Plan Certificate

Prescription Drug Rider

January 2026

Discrimination is against the law

HMSA complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). HMSA does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Services HMSA provides

HMSA offers the following services to support people with disabilities and those whose primary language is not English. There is no cost to you.

- Qualified sign language interpreters are available for people who are deaf or hard of hearing.
- Large print, audio, braille, or other electronic formats of written information is available for people who are blind or have low vision.
- Language assistance services are available for those who have trouble with speaking or reading in English. This includes:
  - Qualified interpreters.
  - Information written in other languages.

If you need modifications, appropriate auxiliary aids and services, or language assistance services, please call 1 (800) 776-4672. TTY users, call 711.

How to file a grievance or complaint

If you believe HMSA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- Phone: 1 (800) 462-2085
- TTY: 711
- Email: appeals@hmsa.com
- Fax: (808) 952-7546
- Mail: HMSA Member Advocacy and Appeals
  P.O. Box 1958
  Honolulu, HI 96805-1958

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1 (800) 368-1019, 1 (800) 537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

This notice is available at HMSA's website: https://hmsa.com/non-discrimination-notice/.

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hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

1020-1276050 6.25 LE

Commercial/ACA/Medicare
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S3994_1020_1276050_L3G4AH717_26_C
H8481_1020_1276050_L3G4AH718_26_C

ATTENTION: If you don't speak English, language assistance services are available to you at no cost. Auxiliary aids and services are also available to give you information in accessible formats at no cost. QUEST members, call 1 (800) 440-0640 toll-free, TTY 1 (877) 447-5990, or speak to your provider. Medicare Advantage and commercial plan members, call 1 (800) 776-4672 or TDD/TTY 1 (877) 447-5990.

'Ōlelo Hawai'i
NĀ MEA: Inā 'a'ole 'oe 'ōlelo Pelekania, loa'a nā lawelawe kōkua 'ōlelo iā 'oe me ka uku 'ole. Loa'a nā kōkua kōkua a me nā lawelawe no ka hā'awi 'ana iā 'oe i ka 'ike ma nā 'ano like 'ole me ka uku 'ole. Nā lālā QUEST, e kelepona iā 1 (800) 440-0640 me ka uku 'ole, TTY 1 (877) 447-5990, a i 'ole e kama'ilio me kāu mea ho'olako. 'O nā lālā Medicare Advantage a me nā lālā ho'olālā kalepa, e kelepona iā 1 (800) 776-4672 a i 'ole TDD/TTY 1 (877) 447-5990.

Bisaya
PAHIBALO: Kung dili English ang imong pinulongan, magamit nimo ang mga serbisyo sa tabang sa pinulongan nga walay bayad. Ang mga auxiliary nga tabang ug serbisyo anaa sab aron mohatag og impormasyon kanimo sa daling ma-access nga mga format nga walay bayad. Mga membro sa QUEST, tawag sa 1 (800) 440-0640 toll-free, TTY 1 (877) 447-5990, o pakig-istorya sa imong provider. Mga membro sa Medicare Advantage ug commercial plan, tawag sa 1 (800) 776-4672 o TDD/TTY 1 (877) 447-5990.

繁體中文
請注意：如果你不諳英文，我們將為您提供免費的語言協助服務。輔助支援和服務也能免費以無障礙的方式為您提供資訊。QUEST **會員請致電免費熱線** 1 (800) 440-0640**、聽障熱線** (TTY) 1 (877) 447-5990 **或與您的服務提供者聯絡。**Medicare Advantage **及商業計劃會員請致電** 1 (800) 776-4672 **或聽障／語障熱線** (TDD/TTY) 1 (877) 447-5990**。**

简体中文
注意：如果您不会说英语，我们可以免费为您提供语言协助服务。同时，我们还配备辅助工具和相关服务，免费为您提供无障碍格式的信息。QUEST 会员请拨打免费电话 1 (800) 440-0640，TTY 1 (877) 447-5990，或咨询您的医疗服务提供者。Medicare Advantage 和商业计划会员请致电 1 (800) 776-4672 或 TDD/TTY 1 (877) 447-5990。

Ilokano
BASAEN: No saanka nga agsasao iti Ingles, mabalinmo a magun-odan ti libre a serbisio a tulong iti lengguahe. Adda met dagiti kanayonan a tulong ken serbisio a makaited kenka iti libre nga impormasion iti nalaka a maawatan a pormat. Dagiti miembro ti QUEST, tawaganyo ti 1 (800) 440-0640 a libre iti toll, TTY 1 (877) 447-5990, wenno makisaritaka iti provider-yo. Dagiti miembro ti Medicare Advantage ken plano a pang-komersio, tawaganyo ti 1 (800) 776-4672 wenno TDD/TTY 1 (877) 447-5990.

