s).
- Date of the injury or start of illness.
- The charge for each service in U.S. currency.
- Description of each service.
- Tooth Number.
- Diagnosis or type of illness or injury.
- Where you received the service (office, outpatient, hospital, etc.).
- If applicable, information about other dental 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 Claims

Send your claim to the address listed on the front cover of this Certificate.

Keep a Copy

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

Explanation of Benefits

Once we receive and process your claim, a report explaining your benefits will be provided no later than 30 days after we receive a claim you submit. You may receive copies of your report online at www.hmaa.com or by mail upon request. The ***Explanation of Benefits*** tells you how we processed the claim. It includes services performed, the actual charge, any adjustments to the actual charge, our eligible charge, the amount we paid, and the amount you owe.

If we require more information to make a decision about your claim or are unable to make a decision due to circumstances beyond our control, we will extend the time for an additional 15 days. We will let you know within the initial 30-day period why we are extending the time and when you can expect our decision. If we require more information, you will have at least 45 days to provide us the information.

If any of your claims are denied, our report will explain the denial.

If, for any reason, you believe we wrongly denied a claim or coverage request, please call us for help. Our phone numbers appear on the front cover of this Certificate. 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 *Chapter 7: 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, there may be a service charge.

Chapter 7: Dispute Resolution

Your Request for an Appeal

Writing Us to Request an Appeal

If you wish to dispute a decision made by HMAA related to coverage, reimbursement, this Agreement, or any other decision or action by HMAA you must ask for an appeal. Your request must be in writing unless you are asking for 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.

Send written requests to:

HMAA, Attn: Appeals Coordinator
220 South King Street, Suite 1200
Honolulu, HI 96813

Or, send us a fax at (808) 591-0463.

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

If you have any questions about appeals, please contact our Customer Service Center.

Appeal of Any Other Decision or Action

We will respond to your appeal within 60 calendar days after we receive your appeal.

Who Can Request an Appeal

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

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

What Your Request Must Include

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

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

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

Information Available From Us

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

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

If You Disagree with Our Appeal Decision

If you are enrolled in a group plan and would like to appeal HMAA's decision, you must request arbitration before a mutually selected arbitrator.

This is an ERISA plan unless your plan is one of the three bulleted types below:

- A church plan as defined in 29 USC 2002(33) and no selection has been made in accord with 26 USC 410(d), or
- A governmental plan as defined in 29 USC 1002(32).
- A sole proprietor

Request Arbitration

If you are eligible for and choose arbitration, you must submit a written request for arbitration to HMAA, 220 South King Street, Suite 1200, Honolulu, Hawaii 96813. Your request for arbitration will not affect your rights to any other benefits under this plan. You must have fully complied with HMAA's appeals procedures described above and we must receive your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the issue. No other parties may be joined in the arbitration. The arbitration is binding and the parties waive their right to a court trial and jury.

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

The arbitration hearing shall be in Hawaii. The rules of the arbitration shall be those of the Dispute Prevention and Resolution, Inc. to the extent not inconsistent with this *Chapter 7: Dispute Resolution.* The arbitration shall be conducted in accord with the Federal Arbitration Act, 9 U.S.C. §1 et seq., and such other arbitration rules as both parties agree upon.

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

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

HMAA waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.

Filing of Lawsuit

A member or dependent may not file a lawsuit or bring other legal action regarding the denial of eligibility or the denial of a claim for benefits under the Plan until the individual has timely filed a claim and has exhausted all the appeal rights made available under the Plan.

Any legal action described above must be filed no later than the earlier of (i) 180 days from the date the final decision on appeal is issued or should have been issued, or (ii) three years from the date that the claim was required to be submitted under the Plan.

A legal action regarding any matter pertaining to the Plan must be filed in the U.S. District Court for Hawaii, in Honolulu, Hawaii, which district court will have exclusive jurisdiction in regard to the matter.

Chapter 8: 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.

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

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

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 benefit plans.
- Non-group insurance.

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

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

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

What Will We Do

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

General Coordination Rules

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

No Coordination Rules

The coverage without coordination of benefits rules pays first.

