HMSA

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

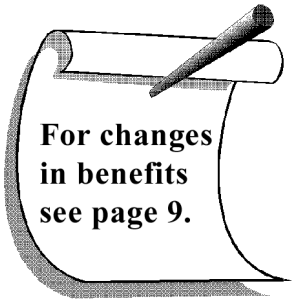
HMSA Plan

http://www.hmsa.com

2003

A Health Maintenance Organization with a point of service product

Serving: All of Hawaii



Enrollment in this Plan is limited. You must live in our Geographic service area to enroll. See page 8 for requirements.

This Plan has "Full" Accreditation from NCQA. See the 2003 Guide for more information on accreditation.

Enrollment codes for this Plan:

871 Self Only
872 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees Health Benefits Program

RI 73-010

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Table of Contents *(continued)*

Table of Contents *(continued)*

Introduction

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. The address for HMSA administrative offices is:

Hawaii Medical Service Association
818 Keeaumoku Street
Honolulu, Hawaii 96814

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in 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, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means HMSA.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

Continued on next page

Stop Health Care Fraud! *(continued)*

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider 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

- Do not maintain as a family member on your policy:
  - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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 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.

We also have Point-of-Service (POS) benefits

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

We have over 3,500 Plan doctors, dentists, and other health care providers in Hawaii who agree to keep their charges for covered services below our 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 the Blue Cross and/or Blue Shield Plan in the area where you need services 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 us.

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, withholds, any other contingent payment arrangements, and other non-claims transactions 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.

Continued on next page

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.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. 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 64th 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 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 2003

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 12% for Self Only or 12% for Self and Family.
- Certain kinds of drugs listed in our Select Prescription Drug Formulary require precertification. A list of these drugs has been distributed to Plan providers.
- Fecal Occult Blood tests provided by HealthPass will be available from age 50, one per calendar year.
- The preventive care benefit screenings have been expanded to include sigmoidoscopy, colonoscopy, and double contrast barium enema for certain age groups.
- We cover diagnostic laboratory tests, X-rays, pathology services, and pre-surgical testing for outpatient medical services not associated with outpatient surgery. Your coinsurance for Plan providers is 20% of eligible charges. For Non-plan providers, your coinsurance is 30% of eligible charges and any difference between our payment and the actual charge.
- Assisted Reproductive Technology benefits will be limited to in vitro fertilization in accord with Hawaii State Law.
- For mental health and substance abuse services, you are no longer required to obtain precertification. There will be a required registration process for a care management program administered by Behavioral Care Connection that your Plan provider will be responsible for. Non-plan providers will not be required to register you.

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 or write to us at P.O. Box 860, Honolulu, HI 96808. You may also request replacement cards through our website at www.hmsa.com.

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 to get covered care

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.

Continued on next page

- **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 our Plan, talk to 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.

Continued on next page

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.

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.

We call this review and approval process precertification. Precertification is a special approval process to ensure that certain medical treatments, procedures, place of treatment or devices meet medical necessity 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
- Certain kinds of drugs listed in our Select Prescription Drug Formulary (see section 5(f) and 5(g) for more information
- Growth hormone therapy
- In vitro fertilization
- Integrated Case Management
- Magnetic Resonance Angiography (MRA)
- Organ and tissue transplants listed in Section 5(b)
- Physical Therapy Visits
  - You must receive approval from HMSA for any outpatient visits beyond the first 10 visits.
- Positron Emission Tomography (PET)
- Routine care associated with clinical trials listed in Section 5(g) of this brochure
- Stereo radiosurgery utilizing particle beams
- Surgeries, therapies or procedures employing new technology
- Surgery to correct morbid obesity
- Transplant evaluations, except for cornea and kidney transplant evaluations
- Wound VAC (Vacuum-assisted closure of chronic wound)

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, facility, pharmacy, etc., when you receive services.

Example: When you use 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 catastrophic protection 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, coinsurance/copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay coinsurance/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 catastrophic protection out-of-pocket maximum.

Be sure to keep accurate records of your coinsurance/copayment. We will also keep records of your coinsurance/copayment and track your catastrophic protection out-of-pocket maximum.

Section 5. Benefits – OVERVIEW

(See page 9 for how our benefits changed this year and page 68 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 claim forms, claims filing advice, or more information about our benefits, contact us at 808/948-6499 or at our website at www.hmsa.com.

