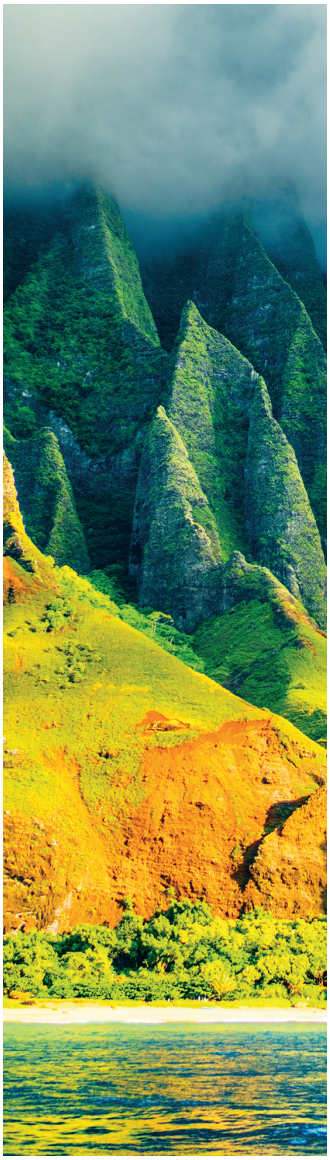
Plan Certificate



Vision Care Plan

January 2023

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

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HAWAII MEDICAL SERVICE ASSOCIATION

Special Vision Care Benefits Certificate

I. DEFINITIONS

When used in this Certificate, enrollment form, each membership card, and any supplements to this Certificate:

(1) "**Association**" is the HAWAIʻI MEDICAL SERVICE ASSOCIATION (HMSA), an independent licensee of the Blue Cross and Blue Shield Association.

(2) "**Beneficiary**" is you, any Member or Dependent covered by this Certificate.

(3) "**Calendar Year**" is the period starting January 1 and ending December 31 of any year. The first Calendar Year for a new Beneficiary shall start on that Beneficiary's Effective Date and end on December 31 of the same year.

(4) "**Certificate**" is this document, i.e., the Vision Care Benefits Certificate and any supplements to this Certificate. The Agreement between HMSA and the Beneficiary is made up of this Certificate, any riders and/or amendments, the enrollment form, and the agreement between HMSA and the Member's employer or group sponsor.

(5) "**Child**" is a:

(a) Member's son, daughter, stepson or stepdaughter,

(b) Member's legally adopted child or a child placed with you for adoption,

(c) child for whom the Member is the court-appointed guardian, or

(d) Member's 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).

(e) The child is under 26 years of age.

A Member's grandchild is not eligible for coverage under the Member's Certificate unless he or she meets one of the qualifications above.

(6) "**Copayment**" is a fixed percentage of the Eligible Charge or a fixed dollar amount that the Beneficiary is required to pay to the provider of services.

(7) "**Dependent**" is the Member's spouse and each eligible Child.

(8) "**Effective Date**" is the date on which a person is accepted as a Beneficiary, as set and noted by HMSA. It is the date when the Beneficiary is eligible for benefits under this Certificate. The date is subject to all applicable waiting periods under this Certificate.

(9) "**Eligible Charge**" is described in Section III(7). It is the charge HMSA uses to calculate a benefit payment for most covered services.

(10) "**Group**" is an:

(a) employing unit,

(b) employee organization that has a collective bargaining agreement with an employer, or

(c) employer-based organization that is approved by HMSA.

Such employing unit or organization must have executed an Agreement with HMSA. By obtaining health plan coverage through the Group, the Member designates the Group as his or her administrator.

(11) "**Member**" is the person who executes the enrollment form that is accepted, in writing, by HMSA. This person must be an employee of the Group unless otherwise approved by HMSA. An employee is a person who works for the Group in return for wages or salary.

(12) "**Ophthalmologist**" **(M.D.)** is a physician who is appropriately licensed to practice by the proper government authority and who renders services within the lawful scope of such license.

(13) "**Optometrist**" **(O.D.)** is a person who is appropriately licensed to practice optometry by the proper government authority and who renders services within the lawful scope of such license.

(14) "**Participating Provider**" is a provider of services who agrees with HMSA to collect not more than

(a) a specified amount paid by HMSA and

(b) the Beneficiary's Copayment as specified in this Certificate.

As an exception, a Special Vision Care Participating Provider does not agree to limit charges for contact lenses and fitting of contact lenses. In this case, HMSA's benefit payment will not exceed the amount specified in Sections IV(2)(a), IV(4)(a), V(2)(a) and V(4)(a) and you are responsible for all charges in excess of HMSA's benefit payment. In addition, the provider must be listed on HMSA's Special Vision Care Rider List of Participating Providers.

When you require routine vision care outside the state of Hawaii, we participate with other Blue Cross and/or Blue Shield Plans in a program called the BlueCard Program. This BlueCard program offers HMSA members advantages when they receive routine vision care outside the area this plan services. Benefit payments for covered services received outside the state of Hawaii are based on contracts negotiated between the out-of-state Blue Cross and/or Blue Shield Plans and BlueCard participating routine vision care providers.

II. ELIGIBILITY AND ENROLLMENT

(1) A person may enroll in this coverage under this Certificate when he or she is first eligible for this health plan coverage in accordance with his or her employer's rules for eligibility. If the person does not enroll in this coverage when he or she first becomes eligible or by the first day of the month immediately following the first four consecutive weeks of employment, he or she will not be eligible to enroll until the next open enrollment period. Open enrollment is held once a year. Exceptions may be made if it is shown to our satisfaction that there was unusual and justifiable cause for submitting the enrollment form late.

(2) The Member's spouse and each of the Member's Children 25 years of age and under are eligible for coverage as Dependents under this Certificate. The Member must enroll a Dependent with HMSA within 31 days of the date of eligibility. If a Dependent is not enrolled within 31 days of the date of eligibility, he or she may be enrolled only at the next open enrollment period. Open enrollment is held once a year.

