HMSA
Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA Plan 2000

A Health Maintenance Organization (HMO)
with a Point of Service Product

Serving: All of Hawaii

Enrollment in this Plan is limited; see page 4 for requirements

Enrollment code:

871 Self Only
872 Self and Family

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.hmsa.com

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Introduction

Hawaii Medical Service Association
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Honolulu, HI 96814

This brochure describes the benefits you can receive from Hawaii Medical Service Association (HMSA), an independent licensee of the Blue Cross and Blue Shield Association under its contract (CS1058) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 3. Premiums are listed 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. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to HMSA Plan as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO with a Point of Service Product. Turn to this section for a brief description of HMOs and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.
4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.
7. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.
8. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations with a Point of Service Product

This Plan is a health maintenance organization (HMO) that offers a point of service, or POS, product. When services are needed, you may choose to obtain them from your primary care physician within this Plan's provider network or go outside the network for treatment.

When you receive services from your primary care physician within the Plan's provider network, you will not have to submit any claim forms. However, you will need to pay a minimal amount for services received. If you receive services from non-Plan doctors or other non-Plan providers, you pay a substantial portion of the charges and less benefits may be available to you.

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 providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, How to get benefits, for more information).

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Your share of the premium will increase by 5.7% for Self Only or 1.2% for Self and Family.

You may now receive services from Optometrists allowed under the expanded scope of their license.

Your copayments for drug benefits have been changed. The copayments from Plan pharmacies for Generic Formulary Drugs have been changed from $2 to $5; for Preferred Name Brand Drugs from $7 to $10; and for Non-Preferred Name-Brand Drugs from a 20% copayment to a 50% copayment of eligible charges but not less than a $10 copayment for Non-Preferred Name Brand Drugs. The copayments for drugs from non-Plan pharmacies and the Mail Order Drug Program can be found on pages 15 - 16 under the "Prescription Drug Benefits" section.

Disposable needles and syringes are now available to you from Plan and non-Plan pharmacies. A 20% coinsurance is no longer required for disposable needles and syringes needed to inject covered prescriptions if purchased at a Plan pharmacy. If you go to a Plan pharmacy you pay nothing; if a non-Plan pharmacy is used, you pay the difference between the Plan's payment and the actual charge. Copayments can be found on page16 under the "Prescription Drug Benefits" section.

The telephone number for the Plan's Benefit Manager for mental conditions and substance abuse services is not listed. If you use a Plan provider, he or she will obtain approval from the Plan's Benefit Manager on your behalf before you receive services. If you use a non-Plan provider, he or she will not necessarily submit a treatment plan to the Plan's Benefit Manager, you are responsible for ensuring that the provider sends the treatment plan to the Plan's Benefit Manager.

Section 3. How to get benefits

What is this Plan's 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.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care or point-of-service benefits. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, 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 should 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.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges).

When you receive services from a non-Plan provider, you are also responsible for any difference between the Plan's payment and the actual charges.

This plan provides you with additional benefits described on pages 18 - 19, "Major Medical Benefits". There is a $2,500 copayment maximum per member per calendar year. The $250 deductible described below counts toward this copayment maximum. After the $2,500 maximum is reached, you are no longer responsible for major medical copayments for the rest of that calendar year.

The deductible is the amount of covered expenses you must incur each calendar year before the Plan pays benefits. For a new enrollee, the 'calendar year' begins on the effective date of enrollment in this Plan and ends on December 31 of that same year. The deductible is $250 per person for major medical benefits and is not reimbursable by the Plan.

The Plan calculates the Plan's payment and your copayment based on Eligible Charge. The Eligible Charge is the lower of either the provider's actual charge or the amount we establish as the maximum allowable fee.

Do I have to submit claims?

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 within 90 days of the last day on which services were received. Payment will be sent to you. No payment will be made on claims filed with us more than a year after the service date. File a separate claim for each covered family member and each provider. For more information, please call the Plan at 808/948-6499. Either OPM or the Plan can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

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 will not be more than the amount shown in the 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 payments 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 rendered 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.

Section 3. How to get benefits *(continued)*

Who provides my health care? *(continued)*

In some cases, this "negotiated price" is a simple discount. In other cases, the negotiated price may be an estimate that factors in expected settlements or other non-claims transactions with your Plan provider (or with a specified group of Plan providers) or it may reflect an average expected savings. Estimated or average prices may be prospectively adjusted to correct for over or underestimation of past prices.

A few states do not allow Blue Cross and/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 laws 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.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 808/948-6499. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get 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 services you will need.