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 • 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 • Pre-surgical testing • 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, limited to: • Total Blood Cholesterol – one per calendar year • Colorectal Cancer Screening, including – Fecal occult blood test – one per calendar year, age 50 and above – Sigmoidoscopy, screening – every 3-5 years starting at age 50	Nothing, if you receive services as a HealthPass screening

Preventive care, adult - continued on next page

Preventive care, adult *(continued)*	**You pay**
• Routine 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 – one per calendar year • TB Tine Test – one per calendar year • Urinalysis – one per calendar year • Glucose screening – one every 3 years, age 45 and above • Fasting lipoprotein profile (Total cholesterol, LDL, HDL, and triglycerides), once every 5 years • Fecal Occult Blood – one every calendar year, age 50 and above • Sigmoidoscopy screening – every 5 years, age 50 and above • Colonoscopy – once every 10 years, age 50 and above • Double contrast barium enema (DCBE) – once every 5-10 years, age 50 and above	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 • 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

Preventive care, adult - continued on next page

Preventive care, adult *(continued)*	**You pay**
• HealthPass You and any dependent defined below are eligible for one routine physical exam or HealthPass exam listed in this section per calendar year. 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. For members age 14 to 17, HealthPass for Teens offers an interactive computer program, screenings and individual counseling. You are eligible to receive a health risk assessment through HealthPass during the period from 30 days before or after the subscriber's birthday. For more information, contact the Customer Service Department at 808/948-6499. 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: • Height 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.	Plan Provider Nothing Non-Plan Provider Not a benefit

Preventive care, children	You pay
• 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
• Ear exams through age 17 to determine the need for hearing correction. • Examinations through age 12 according to the following schedule: – Birth up to 24 months: eight 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 (Hemoglobin or Hematocrit) • 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 page 15, Professional Service of Physicians, and page 30, Hospital Benefit, 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.	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 - continued on next page

Maternity care *(continued)*	**You Pay**
• 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 cover newborn circumcision under the surgical procedures benefits. See Section 5(b) *Surgery benefits*. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) *Hospital benefits* and Section 5(b) *Surgery benefits.* • You have no coinsurance when you use a birthing center (for labor only) that is a Plan provider	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	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5(b))	Plan Providers Nothing Non-Plan Providers 30% of eligible charges and any difference between our payment and the actual charge
• Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms/Cervical Caps Note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. We cover oral contraceptives under the prescription drug benefits. See Section 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	You Pay
Diagnosis and treatment of infertility, limited to: • 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, gamete GIFT, and zygote ZIFT* • *Services and supplies related to excluded ART procedures except in vitro fertilization* • *Cost of donor sperm* • *Fertility drugs* • *Cost of donor egg*	*All charges*
Allergy care	
• Testing (one per calendar year) 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	You Pay
• 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 28. • 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. • Medical foods and low-protein modified food products for the treatment of inborn errors of metabolism in accord with Hawaii Law and Plan guidelines • Growth hormone therapy (GHT) Note: We will only cover GHT when we precertify the treatment. Call 808/948-6499 for more information on precertification. We will ask you to submit information that establishes that GHT is medically necessary. If you do not ask or if we determine GHT is not medically necessary, we will not cover 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
Physical and occupational therapies	
• Short term therapy for the services of each of the following: – Qualified physical therapists – Occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function 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
• 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*

Speech therapy	You Pay
25 visits 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
Hearing services (testing, treatment, and supplies)	
• Diagnostic hearing test • Hearing Aids – one every five years Note: Hearing testing for children through age 17 (see Section 5(a) *Preventive care, children.*)	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 Note: For eye exams for children see Section 5(a) *Preventive care, children.*	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
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	You Pay
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 • Internal prosthetic devices such as artificial joints; pacemakers cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Section 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
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 device* • *Bionic services and devices*	*All charges*

Durable medical equipment (DME)	You Pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your provider, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors • 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* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	
No Benefit	*All charges*
Alternative treatments	
No Benefit	*All charges*
Not covered: • *Biofeedback and other forms of self-care or self-help training and any related diagnostic testing*	*All charges*

Educational classes and programs	You Pay
• Smoking Cessation It is a series of four workshops for smokers who are ready to quit smoking. The copayment is waived for pregnant women participating in HMSA's The Good Pregnancy – He Hapai Pono program, and members who have asthma, diabetes or cardiovascular disease. For more information call 808/948-6499.	$25 per series
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. These programs allow you to take a much larger and more responsible role in controlling your illness. There are currently three disease management programs offered: Asthma Care Connection, Diabetes Care Connection, and Cardiac Care Connection. To find out if these programs are right for you, talk with your primary care physician.	Nothing
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. To register call 888/400-2776 or visit the web site at www.hmsa.com/myhealth.	Nothing
Not covered except as offered through HMSA programs: • *Weight reduction programs* • *Smoking Cessation programs* • *Nutrition Counseling*	*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 FOR 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, such as: • Operative Procedures • 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 procedures • Biopsy procedures • 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 Section 5(a) Orthopedic 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