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

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:

(a) The birth date of a newborn, providing you comply with our usual enrollment process within 31 days of the child's birth.

(b) The date of adoption, providing you comply with our usual enrollment process within 31 days of the date of adoption.

(c) The birth date of a newborn adopted child, providing we get notice of your intent to adopt the newborn within 31 days of the child's birth.

(d) The date the child is placed with you for adoption, providing we get notice of the placement within 31 days of the placement. Placement occurs when you assume a legal obligation for total or partial support of the child in anticipation of adoption.

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

(a) Your child is incapable of self-sustaining support because of a physical or mental disability.

(b) Your child's disability existed before the child turned 26 years of age.

(c) Your child relies primarily on you for support and maintenance as a result of his or her disability.

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

(4) Unless continuation is provided for in the Agreement, membership under this Certificate shall end on the earliest of the following events:

(a) For the Member -- when the Member retires, termination of employment, severance from the Group, or termination of this Agreement,

(b) For the Member's spouse -- when the Member's coverage is terminated or the marriage is dissolved,

(c) For the Member's Children -- when the Member's coverage is terminated, or when a Child reaches the age of 26 years, unless such Child meets the provisions of paragraph II(3) below.

(5) The Member shall inform HMSA, in writing, if a Dependent ceases to be eligible for benefits on or before the first day of the month following the month in which eligibility ceased. If the Member fails to inform us of the Dependent's ineligibility, and we pay for services for the ineligible Dependent, the Member must reimburse HMSA for these payments.

(6) This Certificate shall take effect, on the Member's Effective Date. Coverage for the Member and any Dependents initially listed on the enrollment form shall begin on the Member's Effective Date. These can take place if the Member's initial dues have been paid and HMSA has accepted the Member's enrollment form by giving written notice to the Member of his or her Effective Date.

III. CLAIM AND PAYMENT FOR SERVICES

(1) **Submission of Claim.** A claim for services covered by this Certificate will not be paid unless it is supported by the provider's report on the services. The Member is responsible for making sure that the provider gives this report to HMSA, on the correct forms, within one year of the date of services.

Once we get and process your claim, a report explaining your benefits will be provided. You may get copies of your report online through My Account on hmsa.com or by mail upon request. The Report To Member tells you how we processed the claim. It includes services performed, the actual charge, any adjustments to the actual charge, our eligible charge, the amount we paid, and the amount you owe.

If we need more details to make a decision about your claim, need more time to review your claim due to circumstances beyond our control or deny your claim, this report will let you know within 15 days of receipt of written claims or 7 days of receipt of claims filed electronically. If we need more details, you will have at least 45 days to provide it. Otherwise, we will reimburse you within 30 days of receipt of written claims and 15 days from receipt of claims filed electronically.

(2) **Payment for Services.**

(a) **Participating Provider.** For covered services from a Participating Provider, HMSA will pay benefits directly to the Participating Provider. Participating Providers have agreed to limit their charges to a specified amount. In addition, Participating Providers have agreed not to collect payment from you that is more than the Copayment noted in this Certificate.

(b) **Nonparticipating Provider.** HMSA does not have an agreement with nonparticipating providers. Nonparticipating providers may charge more than the Eligible Charge for any service. HMSA benefit payments for services rendered by nonparticipating providers will be a specified portion or percentage of the Eligible Charge for the service. For services from a nonparticipating provider the benefit level will be a lower percentage of the Eligible Charge than HMSA would pay to a Participating Provider. You are responsible for paying the specified Copayment plus the difference between the provider's charge and the Eligible Charge. Payment of claims from nonparticipating providers for services covered by this Certificate:

1. are not assignable;
2. shall be made directly to the provider Member or Dependent. This decision is up to HMSA. In the case of the Member's death, payment shall be made to his or her executor, administrator, provider, spouse, or relative; and
3. shall not exceed the amount we would pay to a comparable Participating Provider for like services.

(c) **Unclaimed or Uncashed Benefit Checks.** A service charge will apply to benefit checks that have not been cashed, deposited, or otherwise negotiated by the Member before the check's expiration date. A schedule of current service charges can be provided on request.

(3) **Reimbursement for Services.** If you have paid for services covered by this Certificate, HMSA shall reimburse the Member under the terms of this Certificate. To receive payment for such services, a Member must submit a claim within one year after the last day of services.

(4) **Late Claims.** No payment will be made on any claim submitted more than one year after the last day of services.

(5) **Payment Determination Criteria.** This Certificate covers only those services and supplies that meet all of the following criteria:

(a) To treat a medical condition.

(b) The most appropriate delivery or level of service, considering potential benefits and harms to the patient.

(c) Known to be effective to improve health outcomes if:

1. Effectiveness is determined first by scientific evidence;
2. If there is no scientific evidence, then by professional standards of care; and
3. If there are no professional standards of care or if they are outdated or contradictory, then by expert opinion; and

(d) Cost-effective for the medical condition being treated compared to other health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

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

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

The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets the payment determination criteria. This applies even if the service or supply is listed as a covered service in this Certificate.

Participating providers may not bill or collect charges for services or supplies that do not meet HMSA's Payment Determination Criteria. An exception may be made if you or your legal representative signs a written acknowledgement of financial responsibility. The written statement must be specific to the service.

Participating providers may bill you for services or supplies that are excluded from coverage without getting a written acknowledgement of financial responsibility from you or your representative.

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

Before receiving care you may ask your physician to contact us to see if the services that you need meet our Payment Determination Criteria or are excluded from coverage.

(6) **Is the Care Consistent with HMSA's Medical Policies?** To be covered, your care must be consistent with the provider's scope of practice, state licensure requirements, and our medical policies. These policies are drafted HMSA's Medical Directors who work with community physicians and nationally recognized experts. Many of our Medical Directors are practicing physicians. Each policy provides detailed coverage criteria on when a specific service, drug, or supply meets the payment

determination criteria. If you have questions about the policies or would like a copy of a policy related to your care, please call HMSA.