日本語
注意：英語を話されない方には、無料で言語支援サービスをご利用いただけます。また、情報をアクセシブルな形式で提供するための補助ツールやサービスも無料でご利用いただけます。QUESTプログラムの加入者の方は、フリーダイヤル1 (800) 440-0640**までお電話ください。TTYをご利用の場合は**1 (877) 447-5990**までお電話いただくか、担当医療機関にご相談ください。**Medicare Advantage**プランおよび民間保険プランの加入者の方は、**1 (800) 776-4672**までお電話いただくか、TDD/TTYをご利用の場合は**1 (877) 447-5990**までお電話ください。**

한국어
주의: 영어를 사용하지 않는 경우, 무료로 언어 지원 서비스를 이용할 수 있습니다. 무료로 접근 가능한 형식으로 정보를 받기 위해 보조 지원 및 서비스 역시 이용할 수 있습니다. QUEST 가입자는 수신자 부담 전화 1 (800) 440-0640, TTY 1 (877) 447-5990 번으로 전화하거나 서비스 제공자와 상의하십시오. Medicare Advantage 및 민간 플랜 가입자는 1 (800) 776-4672 또는 TDD/TTY 1 (877) 447-5990번으로 전화하십시오.

ພາສາລາວ
ຊຶ່ນຊາບ: ຖ້າທ່ານບໍ່ເວົ້າພາສາອັງກິດແມ່ນມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍພ້ອມໃຫ້ທ່ານ. ນອກຈາກນັ້ນກໍ່ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມເພື່ອໃຫ້ຂໍ້ມູນແກ່ທ່ານໃນຮູບແບບທີ່ ເຊົ້າເຖິງໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ສະມາຊິກ QUEST ແມ່ນໂທບໍ່ເສຍຄ່າ ໄດ້ທີ່ເບີ 1 (800) 440-0640, TTY 1 (877) 447-5990 ຫຼື ປຶກສາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. ສະມາຊິກແຜນປະກັນ Medicare Advantage ແລະ ຊັ້ນທຸລະກິດ, ໂທ 1 (800) 776-4672 ຫຼື TDD/TTY 1 (877) 447-5990.

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Kajin Ṃajōḷ
KŌJELLA: Ñe kwōjab jelā kenono kajin Belle, ewōr jibañ in ukok ñan kwe im ejellok wonnen. Ewōr kein roñjak im jibañ ko jet ñan wāween ko kwōmaron ebōk melele im ejellok wonnen. Armej ro rej kōjrbal QUEST, kall e 1 (800) 440-0640 ejellok wonnen, TTY 1 (877) 447-5990, ñe ejab kenono ibben taktō eo am. Medicare Advantage im ro rej kōjerbal injuran ko rej make wia, kall e 1 (800) 776-4672 ñe ejab TDD/TTY 1 (877) 447-5990.

Lokaiahn Pohnpei
Kohdo: Ma ke mwahu en kaiahn Pohnpei, me mwengei en kaiahn Pohnpei. Me mwengei en kaiahn Pohnpei, me mwengei en kaiahn Pohnpei. QUEST mwengei, kohdo mwengei 1 (800) 440-0640, TTY 1 (877) 447-5990, me mwengei en kaiahn Pohnpei. Medicare Advantage me mwengei en kaiahn Pohnpei, kohdo mwengei 1 (800) 776-4672 me TDD/TTY 1 (877) 447-5990.

Gagana Sāmoa
FAASILASILAGA: Afai e te lē tautala le faa-Igilisi, o loo avanoa mo oe e aunoa ma se totogi auaunaga fesoasoani i le gagana. O loo maua fo'i fesoasoani faaopo'opo ma auaunaga e tuuina atu ai iā te oe faamatalaga i auala eseese lea e maua e aunoa ma se totogi. Sui auai o le QUEST, valaau aunoa ma se totogi i le 1 (800) 440-0640, TTY 1 (877) 447-5990, pe talanoa i lē e saunia lau tausiga. Sui auai o le Medicare Advantage ma sui auai o peleni inisiua tumaoti, valaau i le 1 (800) 776-4672 po o le TDD/TTY 1 (877) 447-5990.

Español
ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia con el idioma. También están disponibles ayuda y servicios auxiliares para brindarle información en formatos accesibles sin costo alguno. Los miembros de QUEST deben llamar al número gratuito 1 (800) 440-0640, TTY 1 (877) 447-5990 o hablar con su proveedor. Los miembros de Medicare Advantage y de planes comerciales deben llamar al 1 (800) 776-4672 o TDD/TTY 1 (877) 447-5990.