Surgical procedures - continued on next page

Surgical Procedures *(continued)*	**You pay**
Cutting and Non-cutting surgical procedures (continued) • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns • Newborn Circumcision	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: • *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. • 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	Plan Providers (cutting) Nothing (non-cutting) 20% of eligible charges Non-Plan Providers (cutting and non-cutting) 30% of eligible charges and any difference between our payment and the actual charge
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 or 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 • 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 • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas Note: We cover related medical and hospital expenses of the donor when we cover the recipient	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

Organ/tissue transplants- continued on next page

Organ/tissue transplants *(continued)*	**You pay**
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 Transplant evaluations: • Must receive our approval (with the exception of corneal and kidney transplant evaluations) • Means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations, which a hospital or facility uses in evaluating a potential transplant candidate Transplants (with the exception of corneal and kidney) must: • Receive our approval. Without our approval for specific transplants, benefits are not available. • Be received from a facility that: – is under contract with us for that type of transplant; and – accepts you as a transplant candidate. – This restriction does not apply to intestinal transplants. ***Please refer to the precertification information shown in Section 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
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 Sections 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • Semiprivate accommodations • General nursing care • 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 semiprivate room rate) Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge (based on semiprivate 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
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

Inpatient hospital - continued on next page

Inpatient hospital *(continued)*	**You pay**
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	
Outpatient medical services provided by a hospital or ambulatory surgical center, such as: • Diagnostic laboratory tests, X-rays, and pathology services • Pre-surgical testing is covered but only when you meet our criteria	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Services associated with outpatient surgery and provided by a hospital or ambulatory surgical center, such as: • 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 • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics • Anesthesia services (Section 5(b)) 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 semiprivate 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 semiprivate 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 • 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	
Ground 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 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

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 our 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 • Emergency care in an emergency room	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 • Emergency care in an emergency room	Plan Provider 20% of eligible charges Non-Plan Provider 20% of eligible charges
Not covered: Elective care or non-emergency 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 Section 5(c) 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

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:

- 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.
- 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.
- Behavioral Care Connection, a management program, will develop a treatment plan and provide care management in conjunction with your Plan provider.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a provider and contained in a treatment plan. 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.	Your cost sharing responsibilities are no greater than for other illnesses or conditions
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, clinical social workers, or advanced practice registered nurses (APRN) • Medication management • Diagnostic tests	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• Inpatient services provided by a hospital or other facility • Inpatient services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization	Plan Provider Nothing 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*

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 page 38.
- Your provider must obtain precertification for certain drugs.
- 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, 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 consists of:
  - **Generic Drugs**. 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 Drugs**. A Brand Name Drug, contraceptive, supply, or insulin that is listed on the HMSA Select Prescription Drug Formulary as Preferred.
  - **Other Brand Drugs.** A Brand Name Drug, contraceptive, supply, or insulin that is not classified as Preferred on the HMSA Select Prescription Drug Formulary.

  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. The list of name brand drugs includes a preferred list of drugs that have been selected to meet patients' clinical and financial needs. Discuss your options with your physician when you need a new prescription.
- **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.
  - 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.
  - 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 full eligible charge of the brand drug. You will then be reimbursed for the value of the generic drug. The total cost to you will be the generic copayment plus the difference in cost between the name brand drug and the generic.
  - Mail order prescriptions are 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.
  - Mail order prescription drug copayment amounts are for a maximum 90-day supply or a fraction thereof.
  - Mail order prescription drugs prescribed by a doctor and obtained through a Plan mail order pharmacy will be dispensed with a maximum limit of a 90-day supply or fraction thereof.

Continued on next page

Section 5 (f). Prescription drug benefits *(continued)*

- **Why use generic drugs?** Generic drugs on the formulary are therapeutically equivalent to the brand name drugs and are less expensive. You may reduce your out-of-pocket costs by choosing to use a generic drug.
- **When you have to file a claim.** Refer to Section 7 *"Filing a claim for covered services"*.
- **Drugs Benefit Management Program.** We have arranged with Plan Pharmacies to assist in managing the usage of certain kinds of drugs, including drugs listed in the HMSA Select Prescription Drug Formulary.