What do I do if I am seeing a specialist when I enroll?

You are encouraged to coordinate your specialty care with your primary care physician. If he or she decides to refer you to a specialist, you may ask to see your current specialist. If your current specialist is not a Plan provider, you will pay a copayment plus the difference between the eligible charge and the specialist's billed charge.

What do I do if my specialist leaves the Plan?

Call your primary care physician, who may refer you to another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

Section 3. How to get benefits *(continued)*

How do you authorize medical services?

Your physician must get our approval before providing you with certain medical treatments, procedures, or devices. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

You are not covered for medical treatment, procedures, drugs, devices, or care, and all related services or supplies, that are experimental or investigational. A medical treatment, procedure, drug, device, or care is experimental or investigative if:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration 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 of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or its efficacy compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only:

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

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

- Be in writing,
- Refer to specific brochure wording explaining why you believe our decision is wrong; and
- Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

- Maintain our denial in writing;
- Pay the claim;
- Arrange for a health care provider to give you the service; or
- Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for services?

Call us 808/948-6499 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division II at (202) 606-3818 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

Section 4. What to do if we deny your claim or request for service *(continued)*

What do I send to OPM? *(continued)*

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

- Anyone enrolled in the Plan;
- The estate of a person once enrolled in the Plan; and
- Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Medical and Surgical Benefits

What is covered

Basic benefits

The following medical and surgical services required as a result of illness or injury are covered as basic benefits.

If you use Plan providers - You pay nothing for surgery (cutting) and well-child care immunizations; a 20% copay of eligible charges for non-cutting surgical procedures, anesthesiologist services, and most medical services.

If you use non-Plan providers - You pay any difference between the Plan's payment and the actual charges, plus a 30% copay of eligible charges for surgery (cutting and non-cutting), anesthesiologist services; and medical services after the first visit per condition for illness or injury; and 100% of the cost of the first visit per condition for medical services for illness or injury; you pay any difference between the Plan's payment and the actual charges for well-child care immunizations.

- Surgery (cutting)
- Non-cutting surgery (diagnostic endoscopic procedures; diagnostic and therapeutic injections, including catheters; orthopedic castings; acne treatment; and destruction of localized lesions by chemotherapy, cryotherapy or electrosurgery)
- Podiatric services
- Immunizations and boosters
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a doctor or a certified nurse-midwife. The eligible charge for delivery includes prenatal and postnatal care. If payments for prenatal care are made separately prior to delivery, these payments will be considered an advance of payment and will be deducted from the maximum allowance for delivery. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services.
- Diagnosis and treatment of diseases of the eye (diagnostic tests covered under "Outpatient X-ray and laboratory benefits section" - see page 10).
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, heart/lung, kidney, single/double lung, pancreas/kidney, and liver transplants; 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, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, breast cancer, multiple myeloma, and epithelial ovarian cancer. Transplant coverage for breast cancer, multiple myeloma and epithelial ovarian cancer is subject to approval by the Plan based on protocols established by the National Cancer Institute (NCI). Related medical and hospital expenses of the donor are covered.

You must obtain the approval from the Plan in advance for all transplant evaluations, except for cornea and kidney transplant evaluations. The Plan will not pay benefits for transplant evaluations if prior authorization by the Plan is not first obtained. Transplant evaluation means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations, which a hospital or facility uses in evaluating a potential transplant candidate.

Section 5. Benefits *(continued)*

Basic benefits *(continued)*

The Plan will not pay any transplant benefits, other than cornea and kidney transplants, unless each of the following conditions are met: the specific organ to be transplanted must be medically necessary and appropriate for the treatment of your illness or injury; you must obtain written approval from the Plan in advance for all transplants; the transplant must be performed at a transplant facility that is under contract with the Plan for that type of transplant; and the contracted transplant facility has accepted you as a transplant candidate.

- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Surgical treatment of morbid obesity
- Home health services, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need.
- Up to 150 visits per calendar year for home health services of nurses and health aides from a Plan approved home health care agency, when medically necessary and prescribed by your doctor, who must certify that you are homebound due to illness or injury and periodically review the program for continuing appropriateness and need.

Limited benefits

Well child care is limited to six visits from birth up to age one year, two visits for children age one year, one visit each calendar year for children age 2 through age 12, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards.