Member Coverage

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

Active Employee Coverage

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

Earliest Effective Date

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

Dependent Children Coordination Rules

Birthday Rule

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

Court Decree Stipulates

For a child who is covered by separated or divorced parents and a court decree says which parent has dental 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 dental insurance responsibility, then the coverage of the parent with custody pays first. The payment order for this dependent child is as follows:

1. Custodial parent.
2. Spouse of custodial parent.
3. Other parent.
4. 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 injury or illness is due to a motor vehicle accident or other event for which we believe motor vehicle insurance coverage reasonably appears available under the motor vehicle insurance law of your applicable State, then that motor vehicle coverage will pay before this coverage.

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

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

We will review the list of expenses to verify that the motor vehicle insurance coverage available under the motor vehicle insurance law of your applicable State is exhausted. After it is verified, you are eligible for covered services in accord with this Certificate.

Please note that you are also subject to the Third Party Liability Rules at the end of this chapter: (1) if your injury or illness is caused or alleged to have been caused by someone else and you have or may have a right to recover damages or receive payment in connection with the illness or injury, or (2) if you have or may have a right to recover damages or receive payment without regard to fault other than coverage available under the motor vehicle insurance law of your applicable State.

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

Third Party Recovery, Subrogation and Reimbursement

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, dental payment provisions, worker's compensation, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of dental benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant(s) is obligated to notify the Plan or its authorized representative within thirty (30) days of the date when the Participant(s) or his or her designee or representative provides notice to any party of the Participant's (or Participants') intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or any other condition sustained or suffered by the Participant(s). The Participant(s) or his or her designee or representative must provide all information to the Plan upon request, including but not limited to the full completion of any forms requested by the Plan. Further, the Participant(s) is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant(s) is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed. Failure to provide this information may result in the termination of health benefits for the Participant(s) or the institution of court proceedings against the Participant(s).

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through dental payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any dental, disability or other benefit payments, and school insurance coverage.

The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including dental, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:

1. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
2. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
3. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
4. hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.
The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through dental payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any dental, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Member(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Member(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of dental benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
8. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

By accepting benefits (whether the payment of such benefits is made to the Participant(s) or made on behalf of the Participant(s) to any provider) from the Plan, the Participant(s) agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Participant(s) hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future dental benefits and any funds or payments

due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Member(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of dental benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Chapter 9: General Provisions

Eligibility for Coverage

When You Are Eligible For Coverage

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

Enrollment Process

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

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

What You Should Know About Enrolling Your Child(ren)

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

- The child is your son, daughter, stepson or stepdaughter, your legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian, or your eligible foster child (defined as an individual who is placed with you by an authorized placement agency or by judgment, decree or other court order).
- The child is under 26 years of age.

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

- Children with Special Needs
- Children who are Newborns or Adopted

Children With Special Needs

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

- Your child is incapable of self-sustaining support because of a physical or mental disability.
- Your child's disability existed before the child turned 26 years of age.
- Your child relies primarily on you for support and maintenance as a result of his or her disability.
- Your child is enrolled with us under this coverage or another HMAA coverage and has had continuous dental care coverage with us since before the child's 26th birthday.

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

Children Who Are Newborns or Adopted

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

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

When Coverage Begins

When You Are Eligible To Receive Benefits

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

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

If you are inpatient when this coverage begins, and you had no other insurance or coverage immediately prior, then coverage for services related to the hospitalization begins on the effective date of this coverage. If you had other insurance or coverage immediately prior, then coverage for any services related to the hospitalization either a) begins on the effective date of this coverage, or b) does not begin until the day after your discharge from the hospital or other inpatient facility. We will work with your prior insurer or coverage to determine which option applies to you. This limitation does not apply to you if you had dental coverage with us immediately prior to the effective date of this coverage. Please call us if this limit applies to you so that we can help you determine your rights to coverage.

