HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA Plan

http://www.hmsa.com

2001

A Health Maintenance Organization with a point of service product

Serving: All of Hawaii

Enrollment in this Plan is limited; see page 3 for requirements.

Enrollment codes for this Plan:

871 Self Only
872 Self and Family

Authorized for distribution by the:

OPM
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Introduction

Hawaii Medical Service Association
818 Keeaumoku Street
Honolulu, Hawaii 96814

This brochure describes the benefits of Hawaii Medical Service Association (HMSA), an independent licensee of the Blue Cross and Blue Shield Association under our contract (CS 1058) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 60. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means HMSA.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB Plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a participating provider without a referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

The Plan has over 3,500 Plan doctors, dentists, and other health care providers in Hawaii who agree to keep their charges for covered services below the Plan's eligible charge guidelines. When you go to a Plan provider, you are assured that your copayments or coinsurance will not be more than the amount shown in this brochure.

You may go to a Non-Plan provider; however, the Plan pays a reduced benefit for certain services from Non-Plan providers. In addition, because Non-Plan providers are not under contract to limit their charges, you are responsible for any charges in excess of eligible charges.

When you need covered services outside the state of Hawaii, you are encouraged to contact out-of-state Blue Cross and/or Blue Shield Plans for information regarding specific Plan providers in their area. Benefit payment for covered services received out-of-state are based on contracts negotiated between the out-of-state Blue Cross and/or Blue Shield Plans and their Plan providers.

When out-of-state Blue Cross and/or Blue Shield Plan providers participate in the BlueCard Program, the amount you pay for covered services provided by these Plan providers is usually calculated on the lower of: 1) the actual billed charges for your covered services, or 2) the negotiated price that the on-site Blue Cross and/or Blue Shield Plan passes on to the Plan.

In some cases, this "negotiated price" is a simple discount. In other cases, the negotiated price may be an estimate. In calculating this estimated price, we may consider the following factors:

- Expected settlements with Plan providers
- An average expected savings
- Prior price estimations

A few states do not allow Blue Cross/or Blue Shield Plans to calculate your payment based on the methods outlined above. When you receive covered health care services in one of these states, your payment will be calculated according to the law of that state.

In order to receive Plan Provider benefits for covered out-of-state services under this Plan, the services you receive must be rendered by a BlueCard PPO provider. Non-Plan provider benefits are applied for covered services rendered by Non-PPO providers, even if they participate in other Blue Cross and/or Blue Shield programs.

Continued on next page

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the president's Advisory Commission on consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- We are currently in compliance with state licensing requirements.
- We are in our 62nd year of continuous service to the people of Hawaii.
- We were founded in 1938 as a non-profit mutual benefit society.

If you want more information about us, call (808)948-6499, or write to P.O. Box 860, Honolulu, HI 96808. You may also contact us by fax at (808)948-5567 or visit our website at http://www.hmsa.com.

Service Area

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

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

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our Plan network will be the same with regard to coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling (808)948-6499, **or** checking our website, www.hmsa.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - •• Speak up if you have questions or concerns.
  - •• Make sure you get the results of any test or procedure.
  - •• Keep a list of all the medicines you take.
  - •• Talk with your doctor and health care team about options if you need hospital care.
  - •• Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-postal premium will increase by 8.2% for Self Only or 8.2% for Self and Family.
- We have removed for Mental Health and Substance Abuse, the 24 outpatient visits and 30 inpatient days per calendar year limitations and 2 per lifetime limit on substance abuse treatment plans.
- We have changed your coinsurance for the majority of your services. If a Plan provider renders your services, you pay a 20% coinsurance. If you go to a Non-Plan provider you pay a 30% coinsurance plus anything above eligible charge.
- The major medical benefits are now a part of the medical benefits in section 5.
- We have added an annual copayment maximum to your Plan for financial protection.
- We have changed your coinsurance for selected preventive services. You pay nothing for services rendered by a Plan provider. If you choose to go to a Non-Plan provider, you will pay any difference between the Plan's payment and the actual charges, plus your coinsurance.
- We have changed your coinsurance for HealthPass referred screening. You pay nothing when a provider selected by HealthPass renders services.
- We have increased the mammography benefit to one mammogram every year for women age 65 and above.
- We are covering hospice residential room and board and hospice referral visits at 100% of eligible charges for Plan providers. Service rendered by a Non-Plan provider is not a benefit of this Plan.
- We now cover medical foods and low-protein modified food products for the treatment of inborn metabolic diseases. We will cover these medical foods at 80% of eligible charges for Plan and 70% for Non-Plan providers when ordered by a physician.
- Advanced Practice Registered Nurse and clinical nurse specialists, certified registered nurse anesthetists, and midwives (for non-maternity services such as routine gynecological care) are now recognized Plan providers.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (808)948-6499.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, and/or coinsurance, and you will not have to file claims. If you use our point-of-service program, you can also get care from Non-Plan providers, but it will cost you more.

We look at some or all the following criteria to determine if a provider is recognized and approved by us:

- Is the provider accredited by a recognized accrediting agency?
- Is the provider appropriately licensed?
- Is the provider certified by the proper government authority?
- Are the services rendered within the lawful scope of the provider's respective licensure, certification, and /or accreditation?