Tagalog
PAUNAWA: Kung hindi ka nakapagsasalita ng Ingles, mayroon kang makukuhang mga serbisyo sa tulong sa wika nang libre. Mayroon ding mga auxiliary na tulong at serbisyo para bigyan ka ng impormasyon sa mga naa-access na format nang libre. Sa mga miyembro ng QUEST, tumawag sa 1 (800) 440-0640 nang toll-free, TTY 1 (877) 447-5990, o makipag-usap sa iyong provider. Sa mga miyembro ng Medicare Advantage at commercial plan, tumawag sa 1 (800) 776-4672 o TDD/TTY 1 (877) 447-5990.

ไทย
โปรดให้ความสนใจ: หากท่านไม่พูดภาษาอังกฤษ เรามีบริการให้ความช่วยเหลือทางภาษาแก่ท่านโดยไม่มีค่าใช้จ่าย และยังมีความช่วยเหลือและบริการเสริมเพื่อให้ข้อมูลแก่ท่านในรูปแบบที่เข้าถึงได้โดยไม่มีค่าใช้จ่าย สำหรับสมาชิก QUEST โปรดโทรไปที่หมายเลขโทรฟรีที่หมายเลข 1 (800) 440-0640, TTY 1 (877) 447-5990 หรือพูดคุยกับผู้ให้บริการของคุณ สำหรับสมาชิก Medicare Advantage และแผนเชิงพาณิชย์ โปรดโทรไปที่หมายเลข 1 (800) 776-4672 หรือ TDD/TTY 1 (877) 447-5990

Tonga
FAKATOKANGA: Kapau óku íkai keke lea Faka-Pilitania, óku í ai e tokotaha fakatonulea óku í ai ke tokonií koe íkai ha totongi. Óku í ai mo e kulupu tokoni ken au óatu e ngaahi fakamatala mo e tokoni íkai ha totongi. Kau memipa QUEST, ta ki he 1 (800) 440-0640 taé totongi, TTY 1 (877) 447-5990, pe talanoa ki hoó kautaha. Ko kinautolu óku Medicare Advantage mo e palani fakakomesiale, ta ki he 1 (800) 776-4672 or TDD/TTY 1 (877) 447-5990.

Foosun Chuuk
ESINESIN: Ika kese sine Fosun Merika, mei wor aninisin fosun fonu ese kamo mi kawor ngonuk. Mei pwan wor pisekin aninis mi kawor an epwe esinei ngonuk porous non och wewe ika nikinik epwe mecheres me weweoch ngonuk ese kamo. Chon apach non QUEST, kekeri 1 (800) 440-0640 namba ese kamo, TTY 1 (877) 447-5990, ika fos ngeni noumw ewe chon awora aninis. Medicare Advantage ika chon apach non ekoch otot, kekeri 1 (800) 776-4672 ika TDD/TTY 1 (877) 447-5990.

Tiếng Việt
CHÚ Ý: Nếu quý vị không nói được tiếng Anh, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Các phương tiện và dịch vụ hỗ trợ cũng có sẵn để cung cấp cho quý vị thông tin ở các định dạng dễ tiếp cận mà không mất phí. Hội viên QUEST, xin gọi số miễn cước 1 (800) 440-0640, TTY 1 (877) 447-5990, hoặc nói chuyện với nhà cung cấp dịch vụ của quý vị. Hội viên Medicare Advantage và chương trình thương mại, xin gọi số 1 (800) 776-4672 hoặc TDD/TTY 1 (877) 447-5990.

HAWAIʻI MEDICAL SERVICE ASSOCIATION

Prescription Drug Benefits Rider

I. ELIGIBILITY

This Rider provides coverage that supplements the coverage provided under HMSA's medical plan. Your coverage under this Rider starts and ends on the same dates as your medical plan coverage.

II. PROVISIONS OF THE MEDICAL PLAN APPLICABLE

All definitions, provisions, exclusions, and conditions of HMSA's Guide to Benefits shall apply to this Rider. Exceptions are specifically modified in this Rider.

III. ANNUAL COPAYMENT MAXIMUM

The ***Annual Copayment Maximum*** for Prescription Drugs and Supplies is the maximum copayment amounts you pay in a calendar year for Prescription Drugs and Supplies. Once you meet the copayment maximum of $3,600 per person or $4,200 per family you are no longer responsible for copayment amounts for Prescription Drugs and Supplies unless otherwise noted.

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

(1) Payments for services subject to a maximum once you reach the maximum.

(2) The difference between the actual charge and the eligible charge that you pay when you receive services from a nonparticipating provider.

(3) Payments for noncovered services.