Members may select from one of the following options for obtaining **routine physical exams**:

- One annual check-up from a physician including routine laboratory and X-rays related to the exam. Lab tests and X-rays are paid at 50% of eligible charges; women may receive an annual routine gynecological examination and pap smear; or
- Free health risk assessment and lifestyle counseling services from HealthPass. Members age 18 and older are eligible to receive an annual screening at a HealthPass Office which includes a comprehensive health questionnaire, physical measurements, blood cholesterol, glucose tests, and health counseling. Members age 14 to 18 years of age may participate in an innovative, interactive computer program at a HealthPass Office which assesses specific adolescent health risks. Additional screening tests, when indicated by HealthPass criteria and performed by a provider selected by HealthPass, are provided at 50% of the eligible charge.

For more information on **HealthPass Program**, contact the Customer Service Department at 808/948-6499.

Doctor visits in a hospital or skilled nursing facility are limited to one per day; a second opinion on the necessity of surgery is covered

Allergy testing, including agents, is limited to one series of tests per calendar year, which is paid at 50% of eligible charges; in addition, 50% of the eligible charges for allergy treatment materials (such as allergy serum) are covered.

Services of an assistant surgeon are limited to cases when the assistance is medically necessary based on the complexity of the surgery and the hospital does not have a resident or intern on its staff who could have assisted the surgeon.

Outpatient X-rays, laboratory tests, radiation therapy, and routine screening by low-dose mammography are covered at 50% of eligible charges, with the following exceptions: X-rays ordered within 48 hours following an injury are covered at 100% of eligible charges; and radiation therapy in the treatment of malignant conditions is covered at 100% of eligible charges; benefits will only be paid for routine chest X-ray, urinalysis, complete blood count, pap smear, and tuberculin skin test when part of annual health appraisals. Laboratory tests in connection with well-child care visits are limited to the following tests through age 12: two tuberculin tests (tine or skin sensitivity), three blood tests (hemoglobin or hematocrit) and three urinalysis. Screening by low-dose mammography benefit guidelines are described in the “Basic Benefits” section on page 9.

Section 5. Benefits *(continued)*

Limited benefits *(continued)*

Prostate specific antigen tests are limited to one test per calendar year for men ages 50 and above.

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered as oral surgery, including any care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance (surgery and treatment services are covered under the "Medical and Surgical Benefits" section; prosthetic devices and supplies are covered under "Other Benefits - Major Medical Benefits" section).

Diagnosis and treatment of infertility is covered; the following types of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI) are covered; cost of donor sperm is not covered. Fertility drugs are not covered. Other **assisted reproductive technology (ART) procedures** such as embryo transfer are not covered, except one in vitro fertilization per qualified married couple per lifetime (diagnostic procedures are covered under "Medical and Surgical Limited benefits - Outpatient X-rays and laboratory tests;" treatment services are covered under "Medical and Surgical-Basic benefits").

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Hearing aids (covered under Major Medical Benefits)
- Foot orthotics, except for specific diabetic conditions
- Chiropractic services
- Homemaker services
- Radial keratotomy
- Treatment of TMJ dysfunction
- Educational programs (except services provided by HMSA's HealthPass program)

Special Notice: Many services that are not listed in the Medical and Surgical section or the Hospital/Extended Care section are covered as Major medical benefits (see pages 18 - 19). In addition, Major medical benefits will provide additional benefits for many services listed under the Medical and Surgical section or the Hospital/ Extended Care section.

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** nothing for Plan hospital services and a 20% copay of eligible charges for inpatient visits by Plan providers; if a non-Plan provider is used, **you pay** a 30% copay of eligible charges, plus any difference between the Plan's payment and the actual charges, for covered services. Doctor visits are limited to one per day. **All necessary services are covered**, including:

- Semiprivate room accommodations; when a doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care (Private duty nursing care is paid at 50% of eligible charges and has a lifetime maximum benefit of $2,000)
- Specialized care units, such as intensive care or cardiac care units

Section 5. Benefits *(continued)*

Extended Care

The Plan provides a comprehensive range of benefits up to 100 days each calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor.

You must be admitted upon the authorization of and be attended by a doctor; if you are in the facility for more than 30 days, the attending doctor must submit an evaluation report to the Plan at the end of the 30-day period. **You pay** nothing for covered Plan skilled nursing facility services and a 20% copay of eligible charges for inpatient visits by Plan providers; if a non-Plan provider is used, **you pay** a 30% copay of eligible charges, plus any difference between the Plan's payment and the actual charges, for covered services. Doctor visits are limited to one per day. **All necessary services are covered**, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a doctor

Hospice Care

Supportive and palliative care for up to 210 days for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling. The hospice and attending physician must certify in writing that the patient is in the terminal stages of illness with a life expectancy of six months or less.