When Coverage Ends

Reasons for Coverage Termination

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

- You choose to end this coverage. In this case, you must provide written notice of your intent to terminate 30 days before the termination date.
- You or your employer or group sponsor fails to make payments to us when due, or your employer or group sponsor decides to discontinue this coverage.
- Your employer or group sponsor decides to replace this coverage with another coverage and there is no lapse in coverage.
- We end our agreement with your employer or group sponsor.
- For the member, upon your retirement, termination of employment, severance from the group, or termination of this Agreement.
- For the member's spouse, upon your termination of coverage or upon the dissolution of the marriage.
- For the member's children, when any of the following occurs:
    - The member's coverage terminates; or
    - The child fails to meet the criteria outlined earlier in this chapter under *What You Should Know about Enrolling Your Child(ren).*

Notifying Us When Your Child's Eligibility Ends

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

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

Termination for Fraud

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

If we determine that you or your employer has committed fraud or made an intentional misrepresentation or concealment of material facts, we will provide you written notice 30 days prior to termination of your coverage. During that time, you have a right to appeal our determination of fraud or intentional misrepresentation. For more information on your appeal rights, see *Chapter 7: Dispute Resolution.*

If your coverage is terminated for fraud, intentional misrepresentation, or the concealment of material facts:

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

Continued Coverage

Continued Coverage Under Federal Law – COBRA Rights

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

Qualifying Events

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

- Employer or group sponsor from whom you retired files bankruptcy under federal law.
- Death of the employee covered under this coverage.
- Divorce or legal separation.

- Child no longer meets our eligibility rules.
- Enrollment in Medicare.
- Termination of employment for reasons other than gross misconduct, or if your work hours are reduced to the point that you are no longer eligible for coverage.

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

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

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

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

Payment of COBRA Premiums

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

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

What You Must Do

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

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

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

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

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

Adding Your Child

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

Length of Coverage Under COBRA

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

- The last day of the 18-, 29-, or 36-month maximum coverage period, whichever is applicable. If you or any of your dependents who has elected COBRA coverage is determined to be disabled under the Social Security Act during the first 60 days of continuation coverage, your COBRA coverage may continue for up to 29 months. The 29-month period will apply to you and your eligible dependents who elected COBRA coverage. You must provide notice of the disability determination to your employer within 60 days after the determination.
- The first day (including grace periods, if applicable) on which timely payment is not made by you.
- The date on which the employer ceases to maintain any group dental plan (including successor plans).
- The first day on which a beneficiary is actually covered by any other group dental plan. However, if the new group dental plan contains an exclusion or limitation relating to any preexisting condition of the beneficiary, then coverage

will end on the earlier of the satisfaction of the waiting period for preexisting conditions contained in the new group dental plan, or the occurrence of any one of the other events stated in this chapter.

If the new group dental plan contains a pre-existing condition exclusion, the preexisting condition exclusion period will be reduced by the qualified beneficiary's preceding aggregate periods of creditable coverage (if any). The creditable coverage is applicable to the qualified beneficiary as of the enrollment date in the new group dental plan as long as there has been no interruption of coverage longer than 63 days. Creditable Coverage means any of the following:

- A group dental plan.
- Dental insurance coverage.
- A dental care program of the Indian Health Service or of a tribal organization.

You may request a certificate of creditable coverage by calling HMAA Customer Service. Our phone number is listed on the front cover of this Certificate.

Confidential Information

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

Dues and Terms of Coverage

Dues

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

Timely Payment

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

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

Terms of Coverage

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

Authority to Terminate, Amend, or Modify Coverage

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

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

We are required to provide a 60 day advance notice to you before the effective date of any material modification, including changes in preventive benefits.

Assignment of Benefits

Without HMAA's prior written consent, the Plan Sponsor, the Group, any Employees, and any Plan Members are expressly prohibited from assigning to any person or entity any of the Plan Documents or any right, interest, claim for payment due, benefit, or obligation under any of the Plan Documents. Except as may be expressly prescribed in an agreement to which HMAA is a party, nothing contained in any written designation of coverage under the Plan will make the Parties liable to any third party to whom Employees or Plan Members may be liable for dental care, treatment, or services.