• Plan providers

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

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

We list Plan providers in a provider directory, which we update periodically.

• Non-Plan providers

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

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

• Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically.

What you must do

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

• Primary care

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

• Specialty care

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

Here are other things you should know about specialty care:

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

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

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

• Hospital care

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

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

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

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

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

Continued on next page

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, you or your physician must obtain approval from us. Before giving approval, we consider if the service is covered, and follows generally accepted medical practice, among other factors.

We call this review and approval process precertification. Precertification is a special approval process to ensure that certain medical treatments, procedures, or devices meet payment determination criteria prior to the services being rendered. If you are under the care of:

- An HMSA participating physician or contracting physician, he or she will :
  - •• obtain approval for you; and
  - •• accept any penalties for failure to obtain approval.
- a BlueCard PPO, BlueCard Plan provider or a Non-Plan provider you are responsible for obtaining precertification. If you do not receive precertification and receive any of the services described in this section, benefits may be denied.

You or your physician must obtain precertification for the following services such as:

- Autologous chondrocyte implants
- Custom durable medical equipment
- Growth hormone therapy
- In vitro fertilization
- Integrated Case Management
- Mental Health Treatment – inpatient
- Mental Health Treatment – outpatient
  - •• You must receive approval from HMSA's benefit manager for any outpatient visits beyond the first 6 hours.
- Organ and tissue transplants listed in Section 5 of this brochure
- Physical Therapy Visits
  - •• You must receive approval from HMSA for any outpatient visits beyond the first 10 visits.
- Positron Emission Tomography (PET)
- Stereo radiosurgery utilizing particle beams
- Substance Abuse Treatment - inpatient or outpatient
- Surgeries, therapies or procedures employing new technology
- Surgery to correct morbid obesity
- Transplant evaluations, except for cornea and kidney transplant evaluations

This list of services requiring precertification may change periodically. To ensure your treatment or procedure is covered, call us at (808) 948-6499.

Section 4. Your costs for covered services

You must share the cost of some services.

You are responsible for:

- **Copayments**

A copayment is a fixed amount of money you pay to the provider when you receive services.

Example: When you see your Plan pharmacy you pay a copayment of $5 for generic drugs.

- **Deductible**

We do not have a deductible.

- **Eligible Charges**

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

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

- **Coinsurance**

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

Example: When you see your physician you pay a coinsurance of 20% per office visit.

Your out-of-pocket maximum for coinsurance and copayments

After your coinsurance totals $2,500 per person or $7,500 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, coinsurances/copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay coinsurances/copayments for these services:

- Dental Care
- Prescription Drugs
- Vision Care

Any payment from the difference of the actual and eligible charge for Non-Plan service does not count toward meeting your out-of-pocket maximum.

You do not need to keep records of you coinsurances/copayment, since we will keep track of when you reach your maximum.

Section 5. Benefits -- OVERVIEW

(See page 4 for how our benefits changed this year and page 60 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at (808)948-6499 or at our website at http://www.hmsa.com.

(a) Medical services and supplies provided by physicians and other health care professionals 10-19

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Rehabilitative therapies
- Hearing services (testing, treatment, and supplies)
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals 20-23

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 24-26

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents 27-28

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits 29-30

(f) Prescription drug benefits 31-34

(g) Special features 35

- Integrated Case Management

(h) Dental benefits 36-37

(i) Point of service benefits (POS) 38-39

(j) Non-FEHB benefits available to Plan members 40

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

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Medical consultations – inpatient and outpatient • At home	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Plan Provider 20% of eligible charges. Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge.
Preventive care, adult	
Routine screenings, such as: • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including •• Fecal occult blood test: age 40-49, one every 2 years; age 50 and older, one every year •• Sigmoidoscopy, screening – every five years starting at age 50	Nothing, if you receive services as a HealthPass referred screening.

Continued on next page

Preventive care, adult *(continued)*	**You pay**
• Prostate Specific Antigen (PSA test) – one per calendar year for men age 50 and older • Routine pap test – one per calendar year • Routine mammogram –covered for women age 35 and older, as follows: •• From age 35 through 39, one during this five year period •• From age 40 and older, one every calendar year Note: A woman of any age may receive the screening more often if she has a history of breast cancer or if her mother or sister has a history of breast cancer.	Plan Providers Nothing. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
• Complete Blood Count – one per calendar year • Routine Chest X-ray (not more than once every two years) • TB Tine Test – one per calendar year • Urinalysis – one per calendar year	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
• Routine Physical Exam or HealthPass exam (listed below) • Well Woman Exam	Plan Providers Nothing. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel	*All charges.*
Immunizations are covered in accord with guidelines set by the Advisory Committee on Immunization Practices (ACIP). • Standard Immunizations • Immunizations for high risk conditions such as Hepatitis B • Travel Immunizations	Plan Provider 20% of eligible charges. Non-Plan Provider 30% of eligible charges plus any difference between the Plan's payment and the actual charges.
You and any dependent defined below are eligible for one routine physical exam or HealthPass exam listed in this section per calendar year. If you are 14 years of age or older when received from or coordinated by the HealthPass program. ***HealthPass*** is a screening program that provides you with information about how to build a healthier life by looking at your current lifestyle, health habits, and family medical history. You are eligible to receive a health risk assessment through HealthPass. For more information contact the Customer Service Department at (808)948-6499.	Plan Provider Nothing. Non-Plan Provider Not a benefit.