Hospice services must be provided by a hospice currently under contract with the Plan to provide hospice services; services rendered by a non-Plan provider are not a benefit of this Plan. The member owes no copay for hospice services.

Birthing center

Benefits will be provided when a Plan approved birthing center is used instead of regular hospital facilities.

Ambulance service

Automobile ambulance service to and between hospitals is paid at 100% of eligible charges (see pages 18-19 – "Major medical benefits" for air ambulance service).

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services, unless the services are covered under dental benefits. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the doctor determines that outpatient management is not medically appropriate. See page 15 for nonmedical substance abuse benefits.

Ambulatory surgical center or outpatient hospital

Charges for surgery will only be paid when the surgery cannot be performed safely and effectively in a doctor's office.

What is not covered

- Personal comfort items, such as telephone and television
- Blood bank service charges
- Custodial care, rest cures, domiciliary or convalescent care

Section 5. Benefits *(continued)*

Emergency Benefits

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.

Emergencies within the service area

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. In extreme emergencies, 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.

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 of the Plan's Service Area.

Emergencies outside the service area

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

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service (see page 11 "Hospital/Extended Care Benefits" -- for automobile ambulance, and page 18 "Major medical benefits" -- for air ambulance)

Filing claims for non-Plan providers

Plan providers will file their claims (submitted on the HCFA 1500 claim form) with the Plan. When services are provided by non-Plan providers, you must submit itemized bills and your receipts to the Plan along with an explanation of the services. For more information, please call the Plan at 808/948-6499. A payment will be sent to you, unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. You may request reconsideration in accordance with the disputed claims procedure set forth on page 7.

Mental Conditions/Substance Abuse Benefits

Mental Conditions

What is covered

To the extent shown below, the Plan covers the following services by psychiatrists, psychologists or qualified clinical social workers and advanced practice registered nurses, when necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders, when the Plan deems such care necessary:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)

Hospitalization (including inpatient professional services)

Outpatient care

Up to 24 outpatient visits to doctors, consultants, or other psychiatric personnel each calendar year; However, benefits for additional visits require that you receive approval from the benefit manager. **If you use Plan providers - You pay** a 20% copay of eligible charges for diagnostic evaluation and psychiatric treatment and a 50% copay of eligible charges for psychological testing.

Section 5. Benefits *(continued)*

Outpatient care *(continued)*

If you use non-Plan providers - You pay any difference between the Plan's payment and the actual charges, plus a 30% copay of eligible charges for diagnostic evaluation and psychiatric treatment and a 50% copay of eligible charges for psychological testing.

Approval from the Plan's Benefit Manager must be obtained in advance for mental conditions or substance abuse services recommended by Plan and non-Plan providers.

If your provider is a Plan provider, he or she will submit a treatment plan on your behalf to the benefit manager.

If your provider is a non-Plan provider, he or she will not necessarily submit a treatment plan on your behalf. You are responsible for ensuring that the provider sends a treatment plan to the benefit manager.

Inpatient care

Up to 30 days of hospitalization each calendar year; additional benefits for inpatient psychiatric care available under Major medical benefits (see page 19).

If you use Plan providers - You pay nothing for up to 30 days of hospitalization. In addition, services of a Plan psychiatrist, psychologist, clinical social workers, and advanced practice registered nurses in an inpatient setting are paid at the same benefit rate as outpatient care for up to 30 visits per calendar year.

If you use non-Plan providers - You pay a 30% copay of eligible charges plus balance of actual charges for up to 30 days of hospitalization-all charges thereafter. In addition, professional services of a non-Plan provider in an inpatient setting are paid at the same benefit rate as outpatient care for up to 30 visits per calendar year.

Approval from the Plan's Benefit Manager must be obtained in advance for mental conditions or substance abuse services recommended by Plan and non-Plan providers.

If your provider is a Plan provider, he or she will submit a treatment plan on your behalf to the benefit manager.

If your provider is a non-Plan provider, he or she will not necessarily submit treatment plan on your behalf. You are responsible for ensuring that the provider sends a treatment plan to the benefit manager.

In case of emergency your physician must contact the Benefit Manager within 48 hours or on the first working day thereafter, whichever is later. The Benefit Manager will be available 24 hours a day.

The Benefit Manager will review the medical necessity and appropriateness of treatment, including the method and place of treatment, and approve the level of treatment eligible for benefits. The Plan will pay benefits only up to the level of treatment approved by the Benefit Manager. Any services beyond the level of treatment approved by the Benefit Manager will not be eligible for benefits.