Governing Law

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

Payment in Error

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

Notice Address

You may send any notice required by this chapter to:

HMAA
220 South King Street, Suite 1200
Honolulu, Hawaii 96813

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

Chapter 10: Glossary

Accidental Injury	An injury, separate from a disease or bodily infirmity of any other cause, that happens by chance and needs medical care right away.
Actual Charge	The amount a provider bills for a covered service or supply.
Agreement	The document made up of: This Dental Certificate; any riders or amendments; the enrollment application submitted to us; and the agreement between us and your employer or group sponsor.
Arbitration	When one person (an arbitrator) reviews the positions of two parties who have a dispute and makes a decision to end the dispute.
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 coverage.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 which may offer you and your eligible dependents continuation of this coverage if you lose coverage due to a qualifying event.
Calendar Year	The period starting January 1 and ending December 31 of any year. The first calendar year for anyone covered by this plan begins on that person's effective date and ends on December 31 of that same year.
Child	Means any of the following: your son, daughter, stepson or stepdaughter, your legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian, or your eligible foster child (defined as an individual who is placed with you by an authorized placement agency or by judgment, decree or other court order).
Claim	A written request for payment of benefits for services covered by this coverage.
Coinsurance	The percentage of the covered expense payable by the Member. After the Calendar Year Deductible has been met and any required copayment has been made, you pay the percentage shown in *Chapter 3: Summary of Benefits and Your Payment Obligations.*
Coordination of Benefits (COB)	Applies when you are covered by more than one insurance policy providing benefits for like 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. You are not covered for complications of recent or past cosmetic surgeries, services or supplies.
Covered Services	Services or supplies that meet payment determination criteria and are listed in this Certificate in *Chapter 4: Description of Benefits.*
Deductible	The fixed dollar amount you pay for certain covered services before benefits are available.
Dental Certificate	This document, along with any riders or amendments that provide a written description of your dental care coverage.
Dentist	A doctor of medicine (D.M.D) or a doctor of dental surgery (D.D.S.). In addition, the dentist must be certified or licensed by the proper government authority to render services within the lawful scope of his or her respective license.
Dependent	The member's spouse and/or eligible child(ren).

ERISA	The Employee Retirement Income Security Act of 1974, a federal law that protects your rights under this coverage.
Effective Date	The date on which you are first eligible to receive benefits under this coverage.
Eligible Charge	The Eligible Charge is the lower of either the provider's actual charge or the amount we establish as the maximum eligible fee. HMAA's payment, and your coinsurance, are based on the eligible charge. Exception: For services provided by participating facilities, HMAA's payment is based on the maximum eligible fee and your coinsurance is based on the lower of the actual charge or the maximum eligible fee.
Emergency	A health condition accompanied by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson could reasonably expect the absence of immediate medical attention to result in: 1) serious risk to the health of the person (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.
Explanation of Benefits (EOB)	The report you receive from us that notes how we applied benefits to a claim. You may receive copies of your report online at hmaa.com or by mail upon request.
False Statement	Any fraudulent or intentional misrepresentation you or your employer made on your membership enrollment form or in any claims for benefits.
Family Coverage	Coverage for the member, his or her spouse, and each of his or her eligible children.
Family Member	The member's spouse and/or children who are eligible and enrolled for this coverage.
Group	Those members who share a common relationship such as employment or membership. The group has executed the group plan agreement with us and by getting health coverage through the group, you designate the group as your administrator.
Immediate Family Member	Your child, spouse, parent, or yourself.
Limited Services	Those covered services that are limited per service, per episode, per calendar year or per lifetime.
Maximum Eligible Fee	The amount we establish as the maximum amount HMAA will pay for covered services and supplies.
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.
Member	The person, and their dependents, who meets eligibility requirements of the Plan.
Member Card	Your member card issued to you by us. You must present this card to your provider at the time you receive services.
Non-Assignment	When benefits for covered services and supplies cannot be transferred or assigned to anyone for use.
Non-Participating Providers	Providers that are not under contract with HMAA's networks.
Oral Surgeon	A dentist licensed as a doctor of dentistry (D.M.D.) or dental surgery (D.D.S.) to diagnose and treat oral conditions that need surgery.