Preventive care, adult *(continued)*	**You pay**
After your assessment, we will work with you to develop a personal health action plan. We can also recommend other health improvement activities and provide support to help you meet your health goals. Yearly visits will enable you to measure your progress and alert you to any changes that might require additional actions to meet your health goals. After you call the HealthPass office for an appointment, we'll send you a health questionnaire. Your answers will be combined with the results from your annual screening, which includes: • Health and weight measurements. • Body fat analysis. • Blood pressure measurement. • Blood cholesterol, HDL and glucose screening tests. • Physical fitness assessment if you return annually. If applicable, we may recommend that you attend programs to learn more about: • Nutrition. • Smoking cessation. • Weight management. • Exercise. If you have certain risk factors that become apparent during your initial screening, you'll be eligible for coverage for additional screenings. Examples include: • Health maintenance physical examination. • Mammogram. • Sigmoidoscopy. • Bone density testing for osteoporosis The HealthPass program operates under the direction of a physician who serves as the program's medical director. HealthPass health consultants are specially trained in preventive health, nutrition, and health promotion.	
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Plan Providers Nothing. Non-Plan Providers Any difference between our eligible charge and the actual charge.
• Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction. See vision services.	Plan Optometrists $7 per visit. Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.

Continued on next page

Preventive care, children *(continued)*	**You Pay**
•• Ear exams through age 17 to determine the need for hearing correction. • Examinations through age 12 according to the following schedule: •• Age birth up to one year: six visits •• Age one year: two visits •• Age two through twelve: one visit each calendar year	Plan Provider Nothing. Non-Plan Provider 30% of eligible charges plus any difference between the Plan's payment and the actual charges.
• Laboratory tests through age 12 •• 2 tuberculin tests (tine or skin sensitivity) •• 3 blood tests •• 3 urinalysis	Plan Provider 20% of eligible charges. Non-Plan Provider 30% of eligible charges plus any difference between the Plan's payment and the actual charges.
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Birthing Center, only for labor • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see Professional Services of Physicians and Hospital Benefit sections for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your physician will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Plan Provider 20% of eligible charges. Non-Plan Provider 30% of eligible charges plus any difference between the Plan's payment and the actual charges.
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*

Family planning	You Pay
• Voluntary sterilization	Plan Providers Nothing. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
• Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms/Cervical Caps Note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. • Oral contraceptives Note: Oral contraceptives are covered under your drug benefits. See 5(f) for benefit level.	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
Not covered: • *reversal of voluntary surgical sterilization,* • *genetic counseling,* • *contraceptives such as condoms, foam, or creams which do not require a prescription.*	*All charges.*
Infertility services	
• Diagnosis and treatment of infertility • Artificial insemination: •• *Intravaginal insemination (IVI)* •• *Intracervical insemination (ICI)* •• *Intrauterine insemination (IUI)* • In vitro Fertilization Coverage is limited to a one time only benefit for one outpatient in vitro procedure in accord with Hawaii law.	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures except in vitro fertilization* • *Cost of donor sperm* • *Fertility drugs*	*All charges.*

Allergy care	You Pay
Testing and treatment Allergy injection Treatment materials	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
Allergy serum	Plan Providers Nothing Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 22. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy, Self-administered injections, Outpatient injections and Intravenous nutrient solutions for primary diet. • Growth hormone therapy (GHT) Note: We will only cover GHT when we precertify the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3.	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
Rehabilitative therapies	
Physical therapy, occupational therapy and speech therapy – • Short term therapy for the services of each of the following: •• qualified physical therapist; •• qualified speech therapist; and •• occupational therapist. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. If you require more than 10 outpatient physical therapy visits for an injury or illness, a precertification request with a current progress evaluation and treatment plan should be completed. If the requested services extend beyond a 30-day period, and updated treatment plan is required with documentation of your progress. Plan providers obtain approval for you, Non-Plan providers do not.	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.

Rehabilitative therapies *(continued)*	**You pay**
• Cardiac rehabilitation is covered for up to 2 complete programs per lifetime when: •• You are referred by your doctor for cardiac rehabilitation within three months after coronary bypass surgery or diagnosis of acute myocardial infarction •• Each program consists of planned exercise to rehabilitate and strengthen the heart and education to provide information and motivation for behavior/lifestyle changes •• Each treatment program must be completed within 180 days (no benefits are paid if the program is not completed)	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge. The Plan's payment is limited to $300.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• Diagnostic hearing test • Hearing Aids – one every five years	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
Not covered: • *All other hearing testing* • *Repair of hearing aids* • *Hearing aid evaluation*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses following cataract surgery.	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
• Annual vision exam • Annual eye refractions.	Plan Optometrists $7 per visit. Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.