Mental conditions/substance abuse services recommended by non-Plan providers which have not been reviewed by the Benefit Manager will be subject to review of the medical necessity and appropriateness of treatment by the Plan at the time the claim is made. The Plan will not pay benefits for any mental conditions/substance abuse services which are determined not to be medically necessary or which would not have been approved for benefits if the Benefit Manager's review had been obtained.

What is not covered

- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by the Plan to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a psychiatric condition

Section 5. Benefits *(continued)*

Substance abuse

What is covered

This Plan provides detoxification services (see page 12 for Acute inpatient detoxification) and diagnosis and treatment of alcohol and drug dependence or abuse. You are eligible for two treatment programs per lifetime - a treatment program is an admission for treatment under a plan designed to produce remission in those who complete treatment. A complete program includes assessment and referral, initial rehabilitative care (up to 30 days), and aftercare (up to 30 hours). Once you start your first treatment program, the entire program must be completed within 12 months.

Benefits available under the **initial rehabilitative** care described above consist of an **outpatient program**, including counseling services, educational program, nutritional therapy, and therapeutic and recreational activities, as well as a **residential program**, including room and board, medication, counseling services, educational program, and therapeutic and recreational activities.

You pay a 20% copay of eligible charges for covered inpatient and outpatient services if a Plan provider is used; if a non-Plan provider is used, you pay any difference between the Plan's payment and the actual charges, plus a 30% copay of eligible charges for covered services. **You pay** all charges after two authorized treatment programs. The Plan has contracted with a limited number of providers to become program providers of substance abuse services. **Benefits for a Plan provider shall be paid only for services rendered by such program providers.**

The substance abuse benefit may be combined with the mental conditions benefits shown on pages 13 - 14 provided such treatment is necessary as a Mental Conditions Benefit and is approved by the Plan or the Plan's Benefit Manager, to permit additional care for the psychiatric aspects of substance abuse, subject to the applicable Mental Conditions Benefit copayments and visit/day limitations.

Approval from the Plan's Benefit Manager must be obtained in advance for substance abuse services recommended by Plan and non-Plan providers. No benefits will be provided for substance abuse services recommended by a non-Plan provider which would not have been approved if the Benefit Manager's review had been obtained.

If your provider is a Plan provider, he or she will submit a treatment plan on your behalf to the benefit manager.

If your provider is a non-Plan provider, he or she will not necessarily submit a treatment plan on your behalf. You are responsible for ensuring that the provider sends a treatment plan to the benefit manager.

Prescription Drug Benefits

What is covered

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, and paid upon submission of a claim to the Plan. When certain generic drugs which are recognized by the Plan for extended dispensing limits are prescribed in quantities of 100 units or a 60-day supply or fraction thereof, whichever is greater, a single copay charge will apply.

If you use a Plan pharmacy - You pay a $5 copay per prescription unit or refill for generic drugs; a $10 copay for preferred name brand drugs; a 50% copay of eligible charges but not less than $10 copay for non-preferred name brand drugs.

If you use a non-Plan pharmacy - You pay 20% of the remaining eligible charges after a $5 copay per prescription unit or refill for generic drugs or a $10 copay for preferred name brand drugs, plus any difference between the Plan's payment and the actual charge; for non-preferred name brand drugs, you pay a 50% copay of eligible charges but not less than $10 copay, plus any difference between the Plan's payment and the actual charge.

The Plan requires the substitution of generic drugs listed on the Hawaii Drug Formulary of Equivalent Drug Products for a name brand drug, except when substitution is not permissible. If you choose not to use the generic equivalent, the Plan will reimburse you the amount that would have been paid for the generic equivalent.

Section 5. Benefits *(continued)*

What is covered *(continued)*

Drug Benefits Management Program: the Plan has arranged with Plan pharmacists to assist in managing the usage of drugs, including drugs listed in the HMSA Drug Formulary. Under the program, Plan pharmacists can only dispense certain drugs listed in the HMSA Drug Formulary after receiving the preauthorization of the Plan.

You pay the entire cost of the drug if preauthorization is not obtained or if the preauthorization is denied.

Plan 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 Plan 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.

Nonformulary drugs will be covered when prescribed by a Plan doctor.

In addition, the Plan offers a Mail Order Drug Program. Up to a 90-day supply or fraction thereof of certain maintenance medications may be obtained by mail. If you are currently taking prescription medication on a regular basis, the Mail Order Drug Program may help you save money on the cost of your medication.