(7) **Eligible Charges.** HMSA's benefit payments and the Beneficiary's Copayments for most services are based on the Eligible Charge for the services (i.e., the Beneficiary pays a specified percentage or portion of the Eligible Charge for each service). HMSA will not pay the portion of any charge that exceeds the Eligible Charge. General excise or other tax is not included in the Eligible Charge. A Beneficiary is responsible for paying all taxes.

(a) **Definition.** The Eligible Charge for a covered service is the lower of the *actual* charge on the claim, the discounted charge negotiated by us, or the charge listed for the service in our Schedule of Maximum Allowable Charges. For a covered service which does not have a charge listed in the Schedule, HMSA will establish the Maximum Allowable Charge. HMSA also reserves the right to annually adjust the charges listed in the Schedule of Maximum Allowable Charges. In adjusting charges, the Association will consider increases in the cost of medical and non-medical services in Hawaii over the previous year, the relative difficulty of the service compared to similar services, changes in technology which may have affected the difficulty of the service, payment for the service under federal, state and other private insurance programs and the impact of changes in the charge on HMSA's health plan rates. The Eligible Charge shall be determined without regard for any general excise tax or other tax added to the provider's charge or charges.

(b) **Claims for Services Provided by Out-of-State Providers.** Benefit payments for covered services rendered outside Hawaii are based on the Eligible Charges for the same or comparable services rendered in Hawaii.

(8) **Qualified Medical Child Support Orders** Qualified Medical Child Support Orders or QMCSOs are court orders that meet certain federal guidelines. These court orders require a person to provide health benefits coverage for a child. Claims for benefits for a Child covered by a QMCSO may be made by the Child or by the Child's custodial parent or court-appointed guardian. Any benefits otherwise payable to the Member with respect to any such claim shall be payable to the Child's custodial parent or court-appointed guardian. If you would like more information about how HMSA handles QMCSOs, you may call HMSA's Customer Service. Our phone number is listed on the back cover.

(9) **Special Provisions Relating to Medicaid and State Assistance.**

(a) Payments shall be made according to the rights as assigned by you or on your behalf, as required by Medicaid or any other State plan for medical aid under title XIX of the Social Security Act.

(b) Payments for benefits under this Plan will be made according to State Law which provides for acquisition by the State of the following rights to payment.

(10) **Precertification Requests.**

(a) **HMSA's Response to Your Non-Urgent Precertification Request.** If your request for precertification is not urgent, we will respond to your request within a reasonable time. This time will be appropriate for your medical case but not later than 15 days after we get your request. We may extend the time for 15 days more if we cannot respond to your request in the first 15 days and if it is due to issues beyond our control. In this case, we will contact you before the end of the initial 15 days. We will tell you why we need more time and give you the date we plan to have an answer. If we need more details from you or your provider, we will let you or your provider know. You will have at least 45 days to provide it.

(b) **HMSA's Response to Your Urgent Precertification Request.** Your precertification request is urgent if the time periods above:

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

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

If you do not provide enough details for us to decide if or to what extent the care is covered, we will contact you within 24 hours after we get your request. We will let you know what details we need and give you a reasonable time to respond. You will have at least 48 hours to provide it.

(c) **Appeal of HMSA's Precertification Decision.** If you do not agree with HMSA's decision, you may appeal the decision.

(11) **Request for an Appeal.**

(a) **Writing Us to Request an Appeal.** If you wish to dispute a decision made by HMSA related to coverage, reimbursement, this Agreement, or any other decision or action by HMSA you must ask for an appeal. Your request must be in writing unless you are asking for an expedited appeal. We must get it within one year from the date of the action or decision you are contesting. In the case of coverage or reimbursement disputes, this is one year from the date we first informed you of the denial or limitation of your claim, or of the denial of coverage for any requested service or supply. Send written request to:

HMSA Member Advocacy and Appeals
P.O. Box 1958
Honolulu, HI 96805-1958
Or, send us a fax at (808) 952-7546 or (808) 948-8206.

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

If you have any questions about appeals, you can call us at (808) 948-5090, or toll free at 1-800-462-2085.

1. **Appeal of Our Precertification Decision.** We will respond to your appeal as soon as possible given the medical circumstances of your case. It will be within 30 days after we get your appeal.
2. **Appeal of Any Other Decision or Action.** We will respond to your appeal within 60 calendar days after we get your appeal.
3. **Expedited Appeal.** You may ask for an expedited appeal if the time periods for appeals above may:
   a. Seriously risk your life or health,
   b. Seriously risk your ability to gain maximum functioning, or
   c. Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

You may request expedited external review of our initial decision if you have requested an expedited internal appeal and the adverse benefit determination involves a medical condition for which the completion of an expedited internal appeal would meet the requirements above. The process for requesting an expedited external review is discussed below.

You may ask for an expedited appeal by calling us at (808) 948-5090 or toll free at 1-800-462-2085.

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

4. **Who Can Request an Appeal.** Either you or your authorized representative may ask for an appeal. Authorized representatives include:
   a. Any person you authorize to act on your behalf as long as you follow our procedures. This includes filing a form with us. To get a form to authorize a person to act on your behalf, call us at (808) 948-5090, or toll free at 1-800-462-2085. (Requests for appeal from an authorized representative who is a physician or practitioner must be in writing unless you are asking for an expedited appeal.)
   b. A court appointed guardian or an agent under a health care proxy.
   c. A person authorized by law to provide substituted consent for you or to make health care decisions on your behalf.
   d. A family member or your treating health care professional if you are unable to provide consent.

5. **What Your Request Must Include.** To be recognized as an appeal, your request must include all of this information:

a. The date of your request.

b. Your name and phone number (so we may contact you).

c. 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.

d. The subscriber number from your member card.

e. The provider name.

f. A description of facts related to your request and why you believe our action or decision was in error.

g. 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.