(4) Any amounts you owe in addition to your copayment for covered services.

IV. DEFINITIONS

When used in this Rider:

(1) **"Biological products"**, or biologics, are medical products. Many products are made from a variety of natural sources (i.e., 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, 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.

(2) **"Biosimilar product"** is a biological product that is FDA-approved based on a showing that it is highly similar to an already FDA-approved reference product. It 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.

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 the intervention of the healthcare provider who prescribed the reference product.

(3) **"Brand Name Drug"** is a drug that 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 HMSA.

(4) **"Eligible Charge"** is the charge HMSA uses to calculate a benefit payment for a covered service or drug. It is the lesser of the following charges:

(a) The actual charge as shown on the claim, or

(b) HMSA's Allowable Fee. This includes an allowance for dispensing the drug.

HMSA negotiates the cost of covered drugs and supplies from drug manufacturers or suppliers. This may include discounts, rebates, or other cost reductions. Any discounts or rebates received by HMSA will not reduce the charges that your copayments are based on. Discounts and rebates are used to calculate your Tier 3 Cost Share. HMSA also applies discounts and rebates to reduce prescription drug coverage rates for all prescription drug plans.

Participating Providers agree to accept the eligible charge as payment in full for covered drugs or supplies. Nonparticipating providers generally do not. Therefore, if you receive drugs or supplies from a nonparticipating provider, you are responsible for a Copayment plus a Tier 3 Cost Share, if any, plus the difference between the actual charge and the eligible charge.

(5) **"Generic Drug"** is a drug or supply that is prescribed or dispensed under its commonly used generic name rather than a brand name. Generic drugs are not protected by patent and are identified by HMSA as "generic". A generic drug shall meet any one of the following:

(a) It is identical or therapeutically equivalent to its brand counterpart in dosage form, safety, strength, route of administration and intended use.

(b) It is a non-innovator product approved by the FDA under an Abbreviated New Drug Application (an application to market a duplicate drug that has been approved by the FDA under a full New Drug Application).

(c) It is defined as a generic by Medi-Span or an equivalent nationally recognized source.

(d) It is not protected by patents(s), exclusivity, or cross-licensure.

(e) Generic drugs include all single-source and multi-source generic drugs as set forth by a nationally recognized source selected and disclosed by HMSA. Unless explicitly defined or designated by HMSA, once a drug has been deemed a generic drug, it must be considered a generic drug for purposes of benefit administration.

(6) **"HMSA Essential Prescription Formulary"** is a list of drugs by therapeutic category published by HMSA.

(7) **"Immunization"** is an injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

(8) **"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 the intervention of the healthcare provider who prescribed the reference product.

(9) **"Non-Preferred Formulary Drug"** is a Brand Name drug or supply that is not identified as preferred or is listed in Tier 3 on the HMSA Essential Prescription Formulary. When you choose Non-

Preferred Formulary drugs, your Copayment plus Tier 3 Cost Share may exceed HMSA's payment to the provider.

(10) **"Non-Preferred Formulary Specialty Drug"** is a Specialty Drug or supply that is not identified as a Preferred Formulary Specialty Drug or is listed in Tier 5 on the HMSA Essential Prescription Formulary.

(11) **"Oral Chemotherapy Drug"** is 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.

(12) **"Over-the-Counter Drugs"** are drugs that may be purchased without a prescription.

(13) **"Preferred Formulary Drug"** is a drug or supply identified as preferred or is listed in Tier 2 on the HMSA Essential Prescription Formulary.

(14) **"Preferred Formulary Specialty Drug"** is a Specialty Drug or supply that is identified as a Preferred Formulary Specialty or is listed in Tier 4 on the HMSA Essential Prescription Formulary.

(15) **"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 nonprescription drug are not covered as a Prescription Drug under this Rider.

(16) **"Reference product"** refers to the original FDA-approved biologic product that a biosimilar is based.

(17) **"Specialty Drugs"** have one or more of the following characteristics:

(a) High in cost (more than $600)

(b) Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.

(c) Coordination of care is required prior to drug therapy initiation and/or during therapy.

(d) Unique patient compliance and safety monitoring requirements.

(e) Unique requirements for handling, shipping and storage.

(f) Restricted access or limited distribution.

(18) **"Tier 3 Cost Share"** is a share of the cost of Tier 3 drugs or devices that you must pay in addition to a Copayment. When you choose Tier 3 drugs, your Copayment plus Tier 3 Cost Share may exceed HMSA's payment to the provider.