If you use the Mail Order Drug Program - You pay a $10 copay per prescription unit or refill for generic drugs and preferred name brand insulin, a $20 copay for preferred name brand drugs and non-preferred name brand insulin; and a $45 copay for non-preferred name brand drugs. You pay nothing for preferred name brand diabetic supplies and you pay a $20 copay for non-preferred name brand diabetic supplies.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Insulin when obtained by prescription, with a copay charge applied to each 30-day supply or fraction thereof. If you use a plan pharmacy, you pay a $5 copay for preferred name brand insulin or a $10 copay for non-preferred name brand insulin. If you used a non-Plan pharmacy, you pay $5 plus any difference between the Plan's payment and the actual charge for preferred name brand insulin or a $10 copay plus any difference between the Plan's payment and the actual charge for non-preferred name brand insulin. (Also see mail order insulin.)
- Diabetic supplies, including insulin syringes, needles, lancets, auto-lancet devices, glucose test tablets and test tape, and acetone test tablets. If you used a plan pharmacy, you pay nothing for preferred name brand diabetic supplies or a $10 copay for non-preferred name brand diabetic supplies. If you use a non-Plan pharmacy, you pay any difference between the Plan's payment and the actual charge for preferred name brand diabetic supplies or a $10 copay plus any difference between the Plan's payment and the actual charge for non-preferred name brand diabetic supplies. (Also see mail order diabetic supplies.)
- Disposable needles and syringes needed to inject covered prescribed medication; you pay nothing at a Plan pharmacy and you pay any difference between the Plan's payment and the actual charge at a non-Plan pharmacy.
- Injectable drugs such as Imitrex, epinephrine emergency kit; (Self administered injectable medication and intravenous fluids and medication for home use see the "Major Medical Benefits" section on page 19; other injectable drugs are covered (see appropriate sections on pages 9 - 10)
- Nicotine patches for the cessation of smoking by prescription only; limited to one treatment cycle per calendar year, with a limit of two treatment cycles per member per lifetime
- FDA-approved prescription drugs, and devices for birth control.
- Internally implanted time-release contraceptive drugs, contraceptive drugs injected periodically and intrauterine devices are covered under the "Major Medical Benefits" section on page 19.

Section 5. Benefits *(continued)*

What is covered *(continued)*

- Oral medication for treatment of impotency such as Viagra. Benefits are limited to the following:
  - Up to 4 pills every 30 days
  - One month dispensed at a time
  - Retail pharmacy access only (not available through mail order)
  - Covered for males only
  - Physician must certify in advance that the patient has impotence due to organic causes from vascular or neurological disease.

What is not covered

- Drugs and devices available without a prescription or for which there is a nonprescription equivalent available
- Medical supplies such as dressings, antiseptics and spacers for inhaled drugs
- Vitamins, minerals, and nutritional substances
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs are not covered except for nicotine patches and Zyban prescription drug
- Drugs related to the diagnosis or treatment of infertility

Other Benefits

Dental Care

What is covered

The following dental services are covered when you use a Plan dental center, Plan provider, or non-Plan provider:

	Services	If you use Plan dental center or Plan provider, you pay:	If you use non-Plan provider, you pay:
Preventive dental care	Annual exam/visit; annual cleaning (prophylaxis)	Nothing	30% of eligible charges plus balance of actual charges
Standard dental services	For permanent teeth only: x-rays (2 annual bite wings and one full mouth series every 5 years); fillings (amalgam & silicate, **you pay** surcharge for gold); extractions; root canal treatment; treatment for diseases of the gum; space maintainers; anesthesia	30% of eligible charges	50% of eligible charges plus balance of actual charges
Dental surgery	Incision and drainage of abscess; alveolectomy; excision of cysts	30% of eligible charges	50% of eligible charges plus balance of actual charges

Occlusal Splint Therapy

When pre-authorized and determined by the Plan, occlusal splint therapy is covered for the treatment of a temporomandibular disorder involving the muscles of mastication (chewing). Plan pays 50% of the eligible charges based on an all-inclusive rate, not to exceed a maximum Plan payment of $125. You pay 50% of eligible charges, plus all costs after the Plan maximum benefit has been paid, whether a Plan or non-Plan provider is used.

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, and is not intended to be for the treatment of bruxism, for the prevention of injuries of the teeth or occlusion, or is related to other treatment of the occlusion; the benefit is limited to one treatment episode per lifetime; and the member must be 15 years of age and above.

Section 5. Benefits *(continued)*

Accidental injury benefit

Restorative services necessary to repair (but not replace) natural teeth is covered. The need for these services must result from an accidental injury. **You pay** nothing if a Plan provider is used; a 30% copay of eligible charges plus balance of actual charges for non-Plan providers.