Continued on next page

Vision services (testing, treatment, and supplies) (*continued)*	**You Pay**
Not covered: • *Eyeglasses or contact lenses except as stated above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Contact lens fitting*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	Plan Providers 20% of eligible charge. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
Not covered: • *Cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Prosthetic devices, such as artificial limbs and lenses following cataract removal. • Orthopedic devices, such as braces. • Rental or purchases of durable medical equipment, such as wheelchairs and hospital beds. • Internal prosthetic devices such as artificial joints; pacemakers cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.

Orthopedic and prosthetic devices *(continued)*	**You Pay**
Not covered: • *Orthopedic and corrective shoes* • *Podiatric shoes* • *Arch supports* • *Foot orthotics, except for specific diabetic conditions* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Bionic services and devices*	*All charges.*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as; oxygen and dialysis equipment. Under this benefit we also cover: • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps.	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
Not covered: • *Convenience items such as motorized wheel chairs*	*All charges.*
Home health services	
• Home health care ordered by a Plan physician and provided by a qualified home health agency for the treatment of an illness or injury when you are homebound. Homebound means that due to an illness or injury, you are unable to leave home, unless you use devices or have assistance from another person. Homebound standards defined by the federal Medicare program apply. • Services provided for up to 150 visits per calendar year Note: If you need home health care services for more than 30 days, a physician must certify that there is further need for the services and provide a continuing plan of treatment at the end of each 30-day period of care.	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any differences between our payment and the actual charge.
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*

Alternative treatments	You Pay
No Benefit	
Educational classes and programs	
Coverage is limited to: • Life Style Management – Health Odyssey HMSA's Health Odyssey programs provide a series of practical, fun-filled health education classes to help you create a healthier, happier life. Sessions are interactive and include a broad range of life style topics such as goal setting, developing new habits, stress management, nutrition and fitness. Call your local HMSA Office for more information or to register for Health Odyssey. • Disease Management HMSA provides new and individualized programs to help you better manage chronic illnesses. Disease management allows you to take a much larger and more responsible role in controlling your illness. There are currently two disease management programs offered: Asthma Disease Management and Diabetes Care Connection Management. To find out if these programs are right for you, talk with your primary care physician. • Prenatal Care Program The Good Pregnancy – He Hapai Pono He Hapai Pono offers many ways to help you have a healthy pregnancy and delivery. As soon as you become pregnant, you'll want to have your primary care physician register you in our program. You'll take an automated telephone survey and receive a personally tailored booklet of information based on your responses. You'll also receive a copy of the pregnancy best seller *What to Expect When You're Expecting* and after delivery, we'll send you a copy of *What to Expect the First Year* to help you and your new baby get off to a good start.	Nothing.
Not covered except as offered through HMSA programs: • *Weight reduction programs* • *Smoking Cessation programs*	*All charges.*

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

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5 (c) for charges associated with the facility. (i.e. hospital, surgical center, etc.).
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical Procedures	
Cutting Surgery includes preoperative and postoperative care. Note: Non-Plan providers may bill separately for preoperative care, the surgical procedure and post operative care. In such cases, the total charge is often more than the eligible charge. You are responsible for any amount that exceeds the eligible charge. **Cutting & Non-cutting surgical** procedures include: • Treatment of fractures, including casting • Acne treatment destruction of localized lesions by chemotherapy (excluding silver nitrate) • Cryotherapy • Diagnostic injections including catheters injections into joints, muscles, and tendons • Electrosurgery • Correction of amblyopia and strabismus • Diagnostic and Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	Plan Providers (cutting) Nothing (non-cutting) 20% of eligible charges. Non-Plan Provider (cutting and non-cutting) 30% of eligible charges and any difference between our payment and the actual charge.

Continued on next page

Surgical Procedures *(continued)*	**You pay**
Cutting & Non-cutting surgical procedures *(continued)* • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns	See above.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip, cleft palate, birth marks, webbed fingers and webbed toes.	Plan Providers (cutting) Nothing (non-cutting) 20% of eligible charges. Non-Plan Provider (cutting and non-cutting) 30% of eligible charges and any difference between our payment and the actual charge.
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	See above.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges.*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip cleft palate; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Plan Providers (cutting) Nothing (non-cutting) 20% of eligible charges. Non-Plan Provider (cutting and non-cutting) 30% of eligible charges and any difference between our payment and the actual charge.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental surgeries generally done by dentists and not physicians* • *Services, drugs or supplies for nondental treatment of temporomandibular joint (TMJ) syndrome.*	*All charges.*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Treatment for breast cancer, multiple myeloma, and epithlial ovarian cancer must be provided in an NCI or NIH approved clinical trial at a Plan-designated center of excellence and approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. This coverage is secondary and the living donor's coverage is primary when: • You are the recipient of an organ from a living donor, and • The donor's health coverage provides benefits for organs donated by a living donor. ***Please refer to the precertification information shown in Sections 3***	Plan Providers (cutting) Nothing (non-cutting) 20% of eligible charges. Non-Plan Provider (cutting and non-cutting) 30% of eligible charges and any difference between our payment and the actual charge.