  We have identified certain kinds of drugs listed in the HMSA Select Prescription Drug Formulary that require precertification. The criteria for precertification are that:

  - The drug is being used as part of a treatment plan,
  - There are no equally effective drug substitutes, and
  - The drug meets the "medical necessity" criteria and other criteria as established by us.

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

  Plan Pharmacists will 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.

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 those listed as *Not covered* • Injectable drugs limited to: – Imitrex – Epinephrine emergency kit – Glucagon Note: Self administered injectable medication and intravenous fluids and medication for home use are covered under your medical coverage. See Section 5(a) *Treatment therapies.* • 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 doses every 30 days – Up to three months dispensed at a time (Multiple copayments will apply) – 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 contraceptive	**Generic:** Plan Pharmacy - $5 copayment Non-Plan Pharmacy - $5 plus 20% of remaining eligible charge and any difference between the actual and eligible charge **Preferred Brand:** Plan Pharmacy - $15 copayment Non-Plan Pharmacy - $15 plus 20% of remaining eligible charge and any difference between the actual and eligible charge **Other Brand:** Plan Pharmacy - 50% of eligible charge not less than $15 Non-Plan Pharmacy - 50% of eligible charge not less than $15 plus any difference between the actual and eligible charge

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You Pay**
• Internally implanted time-release contraceptive drugs • Contraceptive drugs injected periodically and intrauterine devices	Plan Provider - 20% of eligible charges Non-Plan Provider - 30% of eligible charges and any difference between our payment and the actual charge
• Diaphragms	**Preferred Diaphragms** Plan Pharmacy - $10 copayment Non-Plan Pharmacy - $10 copayment plus 20% of remaining eligible charge and any difference between the actual and eligible charge **Other Brand Diaphragms** Plan Pharmacy - 50% of eligible charge not less than $15 Non-Plan Pharmacy - 50% of eligible charge not less than $15 plus any difference between the actual and eligible charge
• 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 20% of eligible charge and any difference between the actual and eligible charge **Other Brand Insulin:** Plan Pharmacy - $15 copayment Non-Plan Pharmacy - $15 copayment plus 20% of eligible charge and any 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 Diabetic Supplies:** Plan Pharmacy - Nothing Non-Plan Pharmacy - Any difference between the actual and eligible charge **Other Brand Diabetic Supplies:** Plan Pharmacy - $15 copayment Non-Plan Pharmacy - $15 copayment plus any difference between the actual and eligible charge

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You pay**
Mail Order Drug Program:	
• Generic Drugs	$10 Copayment
• Preferred Brand Name Drugs	$35 Copayment
• Other Brand Name Drugs	$60 Copayment
• Preferred Brand Name Insulin	$10 Copayment
• Other Brand Insulin	$35 Copayment
• Preferred Diabetic Supplies	Nothing
• Other Brand Name Diabetic Supplies	$35 Copayment
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Medical supplies such as dressings and antiseptics* • *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	We have arranged with Plan Pharmacies to assist in managing the usage of certain kinds of drugs, including drugs listed in the HMSA Select Prescription Drug Formulary. We have identified certain kinds of drugs listed in the HMSA Select Prescription Drug Formulary that require precertification. The criteria for precertification are that: • The drug is being used as part of a treatment plan, • There are no equally effective drug substitutes, and • The drug meets the "medical necessity" criteria and other criteria as established by us. A list of these drugs in the HMSA Select Prescription Drug Formulary has been distributed to all Participating Providers. Plan Pharmacists will 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.
Routine Care Associated With Clinical Trials	Routine care associated with clinical trials is covered in accord with criteria established by us. These services require precertification. Please refer to the precertification information shown in Section 3.

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. See Section 5 (c) for inpatient hospital benefits. 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 and single, stand alone facial surfaces of bicuspids only, amalgam and 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

Point-of-service (POS) 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. 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 and not covered

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

Please refer to the general exclusions listed in Section 6 for additional information.

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 coinsurance/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 coinsurance/copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay coinsurance/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.

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Be sure to keep accurate records of your coinsurance/copayment. We will also keep records of your coinsurance/copayment and track your out-of-pocket maximum.

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 semiprivate room rate). See Section 5(c). 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 5(a). 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. Your coinsurance for services from a non-Plan provider is 20% of the eligible charges. See Section 5(d).

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.

CancerCare 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 808/538-8900 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, except routine care associated with clinical trials. Please refer to the information shown in Section 3 (precertification) and Section 5(g);
- 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;
- Professional services or supplies when furnished to you by a provider who is within your immediate family (i.e., parent, child, or spouse);
- 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; or
- Services, drugs, or supplies you receive without charge while in active military service.