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

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

(b) **If You Disagree with Our Appeal Decision and You are Enrolled in a Group Plan that is not Self Funded.** If you are enrolled in a group plan that is not self-funded and you would like to appeal HMSA's decision, you must do one of the following: 1) Request review by an Independent Review Organization (IRO) selected by the Insurance Commissioner if you are appealing an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness; or a determination by HMSA that the service or treatment is experimental or investigational; 2) For all other issues: (i) Request arbitration before a mutually selected arbitrator; or (ii) File a lawsuit against HMSA under 29 USC 1132(a) unless your plan is one of the two bulleted types below in which case you must select arbitration:

- A church plan as defined in 29 USC 2002(33) and no selection has been made in accord with 26 USC 410(d), or
- A government plan as defined in 29 USC 1002(32).

1. **Request Review by Independent Review Organization (IRO) Selected by the Insurance Commissioner.** If you choose review by an IRO, you must submit your request to the Insurance Commissioner within 130 days of HMSA's decision on appeal to deny or limit the service or supply.

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

Your request must be in writing and include:

a. A copy of HMSA's final internal appeal decision.

b. A completed and signed authorization form releasing your medical records relevant to the subject of the IRO review. Copies of the authorization form are available from HMSA by calling (808) 948-5090 or toll free at 1-800-462-2085 or on HMSA.com.

c. A complete and signed conflict of interest form. Copies of the conflict of interest form are available from HMSA by calling (808) 948-5090 or toll free at 1-800-462-2085 or on HMSA.com.

d. A check for $15.00 made out to the Insurance Commissioner. It will be refunded to you if the IRO overturns HMSA's decision. You are not required to pay more than $60.00 in any calendar year.

You must send the request to the Insurance Commissioner at:

Hawaii Insurance Division
ATTN: Health Insurance Branch – External Appeals
335 Merchant Street, Room 213
Honolulu, HI 96813
Phone: (808) 586-2804

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

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

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

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

2. **Expedited IRO Review.** You may request expedited external review if:

a. 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;

b. 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

c. If the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which you received emergency services; provided you have not been discharged from a facility for health care services related to the emergency services.

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

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

3. **External Review of Decisions Regarding Experimental or Investigational Services**. You may request IRO review of a HMSA determination that the supply or service is experimental or investigational.

Your request may be oral if your treating physician certifies, in writing, that the treatment or supply would be significantly less effective if not promptly started.

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

a. Standard health care services or treatments have not been effective in improving your condition;

b. Standard health care services or treatments are not medically appropriate for you; or

c. 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.

4. **Request Arbitration.** If you choose arbitration, you must submit a written request for arbitration to HMSA, Legal Services, P.O. Box 860, Honolulu, Hawaii 96808-0860. Your request for arbitration will not affect your rights to any other benefits under this plan. You must have fully complied with HMSA's appeals procedures described above and we must get your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the issue. No other parties may be joined in the arbitration. The arbitration is binding and the parties waive their right to a court trial and jury.

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

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

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

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

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

(c) **If You Disagree with Our Appeal Decision and You are Enrolled in a Self Funded Group Plan.** If you are enrolled in a self-funded group plan and you would like review of HMSA's appeal decision, you must do one of the following: (1) Request review by an Independent Review Organization (IRO) selected by HMSA at random from a panel of three IROs; (2) Request arbitration with your employer or group sponsor before a mutually selected arbitrator; or (3) File a lawsuit against your employer or group sponsor under 29 USC 1132(a) unless your plan is one of the two bulleted types below in which case you must select review by an IRO or arbitration:

- A church plan as defined in 29 USC 2002(33) and no selection has been made in accord with 26 USC 410(d), or
- A government plan as defined in 29 USC 1002(32).

1. **Request Review by Independent Review Organization (IRO) Selected by HMSA**. If you choose review by an IRO, you must submit your request in writing within 130 days of HMSA's appeal decision to deny or limit the service or supply. Send written requests to:

HMSA Member Advocacy and Appeals
P.O. Box 1958
Honolulu, HI 96805-1958
Or, send us a fax at (808) 952-7546 or (808) 948-8206

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

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

2. **Expedited Review by an IRO Selected by HMSA**. You may request expedited external review if:

a. The timeframe for completion of an expedited internal appeal would seriously jeopardize your life, health, or your ability to regain maximum functioning and you have filed an expedited internal appeal.

b. The timeframe for completion of standard external review would seriously jeopardize your life, health, or your ability to regain maximum functioning.

c. HMSA's internal appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services and you have not been discharged from a facility.

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

3. **Request Arbitration**. If you choose arbitration, with your employer or group sponsor you must submit a written request for arbitration to HMSA, Legal Services, P.O. Box 860, Honolulu, Hawaii 96808-0860. Your request for arbitration will not affect your rights to any other benefits under this plan. You must have fully complied with HMSA's appeals procedures described above and we must receive your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the issue. No other parties may be joined in the arbitration. The arbitration is binding and the parties waive their right to a court trial and jury.

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

The arbitration hearing shall be in Hawaii. The arbitration shall be conducted in accord with the Hawaii Uniform Arbitration Act, HRS Chapter 658A, and the rules of Dispute Prevention and Resolution, Inc., to the extent not inconsistent with this Section III, and such other arbitration rules as both parties agree upon. The arbitrator may hear and determine motions for summary disposition pursuant to HRS §658A-15(b). The arbitrator shall also hear and determine any challenges to the arbitration agreement and any disputes regarding whether a controversy is subject to an agreement to arbitrate. In order to make the arbitration hearing fair, expeditious and cost-effective, discovery by both parties shall be limited to requests for production of documents material to the claims or defenses in the arbitration. Limited depositions for use as evidence at the arbitration hearing may occur as authorized by HRS §658A-17(b).

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

Your employer or group sponsor will pay the arbitrator's fee. You must pay your attorney's or witness's fees, if you have any, and your employer or group sponsor must pay theirs. The arbitrator will decide who will pay all other costs of the arbitration. Your employer or group sponsor waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.