V. DRUG BENEFITS

You are eligible to receive the following benefits when covered drugs and supplies are obtained with a prescription. Covered drugs and supplies must be 1) approved by the FDA, 2) prescribed by a licensed Provider and 3) dispensed by a licensed pharmacy or Provider. The use of such drugs and supplies must be necessary for the diagnosis and treatment of an injury or illness. To find out which drugs and supplies are covered and which tier your drug or supply is in, refer to the formulary. Changes to the formulary may occur at any time during your plan year. The current formulary can be found at www.hmsa.com.

(1) **Covered Prescription Drugs and Supplies.**

(a) Prescription Drugs that are listed in the HMSA Essential Prescription Formulary, including drugs and supplies covered in accord with Hawaii and Federal law. Except for drugs and supplies listed in Sections V(1)(b) through V(1)(g), every drug on the plan's formulary is covered in one of the five cost-sharing tiers listed below. In general the higher the cost-sharing tier number, the higher your cost for the drug. Drugs approved as Non-Formulary Exceptions, inclusive of Sections V(1)(b) through V(1)(g), will be subject to Tier 3 copayment plus Tier 3 Cost Share for Non-Specialty drugs and Tier 5 copayment for Specialty drugs

- Tier 1 – mostly Generic Drugs
- Tier 2 – mostly Preferred Formulary Drugs
- Tier 3 – mostly Non-Preferred Formulary Drugs
- Tier 4 – mostly Preferred Formulary Specialty Drugs
- Tier 5 – mostly Non-Preferred Formulary Specialty Drugs

(b) Oral Chemotherapy Drugs.

(c) Contraceptives – Over-the-counter (OTC) when you receive a written prescription for the OTC contraceptive.

(d) Immunizations and Immunization Administration.

(e) Other Supplies (limited to those listed in the HMSA Essential Prescription Formulary which can be found at www.hmsa.com.)

(f) Spacers and peak flow meters (limited to those listed in the HMSA Essential Prescription Formulary).

(g) Drugs Recommended by the U.S. Preventive Services Task Force (USPSTF).

(2) **Benefits for Covered Drugs.**

(a) **Tier 1.**

1. When obtained from a Participating Provider, you owe a $7 Copayment per drug to the Participating Provider. HMSA pays the Participating Provider 100% of the remaining Eligible Charge. For Tier 1 contraceptives, HMSA pays 100% of Eligible Charge. You owe no Copayment.

2. When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $7 Copayment per drug when the claim is submitted

(b) **Tier 2.**

1. When obtained from a Participating Provider, you owe a $30 Copayment per drug to the Participating Provider. HMSA pays the Participating Provider 100% of the remaining Eligible Charge.

2. When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $30 Copayment per drug when the claim is submitted.

(c) **Tier 3.**

1. When obtained from a Participating Provider, you owe a $30 Copayment per drug and a $45 Tier 3 Cost Share per drug. HMSA pays 100% of the remaining Eligible Charge after deducting the Copayment and Tier 3 Cost Share.

2. When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $30 Copayment per drug and a $45 Tier 3 Cost Share per drug when the claim is submitted.

(d) **Tier 4.** Preferred Formulary Specialty Drugs are covered only when purchased from select providers. Contact HMSA to get a list of these providers. When obtained from a provider on the list, you owe 20% of the Eligible Charge per drug to the provider. HMSA pays the provider the remaining Eligible Charge.

Benefits for Preferred Formulary Specialty Drugs are limited to a maximum 30-day supply or fraction thereof. Your provider may dispense less than a 30-day supply the first time the prescription is dispensed. Your copayment may be pro-rated when a reduced day supply is dispensed for first time prescriptions.

(e) **Tier 5**. Non-Preferred Formulary Specialty Drugs are covered only when purchased from select providers. Contact HMSA to get a list of these providers. When obtained from a provider on the list, you owe 25% of the Eligible Charge per drug to the provider. HMSA pays the provider the remaining Eligible Charge.

Benefits for Non-Preferred Formulary Specialty Drugs are limited to a maximum 30-day supply or fraction thereof. Your provider may dispense less than a 30-day supply the first time the prescription is dispensed. Your copayment may be pro-rated when a reduced day supply is dispensed for first time prescriptions.

(f) **Oral Chemotherapy – Non-Specialty Drugs.**

1. When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment.

2. When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 90% of Eligible Charge when the claim is submitted.

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

1. When obtained from a contracted provider, you owe a $100 copayment per drug or 10% of Eligible Charge, whichever is less. HMSA pays the provider 100% of the remaining Eligible Charge.

(h) **Contraceptives – Over-the-counter (OTC).** Benefits are available when you receive a written prescription for the OTC contraceptive.

1. When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment for OTC contraceptives.

2. When obtained from a nonparticipating provider, you owe the entire charge for OTC contraceptives. HMSA reimburses you 80% of the remaining Eligible Charge after deducting a $7 Copayment when the claim is submitted.