What is 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

Vision Care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, an annual vision exam and eye refraction (to provide a written lens prescription for eyeglasses) may be obtained. **If you use Plan optometrists - You pay** no more than $7. If you use other Plan providers - You pay 20% of eligible charges. **If you use non-Plan providers - You pay** any difference between the Plan's payment and the actual charges, plus a 30% copay of eligible charges for the eye refraction.

What is not covered

- Corrective eyeglasses or contact lenses, including the fitting of the lenses

Cardiac rehabilitation

What is covered

Cardiac rehabilitation programs are covered at 50% of eligible charges, not to exceed a maximum Plan payment of $300 per program. **You pay** 50% of eligible charges, plus all costs after the Plan maximum benefit has been paid, whether a Plan or non-Plan provider is used. Members must be referred by their doctor for cardiac rehabilitation within three months after coronary bypass surgery or diagnosis of acute myocardial infarction, angina pectoris, or coronary disease. There is a lifetime maximum of two complete programs.

Each program must consist 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.

Major medical benefits

In addition to benefits described elsewhere in this brochure, Major medical benefits are paid for the services and supplies listed below. Each person must meet the $250 deductible before he/she can receive reimbursement under Major medical benefits. Only eligible charges for services and supplies that are listed below and not covered by other Plan benefits count toward the deductible. Once the deductible is met, the Plan will add the Major medical benefit payment to benefits otherwise payable to cover the major portion of most allowable expenses. (**See page 4 for additional information.)** **If you use Plan providers - You pay** a 20% copay of eligible charges under Major medical benefits, after the $250 deductible is met. **If you use non- Plan providers - You pay** any difference between the Plan's payment and the actual charges, plus a 30% copay of eligible charges under Major medical benefits, after the $250 deductible is met. After you have paid $2,500 in Major medical eligible charges during a calendar year, **you pay** nothing for Major medical copayments for the rest of that calendar year.

What is covered

- Doctor's visits, surgery and anesthesiology.
- Hospital expenses
- Laboratory tests, audiograms, X-rays, allergy testing, radiotherapy and chemotherapy.
- Blood and blood products, including cost of administration and blood bank service charges. Any additional charges for autologous blood (reserved for a beneficiary who donated the blood) are excluded as a benefit.

Section 5. Benefits *(continued)*

What is covered *(continued)*

- Short-term physical and speech therapy when rendered by a registered/certified physical or speech therapist, and ordered by a doctor in an individualized treatment plan for restoration of a function impaired by illness or injury. Services of an occupational therapist are covered as physical therapy if the service is also performed by a physical therapist. Long-term maintenance therapy programs are not covered.
- Outpatient services and supplies for the injection or intravenous administration of either medication or nutrient solutions required for primary diet.
- Prosthetic devices, such as artificial limbs and lenses following cataract removal; orthopedic devices, such as braces; breast prostheses, surgical bras, and replacements; rental or purchase of durable medical equipment, such as wheelchairs and hospital beds.
- Air ambulance service limited to inter-island or intra-island transportation within the state of Hawaii, from place where injury occurred or illness first required care, to nearest facility equipped to render proper care.
- Hospitalization for dental surgery as a result of accidental injury or because of medical condition that makes hospitalization necessary.
- Inpatient psychiatric care to a lifetime non-renewable maximum of $10,000 as a Major medical benefit, in addition to the benefits shown on pages 13 - 14.
- Hearing aids (one device per ear every 5 years).
- Internally implanted time-release contraceptive drugs, one every five calendar years; contraceptive drugs injected periodically, 4 injections per calendar year; intrauterine devices, one per calendar year. For other related services such as laboratory test and family planning services, see appropriate sections under “Basic Benefits”. For oral contraceptives and diaphragms, see the “Prescription Drug Benefits” section.

What is not covered

- No payment will be made under this Major Medical Section for immunizations, surgical services, skilled nursing facility services, home health care, out-of-hospital psychiatric care, an illness or injury resulting from a major disaster, or routine or preventive services (except for screening mammograms).

Non FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, out of pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims procedures.

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 948-6373 for more information.

Long-term care

Can you imagine being faced with bills of $40,000, $50,000, or $80,000 a year for long-term care? That's why BSH Life, a subsidiary of HMSA, is pleased to introduce a long-term care protection plan designed specifically for Hawaii residents. Now you can have coverage that puts you in control of your future and protects you and your loved ones from the unexpected.