IV. VISION CARE BENEFITS FOR ADULTS

Subject to the provisions of this Certificate, you are eligible to receive the following vision care benefits.

Your vision care benefit provides benefits for vision services or supplies that are listed in this section. You will note that some of the benefits have limitations. These limitations describe additional criteria, circumstances or conditions that are necessary for a vision service or supply to be a covered benefit. These limitations may also describe circumstances or conditions when a vision service or supply is not a covered benefit. These limitations and benefits should be read in conjunction with Section VIII(1) "General Limitations and Exclusions", in order to identify all items excluded from coverage.

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 Certificate. Up-to-date information related to such circumstances, including emergency declarations, will be posted on our website at www.hmsa.com.

(1) **Payment for one eye examination per Calendar Year**.

(a) For Participating Providers, the Beneficiary owes a $10.00 Copayment to the Participating Provider. The Association pays the Participating Provider 100% of the remaining Eligible Charges.

(b) For nonparticipating providers, the Beneficiary owes the entire charge for the examination -- the Association reimburses the Beneficiary up to $40.00.

(2) **Payment for one of the following lenses per Calendar Year**.

(a) For Participating Providers, the Association pays the Participating Provider:

1. 100% of the remaining Eligible Charges after a $10.00 Copayment for one pair of single vision or multifocal lenses; or
2. up to $130.00 after a $25.00 Copayment for one pair of non-disposable contact lenses; or
3. up to $130.00 after a $25.00 Copayment for disposable contact lenses.

(b) For nonparticipating providers, the Beneficiary owes the entire charge for lenses -- the Association reimburses the Beneficiary:

1. up to $16.00 for single vision lenses; or
2. up to $25.00 for multifocal lenses; or
3. up to $50.00 for contact lenses.

(3) **Payment for one frame every 24 months**.

(a) For Participating Providers, the Association pays the Participating Provider 100% of the remaining Eligible Charges after a $15.00 Copayment for frames from the designated group.

(b) For nonparticipating providers, the Beneficiary owes the entire charge for frames -- the Association reimburses the Beneficiary up to $12.00.

Payment is subject to the provisions of Section VI(2) below.

(4) **Payment for fitting of contact lenses, one fitting per Calendar Year.**

(a) For Participating Providers, the Association pays the Participating Provider up to $45.00 for fitting of contact lenses.

(b) For nonparticipating providers, the Beneficiary owes the entire charge for fitting of contact lenses – the Association reimburses the Beneficiary up to $20.00.

V. VISION CARE BENEFITS FOR CHILDREN (THROUGH AGE 18)

The Annual Copayment Maximum described in Chapter 2 of HMSA's Guide to Benefits applies to the children's vision care benefits listed in this section. The Annual Copayment Maximum is the maximum deductible and copayment amounts you pay in a calendar year. Once you meet the copayment maximum you are no longer responsible for deductible or copayment amounts unless otherwise noted. Refer to your HMSA Guide to Benefits for the annual copayment maximum amount.

Subject to the provisions of this Rider, a Beneficiary is entitled to the following vision care benefits:

(1) **Payment for one eye examination per Calendar Year**.

(a) For Participating Providers, the Beneficiary owes a $10.00 Copayment to the Participating Provider. The Association pays the Participating Provider 100% of the remaining Eligible Charges.

(b) For nonparticipating providers, the Beneficiary owes the entire charge for the examination -- the Association reimburses the Beneficiary up to 50% of Eligible Charge.

(2) **Payment for one of the following lenses per Calendar Year**.

(a) For Participating Providers, the Association pays the Participating Provider:

1. 100% of the remaining Eligible Charges after a $10.00 Copayment for one pair of single vision or multifocal lenses; or
2. up to 50% of Charge for one pair of non-disposable contact lenses; or
3. up to 50% of Charge for disposable contact lenses.

(b) For nonparticipating providers, the Beneficiary owes the entire charge for lenses -- the Association reimburses the Beneficiary:

1. up to 50% of Eligible Charge for one pair of single vision or multifocal lenses; or
2. up to 50% of Charge for contact lenses.

(3) **Payment for one frame every 24 months**.

(a) For Participating Providers, the Association pays the Participating Provider 100% of the remaining Eligible Charges after a $15.00 Copayment for frames from the designated group.

(b) For nonparticipating providers, the Beneficiary owes the entire charge for frames -- the Association reimburses the Beneficiary up to 50% of Eligible Charge.

Payment is subject to the provisions of Section VI(2) below.

(4) **Payment for fitting of contact lenses, one fitting per Calendar Year.**

(a) For Participating Providers, the Association pays the Participating Provider up to 50% of Eligible Charge for fitting of contact lenses.

(b) For nonparticipating providers, the Beneficiary owes the entire charge for fitting of contact lenses – the Association reimburses the Beneficiary up to 50% of Eligible Charge.

(5) **Payment for one pair of polycarbonate lenses per Calendar Year.** Payment for polycarbonate lenses is made in addition to benefits for standard lenses stated under Section V(2).

(a) For Participating Providers, the Association pays the Participating Provider 100% of Eligible Charges.

(b) For nonparticipating providers, the Beneficiary owes the entire charge for polycarbonate lenses -- the Association reimburses the Beneficiary up to 50% of Eligible Charge.

VI. LIMITATIONS AND EXCLUSIONS

(1) **Limitations.** The payments specified in Section IV and V above shall be made by the Association only when services are rendered in connection with an eye examination for correction of a visual defect and when the frame or lenses are required as a result of such examination. In no event will the Association make allowances for more than one such eye examination during any Calendar Year for each Beneficiary and one frame whether as an original or replacement frame every 24 months for each Beneficiary.

(2) **Limitations on Frames and Lenses.**

(a) The allowance specified in Section IV(3) and V(3) above is for a complete frame only. Charges for repair or replacement of a portion of the frame or cost of accessories are not eligible for payment.