Orthodontic Services	Direct or consultative services provided by a licensed dentist with a certification in orthodontics by the American Board of Orthodontics.
Our	Reference to HMAA (Hawaii Medical Assurance Association).
Participating Provider	A provider that participates with us.
Plan	This dental benefits program offered to you as an eligible employee for purposes of ERISA.
Plan Administrator	Your employer or group sponsor for the purposes of ERISA.
Predetermination	The process of getting prior approval for specified dental treatments, procedures, or devices to make sure it meets payment determination criteria before the service is rendered. It provides an estimate of payment for the proposed treatment. HMAA participating providers agree to get approval for you. All other providers do not agree to get approval for you, therefore you are responsible.
Preferred Provider Organization (PPO)	A health care program that offers you advantages when you receive services from contracting and participating providers.
Provider	An approved dentist, facility, or other health care provider where you get dental care services, such as an agency or program.
Qualified Beneficiary	Qualified Beneficiary means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan: ▪ as the spouse of the covered employee; or ▪ as the dependent child of the covered employee.
Qualified Medical Child Support Order (QMSCO)	A Medical Child Support Order that creates or recognizes in the person specified in the order the existence of the right to enroll in the health benefit plan for which the plan member or his/her dependents are eligible. To be a Qualified Medical Child Support Order, the order cannot require a health benefit plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act with respect to a group plan.
Single Coverage	Coverage for the member only.
Spouse	Your husband or wife as the result of a marriage who is legally recognized in the state of Hawaii.
Subscriber ID Number	The number that appears on your HMAA member card.
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 a lawful claim against another party or parties for compensation, damages, or other payment.
Treatment	Management and care of the patient to combat a disease or disorder.
Us	HMAA (Hawaii Medical Assurance Association).
We	HMAA (Hawaii Medical Assurance Association).
You and Your Family	You and your family members eligible for coverage under this Certificate.

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Vision Plus Plan

Schedule of Benefits

Benefits	Plan Pays	
	Participating & Affiliate Provider*	Non-Participating Provider
Examinations		
• Vision Exam	100% after $25 copay	up to $45
Prescription Glasses (instead of contacts)		
• Frame	100% after $25 copay for Frames up to $120 or Featured Frame Brands up to $140 (up to $65 at Costco**)	up to $70
	20% off the amount over your allowance	
• Lenses		
Single Vision Lenses	100%	up to $30
Lined Bifocal Lenses	100%	up to $50
Lined Trifocal Lenses	100%	up to $65
Note: Polycarbonate lenses for dependent children		
• Lens Enhancements		
Standard Progressive Lenses	100%	up to $50
Premium Progressive Lenses	100% after copay ranging from $95 to $105	up to $50
Custom Progressive Lenses	100% after copay ranging from $150 to $175	up to $50
Contacts (instead of glasses)	$120	up to $105
• Contact Lens Exam (fitting and evaluation)	100% after copay up to $60	

Frequency of Services

• Examination	Once every 12 months
• Prescription Glasses	
Frame	Once every 24 months
Lenses	Once every 24 months
Lens Enhancements	Once every 24 months
• Contacts	Once every 24 months

Vision plans are underwritten by Vision Service Plan (VSP)

* Participating Provider network is VSP Choice. Your coverage with a retail chain affiliate provider may be different from the coverage with a Participating Provider.

** Applies to Oahu and participating Neighbor Island Costco Optical locations.

This is a summary of benefits effective January 1, 2024. Please refer to VSP for details.

A Look at your VSP Vision Coverage

With VSP and HMAA Vision Plus Plan, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP® network doctor for you and your family.

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

With private practice doctors and Visionworks retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

vsp PREMIER edge

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

PROVIDER NETWORK:

VSP Choice

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

vsp vision care

BENEFIT	DESCRIPTION	COPAY
YOUR COVERAGE WITH A VSP PROVIDER		
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening • Every 12 months	$25 Up to $39
PRESCRIPTION GLASSES		**$25**
FRAME+	• $120 Frame allowance • $140 Featured Frame Brands allowance • 20% savings on the amount over your allowance • $65 Costco frame allowance • Every 24 months	Included in Prescription Glasses
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 24 months	Included in Prescription Glasses
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every 24 months	$0 $95 - $105 $150 - $175
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 24 months	Up to $60
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.	
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.	
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.	

COVERAGE WITH AN OUT-OF-NETWORK PROVIDER

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. Your plan provides the following out-of-network reimbursements:

Exam ..... up to $45
Frame ..... up to $70
Single Vision Lenses ..... up to $30
Lined Bifocal Lenses ..... up to $50
Lined Trifocal Lenses ..... up to $65
Progressive Lenses ..... up to $50
Contacts ..... up to $105

Create an account today.

Contact us at:
800.877.7195 or **vsp.com**

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.