(i) **Immunizations and Immunization Administration.** The following are covered but only when recommended by the Advisory Committee on Immunization Practices (ACIP):

1. immunizations,
2. travel immunizations, and
3. immunization administration.

a. When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no copayment.

b. When obtained from a nonparticipating provider, you owe the entire charge. HMSA reimburses you 100% of the Eligible Charge when the claim is submitted.

(j) **Other Supplies.**

1. When obtained from a Participating Provider, you owe 20% of the Eligible Charge for other supplies. HMSA pays 100% of the remaining Eligible Charge.

2. When obtained from a nonparticipating provider, you owe the entire charge for other supplies. HMSA reimburses you 70% of the Eligible Charge when the claim is submitted.

(k) **Spacers and Peak Flow Meters**.

1. When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no Copayment for spacers and peak flow meters.

2. When obtained from a nonparticipating provider, you owe the entire charge for spacers and peak flow meters. HMSA reimburses you 100% of Eligible Charge when the claim is submitted.

(l) **Drugs Recommended by the U.S. Preventive Services Task Force (USPSTF)**. Contact HMSA for a list of drugs recommended by the USPSTF. Examples of drugs recommended include, but are not limited to, aspirin and folic acid.

1. When obtained from a Participating Provider, HMSA pays 100% of Eligible Charge. You owe no copayment.

2. When obtained from a nonparticipating provider, you owe the entire charge for the drug. HMSA reimburses you 80% of the Eligible Charge when the claim is submitted.

(m) The Copayment amounts shown in Sections (2)(a) through (2)(l) above are for a maximum 30-day supply or fraction thereof. As used in this Rider, 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. Except for Specialty Drugs, if you get more than a 30-day supply under one prescription:

1. You must pay an additional Copayment for each 30-day supply or fraction thereof, and

2. The pharmacy will fill the prescription in the quantity specified by your Provider up to a 12-month supply for contraceptives. For all other drugs or supplies the maximum benefit payment is limited to two more 30-day supplies or fractions thereof.

(n) **Tier 3 Drug Copayment Exceptions.** You may qualify to purchase Tier 3 drugs at the lower Tier 2 copayment if you have a chronic condition that lasts at least three months, and:

1. have tried and failed treatment with at least two lower tier formulary alternatives (or one drug in a lower tier if only one alternative is available) within the same or similar class of drug, or

2. all other comparable lower tier drugs are contraindicated based on your diagnosis, other medical conditions, or other medication therapy.

When prescription drugs become available as therapeutically equivalent over-the-counter drugs, they must have also been tried and failed before a Tier 3 Drug Copayment Exception is approved. You have failed treatment if you meet 1, 2, or 3 below.

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

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

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

This benefit requires precertification. You or your Provider must provide legible medical records that substantiate the requirements of this section in accord with HMSA's policies and to HMSA's satisfaction.

This exception is not applicable to diabetic supplies, Other Supplies, Specialty Drugs, Non-Formulary Exceptions, controlled substances, off label uses, Non-Preferred Formulary medications if there is an FDA approved A rated generic equivalent, or if HMSA has a drug specific policy which has criteria different from the criteria in this section. You can call HMSA Customer Service to find out if HMSA has a drug policy specific to the drug prescribed for you.

(o) **Non-Formulary Exceptions**. If your drug is not listed in one of the five tiers and is not excluded in Section VI of this Rider, you may qualify for a Non-Formulary exception if:

1. you have a condition in which treatment with formulary alternatives within the same or similar class of drug have been tried and failed. You must have tried and failed treatment with all or 3 formulary alternatives, whichever is less; or

2. formulary alternatives are contraindicated based on your diagnosis, other medical conditions, or other medication therapy.

When prescription drugs become available as therapeutically equivalent over-the-counter drugs, they must have also been tried and failed before a Non-Formulary Exception is approved. You have failed treatment if you meet 1, 2, or 3 of the Tier 3 Copayment Exception criteria.

If you qualify for a Non-Formulary Exception you owe the Tier 3 Copayment and Tier 3 Cost Share for Non-Specialty drugs or Tier 5 Copayment for Specialty drugs.

(3) **Limitations on Covered Drugs.**

(a) **Limitations on Prescription Drugs.**

1. Products not approved by the U.S. Food and Drug Administration (FDA) are not covered, except those designated as covered in HMSA's Essential Prescription Formulary (for example Phenobarbital).