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 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 services you receive outside of the Plan's service area -- submit it on one of the forms indicated above or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number
- Name and address of the 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)
- 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, Attn: Appeals Coordinator, 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 2, 1900 E Street, NW, Washington, DC 20415-3620. 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 more than one claim, you must clearly identify which documents apply to which claim.

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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 include 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.

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 or from the year in which you were denied precertification or prior approval. 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 may call OPM's Health Benefits Contracts Division 2 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 or a covered family member have coverage 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 pay after the primary plan pays. We will pay what is left, up to our eligible charge.

The benefits payable under this plan, when combined with benefits paid under your other coverage, will not exceed the lesser of:

- 100 percent of eligible charge, or
- the amount payable by your other coverage plus any deductible and copayment you would owe if the other coverage were your only coverage.

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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance (Someone who was a federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800/MEDICARE (800/633-4227) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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 show how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

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- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Original Medicare does not cover everything, like hearing aids.

When you are enrolled in Original Medicare along with this Plan, 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 for services or supplies that are not covered by Original Medicare (for example, hearing aids).

Claims process when you have the Original Medicare Plan: You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- 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 then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 808/948-6499.
- If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

We do not waive any costs if the Original Medicare is your primary payer.

Facilities or Providers Not Eligible or Entitled to Medicare Payment. When services are rendered at a facility or by a provider that is not eligible or entitled to receive reimbursement from Medicare, and Medicare is allowed by law to be the primary payer, we will limit payment to an amount that supplements the benefits that would have been payable by Medicare had the facility or provider been eligible or entitled to receive such payments, regardless of whether or not Medicare benefits are paid.

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The following chart illustrates whether the Original Medicare Plan 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, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

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- **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 provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 800/MEDICARE (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. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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's service area.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) 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 under the program.

Continued on next page

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness 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 care.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these State programs, eliminating your FEHB 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 under the State program.

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.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

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. Custodial care lasting 90 days or more is sometimes known as long term care.

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.

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.

The maximum allowable fee is the maximum dollar amount paid for a covered service, supply, or treatment. We use the following method to determine the maximum allowable fee:

- For most services, supplies, or procedures, we consider:
  - increases in the cost of medical and non-medical services in Hawaii over the previous year;
  - the relative difficulty of the services compared to other services;
  - changes in technology; and
  - payment for the service under federal, state, and other private insurance programs.
- For some facility-billed services (not to include practitioner-billed facility services), we use a per case, per treatment, or per day fee (per diem) rather than an itemized amount (fee for service). For Non-Plan hospitals, our maximum allowable fee for all-inclusive daily rates established by the hospital will never exceed more than if the hospital had charged separately for services.

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.

Continued on next page

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.

Medical necessity

Care, treatment, service, or supply, which is all of the following:

- Appropriate and necessary for the symptoms, diagnosis, and direct care or treatment of your illness or injury;
- Consistent with professionally recognized standards of health care in the United States, and given at the right time and in the right setting;
- Not primarily for your convenience or the convenience of your provider;
- The most appropriate supply or level of service that can safely be provided; and
- Consistent with our medical guidelines and policies.

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 your FEHB coverage. These materials tell you:

- 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
- 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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- if you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact you employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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.

Continued on next page

- **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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). 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. You can also download the guide from OPM's website, www.opm.gov/insure.

- **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 Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

  Enrolling in TCC. 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. It explains what you have to do to enroll.

- **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.

Continued on next page

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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. For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the HMSA Plan – 2003

- **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 Plan Providers	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	20% of eligible charges	15
Services provided by a hospital:		
• Inpatient	Nothing	30
• Outpatient	20% of eligible charges	31
Emergency benefits:		
• In-area	20% of eligible charges	33
• Out-of-area	20% of eligible charges	33
Mental health and substance abuse treatment	Regular benefits	35
Prescription drugs	$5 copayment for generic drugs $15 copayment for preferred name brand drugs 50% copayment of eligible charges not less than $15 copayment for other brand name drugs	36
Dental Care	Nothing for preventive dental care	42
Vision Care	$7 copayment for optometrist 20% of eligible charges for other Plan providers	22
Point of Service benefits – Yes		44
Protection against catastrophic costs (your catastrophic protection 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	13

2003 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 a special FEHB guide is published 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 who are not career postal employees. 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	$90.35	$30.12	$195.77	$65.25	$106.92	$13.55
Self and Family	872	$201.13	$67.04	$435.78	$145.26	$238.00	$30.17