Continued on next page

Organ/tissue transplants *(continued)*	**You pay**
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Non-human organs*	*All charges.*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Plan Providers 20% of eligible charges. Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge.
Professional services include: • General anesthesia • Regional anesthesia • Monitored anesthesia when you meet the Plan's high-risk criteria	

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • semiprivate accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Plan Provider Nothing (based on semi private room rate). Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge (based on semi private room rate).
Special care units, such as • Intensive care • Cardiac care units	Plan Provider Nothing. Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge.

Continued on next page

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma costs, blood processing, blood bank services • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	Plan Provider Nothing. Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge.
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as adult day care, intermediate care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Additional charges for autologous blood.*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma cost, blood processing, blood bank services • Pre-surgical testing is covered but only when you meet HMSA's criteria. • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures except those services that are described in the Dental Benefits section.	Plan Provider Nothing. Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge.

Extended care benefits/skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF) A facility that provides continuous skilled nursing services as ordered and certified by your attending physician Room and Board is covered, but only for semi-private rooms when: • You are admitted by your physician. • Care is ordered and certified by your physician. • We approve the confinement. • Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care. • If days exceed 30 the attending physician must submit a report showing the need for additional days at the end of each 30-day period. • The confinement is not longer than 100 days in any one calendar year. Services and supplies are covered, including routine surgical supplies, drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy benefits.	Plan Provider Nothing (based on semiprivate room). Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge (based on semi private room rate).
Not covered: custodial care, rest cures, domiciliary or convalescent care	*All charges.*
Hospice care	
A hospice program provides care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. Benefits are limited to 210 visits (or days if the hospice services are inpatient). • Inpatient residential room and board • Referral visits	Plan Provider Nothing. Non-Plan Provider Not a benefit.
Not covered: • *Independent nursing,* • *Homemaker services*	*All charges.*
Ambulance	
Inter-island group professional ambulance service is covered when: • Medically appropriate. • Services to treat your illness or injury are not available in the hospital or nursing facility where you are an inpatient.	Nothing.

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

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

Emergencies within and outside our service area:

Emergency care is covered the same as routine care provided by Plan providers, regardless of whether a Plan provider or Non-Plan provider is used. Benefits are the same within or outside the Plan's Service Area.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	Plan Provider 20% of eligible charges. Non-Plan Provider 20% of eligible charges.
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	Plan Provider 20% of eligible charges. Non-Plan Provider 20% of eligible charges.
Not covered: Elective care	*All charges.*

Ambulance	You Pay
Professional ambulance service when the following apply: • Transportation begins at the place where an injury or illness occurred or first required emergency care. • Transportation ends at the nearest facility equipped to furnish emergency treatment. • Transportation is for the purpose of emergency treatment.	Nothing.
Air ambulance is limited to intra-island or inter-island transportation within the state of Hawaii. See 5(c) Ambulance for non-emergency service.	Plan Provider 20% of eligible charges. Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge.

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRECERTIFICATION FOR THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrist, psychologists, clinical social workers, or advanced practice registered nurses (APRN) • Medication management • Diagnostic tests • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization	Plan Provider 20% of eligible charges. Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge.
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Precertification

To be eligible to receive these benefits you must follow your treatment plan and all the following precertification processes as applicable

Generally, if your provider is a Plan provider, he or she will obtain approval for you and submit a treatment plan, as applicable, to a benefit manager designated by HMSA. If your provider is a Non-Plan provider, he or she will not necessarily obtain approval for you. You are responsible for ensuring that approval is obtained. Unless otherwise stated, approval must first be obtained before treatment. Without approval, benefits are not available.

- Approval for outpatient mental health

  You may go to any provider for your first 6 hours of outpatient mental health treatment. However, benefits for additional hours require that you receive approval from the benefit manger.

- Approval for inpatient mental health

  In case of emergency, your provider must contact the benefit manager within 48 hours or on the first working day thereafter, which ever is later.

- Approval for inpatient and outpatient substance abuse

Special transitional benefit

If a mental health or substance abuse provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days as approved by the benefit manager under the following conditions:

- If your mental health or substance abuse provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a mental health or substance abuse provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will last for up to 90 days from the date you receive notice of the change. You may receive this notice prior to January 1, 2001, and the 90 day period begins with receipt of the notice.

Limitation

We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed practitioner who has the legal authority to prescribe medication.
- **Where you can obtain them.** You may fill the prescription at a Plan or Non-Plan pharmacy, or by mail or by a Plan or Non-Plan physician. We pay a higher level of benefits when you use a Plan provider than if you use a Non-Plan provider.
- **We use a formulary.** Our formulary, called the HMSA Select Prescription Drug formulary is a book that we publish which contains a list of drugs by therapeutic category, and is meant to assist physicians in their selection of drugs for your treatment. Our formulary consist of:
  - **Generic Drug**. A drug, which is prescribed or dispensed under its commonly used generic (chemical) name, no longer protected by patent laws or as determined by us.
  - **Preferred Drug**. A Brand Name Drug, contraceptive, supply, or insulin that is listed on the HMSA Select Prescription Drug Formulary as Preferred.
- **Non-formulary**
  - **Other Brand Drug.** A brand Name Drug, contraceptive, supply, or insulin that is not classified as Preferred on the HMSA Select Prescription Drug Formulary.
- **These are the dispensing limitations.**
  - Prescription drugs prescribed by a doctor and obtained at a pharmacy will be dispensed with a maximum limit of a 30-day supply or fraction thereof.
  - When certain generic drugs which are recognized by the Plan for extended dispensing limits are prescribed in quantities of up to 100 units or up to 60-day supply, whichever is greater, a single copayment charge will apply.
  - Refills are available if indicated on the original prescription, provided that the refill prescription is purchased only after two-thirds of the original prescription has already been used.
  - Mail order program limitations.