Our plan offers a variety of long-term care services to meet your diverse needs, including:

- Personal Care
- Home Health Care
- Adult Day Care
- Assisted Living Facility Care
- Adult Residential Care Homes (ARCH)
- Nursing Home Care

BSH Life's Long-Term Care Plan is available to all Hawaii residents between the ages of 20 to 84.

Please Call 1-888-820-4672 for more information.

Expanded Prescription Drug Benefit:

Special Notice: Spacers for inhaled drugs are not a benefit of this Plan. However, HMSA has arranged with specific drug manufacturers to provide these items to members, at special member rates, when they are purchased from a Plan pharmacy. Any charges for these services do not count toward your deductibles, out-of-pocket maximum copay charges, etc.

Benefits on this page are not part of the FEHB contract

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 Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and 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;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you need more information, contact us for our third party liability procedures.

Section 7. Limitations – Rules that affect your benefits *(continued)*

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. 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 determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 808/948-6499, or write to 818 Keeaumoku Street, Honolulu, HI 96814. You may also contact us by fax at 808/948-5567, or visit our website at http://www.hmsa.com.

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

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 January 1.

What happens when I 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, which is described later in this section.

Section 8. FEHB FACTS *(continued)*

What types of coverage are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in another FEHB plan.

Are my medical and claims records 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,
- 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

Section 8. FEHB FACTS *(continued)*

What is TCC?

Temporary Continuation of Coverage (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 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.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

Section 8. FEHB FACTS *(continued)*

How can I get 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. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

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

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 or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for HMSA Plan - 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS**.

	Benefits	Plan pays/provides	Page
Inpatient Care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing for Plan hospital services and a 20% copay of eligible charges for inpatient visits by Plan providers.	11-12
	Extended care	All necessary services up to 100 days per year. You pay nothing for services of Plan providers	12
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. You pay nothing for Plan hospital services and a 20% copay of eligible charges for inpatient visits by Plan providers	14
	Substance abuse	Medical complications and acute detoxification covered under hospital benefits. Lifetime maximum of two 30-day substance abuse rehabilitation programs (includes inpatient residential and outpatient care); you pay a 20% copay of eligible charges for services of Plan providers.	15
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care, preventive care, including well-child care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay nothing for surgery (cutting) and well-child care immunizations; a 20% copay of eligible charges for non-cutting surgery, medical services and anesthesiology; a 50% copay for laboratory tests and X-rays	9-11
	Home health care	Up to 150 visits per calendar year by nurses and health aides. You pay a 20% copay of eligible charges for services of Plan approved providers.	10
	Mental conditions	Up to 24 outpatient visits per year; you pay a 20% copay of eligible charges for diagnosis and treatment, and a 50% copay of eligible charges for psychological testing, for services of Plan providers	13-14
	Substance abuse	Lifetime maximum of two substance abuse rehabilitation programs (includes inpatient residential and outpatient care); up to 30 days initial rehabilitative care and up to 30 hours after-care per program; you pay a 20% copay of eligible charges for services of Plan providers.	15
Emergency care		Eligible charges for services and supplies required because of a medical emergency, to the extent these services would have been covered if received from Plan providers. You pay applicable copays as if routine services were rendered by Plan providers, regardless of whether a Plan or non-Plan provider is used, and any charges for services that are not covered benefits of this Plan	13
Prescription drugs		Drugs prescribed by a doctor and obtained at a Plan pharmacy. You pay a $5 copay per prescription unit or refill for generic drugs; a $10 copay for preferred name brand drugs; a 50% copay of eligible charges but not less than $10 copay for non-preferred name brand drugs.	15-17
Dental care		Accidental injury benefit; preventive dental care, and other services. You pay copayments for most services	17-18
Vision care		One refraction annually. You pay 20% copay of eligible charges for Plan providers per refraction; if you use Plan optometrists, you pay no more than $7 per refraction	18
Out-of-pocket maximum		Copayments are required for some benefits; however, the Plan has set a maximum of $2,500 per member per calendar year for total Major medical copayments you must pay for services covered by the Plan. This copayment maximum only applies to services covered under Major medical benefits.	18-19

2000 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 most career U. S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
All of Hawaii									
Self Only	**871**	**$68.44**	**$22.81**	**$148.28**	**$49.43**	**$80.98**	**$10.27**	**$80.98**	**$10.27**
Self and Family	**872**	**$152.33**	**$50.77**	**$330.04**	**$110.01**	**$180.25**	**$22.85**	**$180.25**	**$22.85**