(b) If lenses are replaced without furnishing a new frame, the total allowance for both a frame and lenses **may not** be used toward the cost of such lenses or the cost of contact lenses.

(c) Benefits for lenses and frames from a Participating Provider are for standard-size lenses and a frame from the Participating Provider's "designated group". If a Beneficiary selects nonstandard-size lenses or frames that are not from the "designated group", the Association will pay up to 100% of the maximum charges allowed for standard-size lenses or a "designated group" frame. The Beneficiary then pays the balance of the charges.

(d) If contact lenses are furnished, no benefits are payable for frames in the same Calendar Year. If benefits for a frame have already been paid in a Calendar Year, those benefits shall be deducted from the benefits payable for any contact lenses furnished in the same Calendar Year.

(e) Vision Care Benefits for Adults (eye examination, lenses, and frames) will not be available in the same calendar year the Beneficiary received similar benefits allowed under Vision Care Benefits for Children.

(3) **Exclusions.** No payment will be made under this Rider for: sunglasses; prescription inserts for diving masks and any protective eyewear; nonprescription industrial safety goggles; nonstandard items for lenses including tinting, blending, oversized lenses, and invisible bifocals or trifocals, except polycarbonate lenses stated in Section V(5); repair and replacement of frame parts and accessories; and contact lenses after cataract surgery.

VII. DUES AND TERMS

Payment of Dues. The Member and/or the Member's Group shall pay monthly dues promptly in advance on or before the first day of the month. HMSA will accept dues payments directly from:

(1) you,
(2) your employer or group sponsor,
(3) your family,
(4) government programs,
(5) Ryan White HIV/AIDS programs
(6) Native American tribal organizations and/or governments, and religious institutions and other not-for-profit organizations where the following criteria is met:

(a) The assistance is provided on the basis of the insured's financial need;

(b) The organization is not a healthcare provider; and

(c) The organization is financially disinterested (i.e., the organization does not receive funding from an entity that has a pecuniary interest in the payment of health insurance claims and/or benefits).

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

(7) **Modification.** Except where otherwise expressly agreed to in writing between the Group and HMSA:

(a) HMSA has the right to increase the dues rates applicable to the Group if we give 30 days prior written notice to the Group of any increase.

(b) HMSA has the right to modify the Agreement if we give 30 days prior written notice to the Group of the change.

(8) **Terms of Coverage**. By submitting the enrollment form, the Member also accepts and agrees to the provisions of HMSA's constitution and bylaws now in force and as amended in the future. The Member also appoints the employer or Group as his or her administrator for dues payment and to send and receive all notices to and from HMSA concerning the plan.

(9) **Termination.**

(a) Except where otherwise expressly agreed to in writing between the Group and HMSA: the Member or the Member's agent may terminate this Agreement by giving 30 days notice, in writing, to the other party.

(b) HMSA may end the Agreement by giving 30 days notice, in writing, to an organization or employing unit upon that organization's or employing unit's failure to maintain HMSA's Group enrollment requirements.

(c) In the event the Group fails to pay monthly dues on or before the due date, HMSA may end the Agreement for failure to pay dues, unless all dues are brought current within 10 days of HMSA's written notice of default to the Group. HMSA will not be liable to pay any benefits for services done after the date of termination.

(d) HMSA is not liable to pay benefits for services for a Beneficiary enrolled in this plan under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) during any month for which dues have not been paid. All of your rights to benefits shall cease effective as of the last day for which the required dues were paid. The provisions of this paragraph shall apply whether or not HMSA has given any notice of default or termination to you or the Group.

VIII. GENERAL PROVISIONS

(1) **General Limitations and Exclusions.** The limitations and exclusions provided under this Section VI shall be in addition to any limitations and exclusions provided elsewhere in this Certificate.

Any vision service or supply not specifically listed as an exclusion in this section or as a limitation exclusion in Section IV "Vision Care Benefits" will not be covered unless it is described in Section IV, and meets all of the criteria, circumstances or conditions described, and it meets all of the criteria described in Section III under "Payment Determination Criteria". If a vision service or supply does not meet the criteria described in Section IV, then it should be considered an exclusion or vision service or supply that is not covered. This section should be read in conjunction with Section IV in order to identify all items that are excluded from coverage.

(a) HMSA will not pay benefits for any services when you are entitled to receive disability benefits or compensation (or forfeits his or her rights thereto) under any Workers' Compensation or Employer's Liability Law for injury or illness. If you formally appeal the denial of a claim for Workers' Compensation, you shall notify HMSA of such appeal. HMSA will then provide benefits under this Certificate, but such benefits shall be considered an advance or loan to you. If the claim is declared eligible for benefits under Workers' Compensation or Employer's Liability Law or if you reach a compromise settlement of the Workers' Compensation claim, you agree to repay the advance or loan.

(b) HMSA will not pay benefits for any services:

1. when services for an injury or illness are provided without charge to you by any federal, state, territorial, municipal, or other government instrumentality or agency, or

2. when services for an injury or illness would have been provided without charge or collection but for the fact that the person is a Beneficiary under this Certificate.

(c) HMSA will not pay any benefits, to the extent that such benefits are payable, by reason of any fraudulent statement or other intentional misrepresentation that the Member or Member's employer made on an enrollment form for membership or in any claims for benefits. If HMSA pays such benefits before learning of any false statement, the Member or Member's employer are responsible for reimbursing HMSA for such payment.

(d) HMSA is not an insurer against nor liable for the negligence or other wrongful act or omission of any provider, provider's employee, or other person or for any act or omission of any Beneficiary.

(e) To the extent permitted by law, you are not covered for services required in the treatment of an injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists.

(f) HMSA will not pay benefits for treatment of illness or injury related to military service when you get care in a hospital operated by an agency of the United States government. HMSA will not cover services or supplies that are required to treat an illness or injury received while you are on active status in the military service.