    Mail order prescription is limited to prescribed maintenance medications.

    Mail order prescription drugs are available only from contracted providers. For a list of contracted providers call us at (808)948-6499.

    Copayment amounts are for a maximum 90-days supply or a faction thereof. However , if your physician prescribes medication of less than a 90-day supply, mail order drug pharmacies must, by Federal law, fill that prescription in the exact quantity specified by the physician.

    Unless your prescribing physician requires the use of a brand name drug by clearly indicating it on the prescription, your prescription will be filled with the generic equivalent when available and permissible by law.
- **When you have to file a claim.** Refer to section 7 *"Filing a claim for covered services."*

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a licensed practitioner and obtained from a Plan or Non-Plan Pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Injectable drugs •• Injectable drugs such as Imitrex •• Epinephrine emergency kit Note: Self administered injectable medication and intravenous fluids and medication for home use is covered under your medical coverage. See 5(a), *Treatment thereapies*. • Nicotine patches for the cessation of smoking by prescription only. Note: Limited to one treatment cycle per calendar year, with a limit of 2 treatment cycles per lifetime. • Drugs for sexual dysfunction Benefits are limited to the following; •• Up to four does every 30 days •• Up to three months dispensed at a time •• Retail pharmacy access only (not available through mail order) •• Covered for gender approved by FDA •• Physician must certify in advance that the patient has impotence due to organic causes from vascular or neurological disease. • Oral contraceptives	Generic: Plan Pharmacy - $5 copayment. Non-Plan Pharmacy - $5 plus 20% of remaining eligible charges. Preferred Brand: Plan Pharmacy - $10 copayment. Non-Plan Pharmacy - $10 plus 20% of remaining eligible charges. Other Brand: Plan Pharmacy - 50% of eligible charge not less than $10. Non-Plan Pharmacy - 50% of eligible charge not less than $10 plus any difference between the actual and eligible charge.
• Internally implanted time-release contraceptive drugs • Contraceptive drugs injected periodically and intrauterine devices	Plan Pharmacy - 20% of eligible charges. Non-Plan Pharmacy - 30% of eligible charges and any difference between our payment and the actual charge.

Continued on next page

Covered medications and supplies *(continued)*	**You Pay**
• Insulin Note: When obtained by prescription, with a copayment charge applied to each 30-day supply or fraction thereof.	Preferred Brand Insulin Plan Pharmacy - $5 copayment. Non-Plan Pharmacy - $5 plus the difference between the actual charge and eligible charge. Other Brand Insulin Plan Pharmacy - $10 copayment. Non-Plan Pharmacy - $10 copayment plus the difference between the actual and eligible charge.
Diabetic Supplies include: • Insulin syringes • Needles • Lancets • Auto-lancet devices • Glucose test tablets and test tapes • Acetone test tablets	Preferred Brand: Plan Pharmacy - Nothing. Non-Plan Pharmacy - The difference between the actual and eligible charge. Other Brand: Plan Pharmacy - $10 copayment. Non-Plan Pharmacy - $10 copayment plus the difference between the actual and eligible charge.
Mail Order Drug Program • Generic and preferred brand insulin • Preferred Brand and other brand insulin • Other Brand Note: You pay nothing for preferred brand diabetic supplies and you pay a $20 copayment for other brand diabetic supplies.	Generic: $10 copayment. Preferred Brand and other brand insulin: $20 copayment Other Brand: $45 copayment.

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs includes a preferred list of drugs that we selected to meet patients' clinical and financial needs. Discuss your options with your physician when you need a new prescription.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Medical supplies such as dressings, antiseptics* • *Drugs to enhance athletic performance* • *Smoking cessation drugs except for nicotine patches and Zyban prescription drug* • *Drugs related to the diagnosis or treatment of infertility*	*All charges.*

Section 5 (g). Special Features

Feature	Description
Integrated Case Management	Integrated Case Management is a special program for certain medical conditions that may require costly, long-term care. A hospital may not be the most appropriate setting for your treatment. That's why your coverage provides you with the opportunity to receive alternative benefits to help meet health care needs resulting from extreme illness or injury (providing costs do not exceed inpatient facility costs). You, your physician, and the hospital can work with our case managers to identify and arrange alternative treatment plans to meet your special needs and to assist in preserving your health care benefits.
Drug Benefits Management Program	The Plan has arranged with participating pharmacists to assist in managing the usage of drugs, including drugs listed in the HMSA Drug Formulary. Under the program, participating pharmacists can only dispense certain drugs listed in the HMSA Drug Formulary after receiving the precertification from the Plan. You pay the entire cost of the drug if precertification is not obtained or if the precertification is denied. Participating pharmacists may also dispense a maximum of a 30-day supply or fraction thereof for first time prescriptions of maintenance drugs. For subsequent refills, the participating pharmacist may dispense a maximum 90-day supply or fraction thereof after confirming that you have tolerated the drug without adverse side effects that may cause you to discontinue using the drug and your doctor has determined that the drug is effective.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Plan Provider Nothing. Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge.