2. Compound preparations are covered if they contain at least one Prescription Drug that is not a vitamin or mineral. For compounds made with covered Non-Specialty drugs, you owe the Tier 3 copayment. For compounds made with a covered Specialty drug(s), you owe the Tier 5 copayment. Subject to a and b below:

a. Compound drugs that are available as similar commercially available prescription drug products are not covered.

b. Compound drugs made with bulk chemicals are not covered.

c. Non-FDA approved drugs are not covered

3. Coverage of vitamins and minerals that are Prescription Drugs is limited to:

a. The treatment of an illness that in the absence of such vitamins and minerals could result in a serious threat to your life. For example, folic acid used to treat cancer.

b. Sodium fluoride, if dispensed as a single drug (for example, without any additional drugs such as vitamins) to prevent tooth decay.

(b) **Drug Benefit Management.** HMSA has arranged with Participating Providers to assist in managing the use of certain drugs. This includes drugs listed in the HMSA Essential Prescription Formulary.

1. HMSA has identified certain kinds of drugs in the HMSA Essential Prescription Formulary that require the preauthorization of HMSA. The criteria for preauthorization are that:

a. the drug is being used as part of a treatment plan,

b. there are no equally effective drug substitutes, and

c. the drug meets Payment Determination and other criteria established by HMSA.

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

2. Participating Providers may prescribe up to a 30-day supply for first time prescriptions of maintenance drugs and contraceptives. For subsequent refills, the Participating Provider may prescribe up to a 12-month supply for contraceptives and a maximum 90-day supply for all other drugs or supplies after confirming that:

a. you have tolerated the drug without adverse side effects that may cause you to discontinue using the drug, and

b. your Provider has determined that the drug is effective.

(c) **Smoking Cessation Drugs.** Coverage of smoking cessation drugs is limited to 180 days of treatment per calendar year.

(d) This Rider requires the substitution of Generic Drugs listed on the FDA Approved Drug 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, HMSA will pay only the amount that would have been paid for the generic equivalent. This provision regarding reduced benefits shall apply even if the particular generic equivalent was out-of-stock or was not available at the pharmacy. You may seek other Participating Providers when purchasing a generic equivalent in cases when the particular generic equivalent is out-of-stock or not available at that pharmacy.

(e) Except for certain drugs managed under Drug Benefit Management, refills are available if indicated on your original prescription. The refill prescription must be purchased only after two-thirds of your prescription has already been used. For example, for coverage under this Rider, if the previous supply was a 30-day supply, you may refill the prescription on the 21st day, but not earlier. At the discretion of your pharmacist, you may refill your prescriptions for maintenance drugs earlier if you need to synchronize such prescriptions to pick them up at the same time. Your copayment for each prescription may be adjusted accordingly. *Please Note:* Certain limitations or restrictions apply. Please see our Medication Synchronization policy at www.hmsa.com.

(f) If you receive benefits from your HMSA medical plan for drugs or supplies, your medical plan benefits apply and not the benefits described in this Rider. Please refer to HMSA's Guide to Benefits for benefit details, as benefits may differ from those listed in this Rider. For example, the copayment you pay for drugs or supplies covered by your medical plan apply to the medical plan's annual copayment maximum, not the annual copayment maximum described in this Rider. There shall be no duplication or coordination between benefits of this drug plan and any other similar benefit of your HMSA medical plan.

(4) **HMSA's 90-Day at Retail Network and Mail Order Prescription Drug Program.**

(a) HMSA has contracted with selected providers to make prescription maintenance medications available for pickup or by mail. Specialty Drugs, including Specialty Oral Chemotherapy Drugs are not available through HMSA's 90-Day at Retail Network or Mail Order Prescription Drug Program.

1. You owe the contracted provider an $11 Copayment per Tier 1 drug, a $65 Copayment per Tier 2 drug, and a $65 Copayment plus a $135 Tier 3 Cost Share per Tier 3 drug. HMSA pays 100% of the remaining charges. For Tier 1 contraceptives, HMSA pays 100% of Eligible Charge. You owe no Copayment.

2. Oral Chemotherapy - Non-Specialty Drugs. You owe the contracted provider no Copayment for non-specialty oral chemotherapy drugs. HMSA pays 100% of the charges.

3. Contraceptives - Over-the-counter (OTC). Benefits are available when you receive a written prescription for the OTC contraceptive. You owe the contracted provider no Copayment for OTC contraceptives. HMSA pays 100% of the charges.

4. Other Supplies. You owe the contracted provider 20% of the Eligible Charge per other supplies. HMSA pays 100% of the remaining charges.

5. Spacers and Peak Flow Meters. You owe the contracted provider no Copayment for spacers and peak flow meters. HMSA pays 100% of the charges.

6. USPSTF Recommended Drugs. You owe the contracted provider no Copayment for USPSTF recommended drugs. HMSA pays 100% of the charges.