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

(h) Except as otherwise stated in this Certificate, HMSA will not pay benefits in connection with:

1. Biofeedback and other forms of self-care or self-help training and any related diagnostic testing.

2. Convenience treatments, services or supplies.

3. Cosmetic services (services, supplies, or drugs that may improve the physical appearance, but do not restore or materially improve a bodily function, including related services such as laboratory tests, anesthesia, hospitalization, and complications of recent or past cosmetic surgeries, services, or supplies. This exclusion also applies to cosmetic services because of psychological or psychiatric reasons.

4. Lenses including:

(i) Nonstandard items for lenses including tinting, blending.

(ii) Oversized lenses, and invisible bifocals or trifocals, except polycarbonate lenses stated in Section V(5).

(iii) Telescopic lenses.

(iv) Low vision lenses.

(v) Corrective low vision lenses.

(vi) Contact lenses following cataract surgery.

1. Nonprescription industrial safety goggles.

2. Prescription inserts for diving masks and any protective eyewear.

3. Repair and replacement of frame parts and accessories.

4. Services from a member of the Beneficiary's immediate family or household.

5. Services not described as covered in this Certificate.

5. Sunglasses.

6. Treatment of any complications as a result of recent or past cosmetic surgeries, services, or supplies, or other services not covered under this Certificate -- regardless of how long ago such services were performed.

7. Services or supplies we are prohibited from covering under the law.

(i) HMSA shall not be required to pay any claim until it determines that you received services covered by this Certificate. Payment will not be made for services not actually done.

(2) **Default in Payment of Dues.** HMSA is not liable to pay any benefits provided under this Certificate if there shall be any default or delinquency in the payment of dues by the Member when services are done or charges incurred.

(3) **What Coordination of Benefits Means**

(a) Coverage that provides same or Similar Coverage. You may have other benefit coverage that provides benefits that are the same or similar to this plan.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced when the combination of the primary plan's payment and this plan's payment exceed the Eligible Charge. As the secondary plan, this plan's payment will not exceed the amount this plan would have paid if it had been your only coverage. 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 eye examination per calendar year, if this plan is secondary and your primary plan covers one eye exam per calendar year, the eye exam covered under the primary plan will count toward the yearly benefit maximum and this plan will not provide benefits for a second eye exam within the calendar year.

(b) What You Should Do.

1. When you get services, let HMSA know if there is other coverage. Other coverage includes:

a. group insurance;

b. other group benefit plans;

c. nongroup insurance;

d. Medicare or other governmental benefits; and

e. the medical benefits coverage in automobile insurance (whether issued on a fault or no fault basis).

You should also let HMSA know if the other coverage ends or changes. You will get a letter from HMSA if we need more details. If you do not give us the details we need to coordinate your benefits, your claims may be delayed or denied.

2. To help us coordinate benefits, you should:

a. inform your provider by giving him or her information about the other coverage at the time services are rendered, and

b. indicate the other coverage when filling out a claim form by completing the appropriate boxes on the form.

(c) What HMSA Will Do. Once we have the details about your other coverage, we will coordinate benefits for you. There are certain rules HMSA follows 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.

(4) **General Coordination Rules.**

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

(a) No Coordination Rules. The coverage without coordination of benefits rules pays first.

(b) Member Coverage. Your coverage as an employee pays before your coverage as a spouse or dependent child.

(c) Active Employee Coverage. Your coverage as the result of active employment pays before your coverage as a retiree or under which you are not actively employed.

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

(5) **Dependent Children Coordination Rules.**

(a) 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.

(b) Court Decree Stipulates. For a child who is covered by separated or divorced parents and a court decree says which parent has health/dental insurance responsibility, that parent's coverage pays first.

(c) 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/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. non-custodial parent.
4. spouse of non-custodial parent.

(d) Earliest Effective Date. If none of these rules apply, the parent's coverage with the earliest continuous effective date pays first.

(6) **Automobile Coverage.**

If your injuries or illness are due to a motor vehicle accident or other event for which HMSA believes motor vehicle insurance coverage reasonably appears available under Hawaii Revised Statutes Chapter 431, Article 10C, then that motor vehicle coverage will pay before this coverage. You are responsible for any cost sharing payments required under such motor vehicle insurance coverage. We do not cover such cost sharing payments. Before we pay benefits under this coverage for an injury covered by motor vehicle insurance, you must give us a list of medical expenses paid by the motor vehicle insurance. The list must show the date expenses were incurred, the provider of service, and the amount paid by the motor vehicle insurance. We will review the list of expenses to verify that the motor vehicle insurance coverage available under Hawaii Revised Statutes Chapter 431, Article 10C is exhausted. After it is verified, you are eligible for covered services in accord with this Guide to Benefits.

Please note that in the following two situations, you are also subject to the Third Party Liability Rules if:

(a) your injury or illness was 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

(b) you have or may have a right to recover damages or receive payment without regard to fault (other than personal injury protection coverage available under Hawaii Revised Statutes Chapter 431, Article 10C-103.5).

Any benefits paid by HMSA under this section or the Third Party Liability Rules, are subject to the provisions described under Third Party Liability Rules.

(7) **Third Party Liability Rules.**

(a) **If You have Coverage Under Workers' Compensation or Motor Vehicle Insurance**. If you have or may

have coverage under workers' compensation or motor vehicle insurance for the illness or injury, please note the following:

1. Workers' Compensation Insurance. If you have or may have coverage under workers' compensation insurance, such coverage will apply instead of the coverage under this Certificate. Medical expenses arising from injuries or illness covered under workers' compensation insurance are excluded from coverage under this Certificate.

2. Motor Vehicle Insurance. If you are or may be entitled to medical benefits from your automobile coverage, you must exhaust those benefits first, before receiving benefits from HMSA. Please refer to the section entitled "Automobile Coverage" for a detailed explanation of the rules applicable to your automobile coverage.