Dental Benefits

Service	You pay
Preventive dental care for permanent teeth only • Annual exam/visit • Annual cleaning (prophylaxis)	Plan Provider Nothing. Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge.
Standard Dental service for permanent teeth only • X-rays (2 annual bite wings and one full mouth series every 5 years); • Fillings (composite resin for anterior teeth only, amalgam & silicate) • Extractions • Root canal treatment • Treatment for diseases of the gum • Space maintainers • Anesthesia	Plan Provider 30% of eligible charges. Non-Plan Provider 50% of eligible charges and any difference between our payment and the actual charge.
Dental Surgery • Incision and drainage of abscess • Alveolectomy • Excision of cysts	Plan Provider 30% of eligible charges. Non-Plan Provider 50% of eligible charges and any difference between our payment and the actual charge.

Service	You pay
Occlusal Splint When precertified and determined by the Plan occlusal splint therapy is covered for the treatment of temporomandibular disorder involving the muscles of mastication (chewing). Coverage of occlusal splint therapy is subject to the following limitations. • A removable acrylic appliance is used in conjunction with the therapy • The disorder is present at least one month prior to the start of the therapy and the therapy does not exceed ten weeks • The therapy does not result in any irreversible alteration in the occlusion • It is not intended to be for the treatment of bruxism • It is not for the prevention of injuries of the teeth or occlusion • The benefit is limited to one treatment episode per lifetime • The member must be 15 years of age or older.	Plan Provider or Non-Plan Provider 50% of eligible charges, plus any difference between our payment and the actual charge. Note: Maximum Plan payment not to exceed $125.
Not covered: • *All other dental services, including topical application of fluoride* • *Dental appliances, such as false teeth, crowns, bridges, and repair of dental appliances* • *Dental prostheses, dental splints (except as covered under occlusal splint therapy), dental sealants, orthodontia, or other dental appliances regardless of the symptoms or illness being treated* • *Osseointegration (dental implants) and all related services*	*All charges.*

Section 5 (i). Point of service benefits

Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from Non-Plan doctors and hospitals whenever you need care. Benefits not covered under Point of Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a Non-Plan doctor you are subject to a higher copayment/coinsurance.

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

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

What is covered

- Medical services and supplies (section 5a)
- Surgical and anesthesia services (section 5b)
- Services provided by a hospital or other facility, and ambulance service (section 5c)
- Emergency services/accidents (section 5d)
- Mental health and substance abuse benefits (section 5e)
- Prescription drug benefits (section 5f)

Precertification

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

You may receive services from a Non-Plan provider without a referral. Non-Plan provider services have higher out-of-pocket cost. Please refer to the Non-Plan provider benefits in section 5.

Your cost for covered services from Non-Plan providers

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

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

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

Coinsurance is the percentage of our eligible charge that you must pay for your care. After your coinsurance totals $2,500 per person or $7,500 per family enrollment in any calendar year you are no longer responsible for coinsurances/copayments. However, when you receive services from a Non-Plan provider, you are also responsible for any charges in excess of the eligible charge. In addition coinsurances/copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay coinsurances/copayments for these services:

- Dental Care
- Prescription Drugs
- Vision Care

Any payment from the difference of the actual and eligible charge for Non-Plan service does not count toward meeting your out-of-pocket maximum.

You do not need to keep records of you coinsurances/copayment, since we will keep track of when you reach your maximum.

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Hospital/extended care

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

Emergency benefits

Emergency care is covered the same as routine care provided by Plan providers, regardless of whether a Plan provider or Non-Plan provider is used.

Section 5 (j). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Cancer Care Plan

Benefit Services of Hawaii, a subsidiary of Blue Cross and Blue Shield of Hawaii, is pleased to make available a supplemental plan called **CancerCare**, a cancer and specified disease protection plan.

CancerCare provides inpatient and outpatient benefits for cancer and 34 specified diseases. The Plan pays cash benefits directly to you regardless of any other coverage you may already have. The extra funds can help pay for any out-of-pocket medical expenses and many non-medical expenses such as rent or mortgage, utility bills, etc.

Plan Features:	Hospital confinement	Surgery
	Experimental treatment	Radiation/Chemotherapy
	Blood Plasma	Transportation cost

Two **CancerCare** Plans are available which vary in benefits and rates. You may also choose two optional riders, the Cancer Diagnosis Benefit Rider and the Intensive Care/Coronary Care Rider.

If you are a Hawaii resident under the age 65, you can apply for coverage for yourself and your eligible family members. Please call us at (808)948-6373 for more information.

Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services when someone else has the legal obligation to pay for your care, and when, in the absence of this brochure, you would not be charged.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance. If you need to file the claim, here is the process:

Medical, Hospital and Drug benefits

In most cases, providers, facilities and pharmacies file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form, facilities must file on the UB-92 form, dental services must be filed on the American Dental Association (ADA) form and pharmacies must file on the Universal Drug form. For claims questions and assistance, call us at (808) 948-6499.

When you must file a claim -- such as for out-of-area care -- submit it on the forms indicated below. Bills and receipts should be itemized and show:

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

Submit your claims to:

For Physician claims
HMSA-HCFA 1500 claims
P.O. Box 44500
Honolulu, Hawaii 96804-4500

For Facility claims
HMSA-UB92 claims
P.O. Box 32700
Honolulu, Hawaii 96803-2700

For Dental claims
HMSA-Dental claims
P.O. Box 13400
Honolulu, Hawaii 96801-3400

For Pharmacy claims
HMSA-Drug claims
P.O. Box 13400
Honolulu, Hawaii 96801-3400

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Deadline for filing your claim

All Plan and most Non-Plan providers in the State of Hawaii file claims for you. If your Non-Plan provider does not file the claim for you, you must submit an itemized bill and receipt for the services you received by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. File a separate claim for each covered family member and each provider. For more information, please call us at (808)948-6499.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for precertification:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Hawaii Medical Service Association, P.O. Box 860, Honolulu, Hawaii 96808; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or if applicable arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your medical provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20044-0436. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Continued on next page

The Disputed Claim process *(Continued)*

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

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

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

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

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

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

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or precertification/prior approval, then call us at (808)948-6499 and we will expedite our review; or

(b) We denied your initial request for care or precertification/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division II at (202)606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

When we are the secondary payer, we will determine our eligible charge. After the primary plan pays, we will pay what is left, up to our eligible charge. We will not pay more than our eligible charge.

• What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

•• Some people with disabilities, under 65 years of age.

•• People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance).

Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

• The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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

We will not waive any of our copayment/coinsurance.

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee		✓

Note: If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

- **Claims process**

You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at (808)948-6499.

We waive some costs when you have Medicare – In this case we do not waive any out-of-pocket costs.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB Plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB coverage.

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB Plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, but we will not waive any of our copayments or coinsurance.

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

· **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

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TRICARE

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

We may cover your medical or hospital care for an injury or illness that may have been caused by another person. However, you must first fill out and return to us all papers we require to secure our reimbursement from you for the amounts we paid. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you need more information, contact us for third party liability procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 8.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 8.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Helps you meet your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. We do not have a deductible.

Experimental or investigational services

A medical treatment, procedure, drug, device, or care is experimental or investigative if:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug administration and approval for marketing has not been given at the time the drug or device is furnished; or
- The drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
- Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is for the research, experimental, study or investigational arm or ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or its efficacy compared with a standard means of treatment or diagnosis.

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Medical necessity

Services, drugs, supplies or equipment recommended by your treating provider and approved by our medical director, and is:

- For the purpose of treating a medical condition;
- The most appropriate delivery or level of service, considering potential benefits and harms to the patient;
- Known to be effective. Effectiveness is determined first by criteria below in the following order:
  - Scientific evidence;
  - Professional standards of care; and
  - Expert opinion; and
- Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. Cost-effective shall not necessarily mean the lowest price.

Eligible Charge

Eligible charge is the amount we use to determine our payment and your coinsurance for covered services. We determine our eligible charge as the lower of either the provider's actual charge or the amount we establish as the maximum allowable fee.

Plan providers agree to accept the eligible charge for covered services. Non-Plan providers generally do not. Therefore, if you received services from a Non-Plan provider you are responsible for any difference between the actual charge and the eligible charge.

Us/We

Us and we refer to HMSA.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you *a Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

Continued on next page

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

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

When you lose benefits

· When FEHB coverage ends

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

· Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

· **TCC**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire.

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

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

· **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Continued on next page

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (808)948-5166 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—(202)418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or are no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

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Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

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Summary of benefits for the HMSA Plan - 2001

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

Benefits	You Pay for Plan Providers	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	20% of eligible charges.	10
Services provided by a hospital:		
• Inpatient.....	Nothing.	24
• Outpatient.....	Nothing.	25
Emergency benefits:		
• In-area	20% of eligible charges.	27
• Out-of-area	20% of eligible charges.	27
Mental health and substance abuse treatment	Regular benefits	29
Prescription drugs.....	$5 copayment for generic drugs. $10 copayment for preferred name brand drugs. 50% copayment of eligible charges not less than $10 copayment for other brand name drugs.	31
Dental Care.....	Nothing for preventive dental care.	36
Vision Care.....	$7 copayment for optometrist 20% of eligible charges for other Plan providers.	16
Point of Service benefits		38
Your out-of-pocket maximum.....	Nothing after $2,500/Self Only or $7,500/Family enrollment per year. Some costs do not count toward this protection.	8

2001 Rate Information for
Hawaii Medical Service Association Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
All of Hawaii							
Self Only	871	$74.02	$24.67	$160.37	$53.46	$87.59	$11.10
Self and Family	872	$164.75	$54.92	$356.96	$118.99	$194.96	$24.71