(b) **HMSA's 90-Day at Retail Network and Mail Order Prescription Drug Program Limitations.**

1. Prescription Drugs are available only from contracted providers. Contact HMSA to get a list of providers. If you receive prescription maintenance drugs from a provider that does not contract with HMSA, no benefits will be paid.

2. Prescription Drugs are limited to prescribed maintenance medications taken on a regular or long-term basis.

3. 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, copayment amounts are for a maximum 90-day supply or fraction thereof. A 90-day supply is a supply that will last for 90 consecutive days or a fraction thereof. These are examples on how your copayments are calculated:

a. 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 owe the 90-day copayment even though the supply dispensed is fifteen pills.

b. You are prescribed a 30-day supply with two refills. The contracted 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 30-day copayment.

c. 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 a 28-day supply. You owe the 30-day copayment. 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. You would owe a 90-day copayment for the 84-day supply.

4. Unless the prescribing Provider requires the use of a Brand Name Drug, your prescription will be filled with the Tier 1 equivalent when available and permissible by law. If a Brand Name Drug is required, it must be clearly indicated on the prescription.

5. Refills are available if indicated on your original prescription. The refill prescription must be purchased only after two-thirds of your prescription has already been used.

VI. EXCLUSIONS

This Rider is subject to all exclusions in HMSA's Guide to Benefits. The Guide to Benefits describes the medical benefits plan that accompanies this Rider.

Except as otherwise stated in this Rider or as designated as covered in the HMSA Essential Prescription Formulary, no payment will be made for:

(1) Products not approved by the U.S. Food and Drug Administration (FDA).

(2) Agents used in skin tests to determine allergic sensitivity.

(3) Appliances and other nondrug items.

(4) Convenience packaged drugs, including kits.

(5) Drugs dispensed to a registered bed patient.

(6) Drugs from foreign countries.

(7) Drugs that need to be administered by a provider or drugs that are self-administered under the supervision of a provider.

(8) Drugs to treat sexual dysfunction, except suppositories listed in the HMSA Essential Prescription Formulary and used to treat sexual dysfunction due to an organic cause as defined by HMSA.

(9) Immunization agents.

(10) Injectable drugs.

(11) Lifestyle drugs and pharmaceutical products that improve a way or style of living rather than alleviating a disease. Lifestyle drugs that are not covered include, but are not limited to: creams

used to prevent skin aging and drugs to enhance athletic performance.

(12) Medical foods.

(13) Over-the-counter drugs that may be purchased without a prescription.

(14) Replacements for lost, stolen, damaged, or destroyed drugs and supplies.

(15) Unit dose drugs.

VII. COORDINATION OF BENEFITS

The coordination of benefits described in Chapter 9 of HMSA's Guide to Benefits in the section labeled "Coverage that Provides Same or Similar Coverage" is modified as follows:

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 because of the primary plan's payment. 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.

Any Tier 3 Cost Share you owe under this plan will first be subtracted from the benefit payment. You remain responsible for the Tier 3 Cost Share owed under this plan, if any.

All other provisions of Chapter 9 of HMSA's Guide to Benefits remain unchanged.

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Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center in Pearl City

Pearl City Gateway | 1132 Kuala St., Suite 400
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

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Waiakea Center | 303A E. Makaala St.
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

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Kuhio Medical Center | 3-3295 Kuhio Highway, Suite 202
Monday–Friday, 8 a.m.–4 p.m

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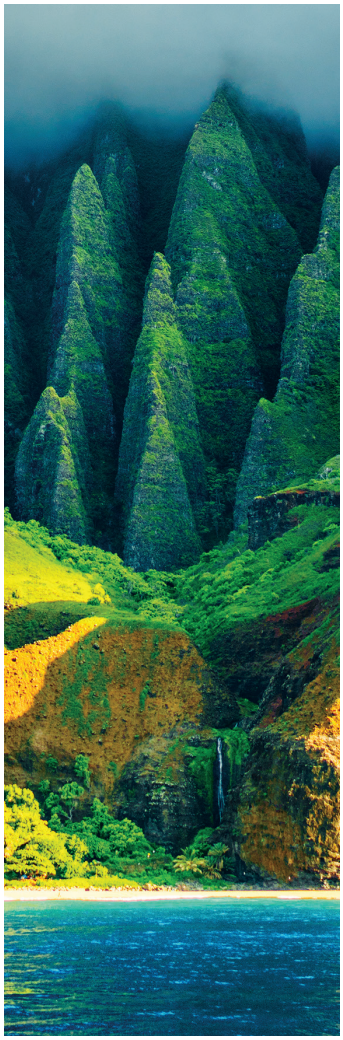

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