(b) **What Third Party Liability Means.** Third party liability is when you are injured or become ill and:

1. The illness or injury is caused or alleged to have been caused by someone else and you have or may have a right to recover damages or get payment in connection with the illness or injury; or

2. You have or may have a right to recover damages or get payment without regard to fault.

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

(c) **What You Need To Do**. Your cooperation is necessary for HMSA to determine its liability for coverage and to protect our rights to recover payments. We will provide benefits in connection with the injury or illness in accordance with the terms of this Certificate only if you cooperate by doing the following:

1. Give HMSA Timely Notice. You must give us timely notice in writing of each of the following:

a. your knowledge of any potential claim against any third party or other source of recovery in connection with the injury or illness;

b. any written claim or demand (including legal proceeding) against any third party or against other source of recovery in connection with the injury or illness; and

c. any recovery of damages (including any settlement, judgment, award, insurance proceeds, or other payment) against any third party or other source of recovery in connection with the injury or illness.

To give timely notice, your notice must be no later than 30 calendar days after the occurrence of each of the events stated above;

2. Sign Requested Documents. You must promptly sign and deliver to HMSA all liens, assignments, and other documents we deem necessary to secure our rights to recover payments, and you hereby authorize and direct any person or entity making or receiving any payment on account of such injury or illness to pay to HMSA so much of such payment as necessary to discharge your reimbursement obligations described above;

3. Provide HMSA Information. You must promptly provide us with any and all information reasonably related to its investigation of our liability for coverage and our determination of our rights to recover its payments. We may ask you to complete an Injury/Illness report form, and provide medical records and other relevant information;

4. Do Not Release Claims Without HMSA's Consent. You must not release, extinguish, or otherwise impair HMSA's rights to recover its payments, without our express written consent; and

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

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

HMSA
Attn: 8 CA/Other Party Liability
P.O. Box 860
Honolulu, HI 96808-0860

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

(d) **Payment of Benefits Subject to The Association's Right to Recover its Payments.** If you have complied with the rules above, HMSA will pay benefits in connection with the injury or illness to the extent that the medical treatment would otherwise be a covered benefit payable under this Certificate. However, HMSA has a first-priority right to subrogation and reimbursement for any benefits it provides, from any recovery received from or on behalf of any third party or other source of recovery in connection with the injury or illness, including, but not limited to, proceeds from any:

1. settlement, judgment, or award;
2. motor vehicle insurance (other than personal injury protection benefits) including liability insurance or your underinsured or uninsured motorist coverage;
3. workplace liability insurance;
4. property and casualty insurance;
5. medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowner's insurance coverage;
6. medical malpractice coverage; or
7. any other payments from a source intended to compensate you for injuries resulting from an accident or alleged negligence.

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

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

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

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

HMSA has a first lien on such recovery proceeds, up to the amount of total benefits HMSA pays or has paid related to the injury or illness. You must reimburse HMSA for any benefits paid, even if the recovery proceeds obtained (by settlement, judgment, award, insurance proceeds, or other payment):

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

4. are obtained on your behalf by any person or entity, including your estate, legal representative, parent, or attorney;

5. are without any admission of liability, fault, or causation by the third party or payor.

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

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

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

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

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

Nothing in these Third Party Liability Rules shall limit HMSA's ability to coordinate benefits as described in this Certificate.

(8) **Notice.** HMSA may give any notice required by this Certificate to the Group. Any written notice to HMSA required by this Certificate shall be sent to

HMSA
P.O. Box 860,
Honolulu, Hawaii 96808-0860.

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

(10) **Verbal Representations.** No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this Certificate, convey or void any coverage, or increase or reduce any benefits under this Certificate.

Serving you

Meet with knowledgeable, experienced health plan advisers. We'll answer questions about your health plan, give you general health and well-being information, and more. Visit hmsa.com for directions.

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

HMSA Center @ Pearl City
Pearl City Gateway | 1132 Kuala St., Suite 400
Monday through Friday, 9 a.m.-6 p.m. | Saturday, 9 a.m.-2 p.m.

HMSA Center @ Hilo
Waiakea Center | 303A E. Makaala St.
Monday through Friday, 9 a.m.-6 p.m. | Saturday, 9 a.m.-2 p.m.

HMSA Center @ Kahului
Puunene Shopping Center | 70 Hookele St.
Monday through Friday, 9 a.m.-6 p.m. | Saturday, 9 a.m.-2 p.m.

Customer Relations representatives are also available in person at our Kauai office, Monday through Friday, 8 a.m.-4 p.m.:

Lihue, Kauai
4366 Kukui Grove St., Suite 103 | Phone: (808) 245-3393

Contact HMSA. We're here with you.
Call (808) 948-6111 or 1 (800) 776-4672.

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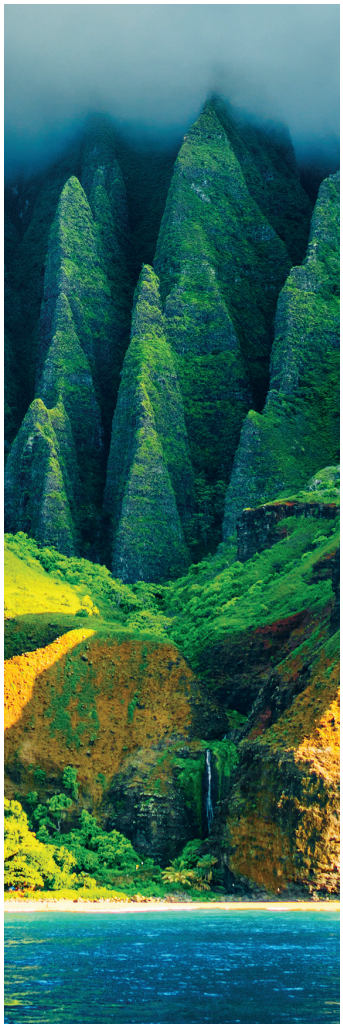

Together, we improve the lives of our members and the health of Hawaii.
Caring for our families, friends, and neighbors is our privilege.

hmsa

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